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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Hain,
Petitioner,

vs. No. 11 WC 08828

20IWCC0086

Northshore University Health System,
(Glenbrook Hospital),
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed March 13, 2018, is hereby affirmed and adopted.

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

20 I W CC0086

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 3 - 2020

mp/wj
01/23/20
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAIN, JOSEPH
Employee/Petitioner

Case# **11WC008828**

NORTHSHORE UNIVERSITY HEALTH SYSTEM (GLENBROOK HOSPITAL)
Employer/Respondent

20IWCC0086

On 3/13/2018, 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 1.85% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID MENCHETTI
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph Hain,
Employee/Petitioner

Case # **11WC008828**

v.

Consolidated cases: **NA**

NorthShore University Health System (Glenbrook Hospital),
Employer/Respondent

20IWCC0086

An *Application for Adjustment 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 22, 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 **05/17/2009**, 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 $**83,200.00**; the average weekly wage was $**1,600.00**.

On the date of accident, Petitioner was **63** 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 $**13,071.78** for TTD, $**3,305.40** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**16,377.18**. The parties stipulated that all TTD and TPD has been paid and that there is no overpayment or underpayment of TTD or TPD.

Respondent is entitled to a credit as stipulated by the parties under Section 8(j) of the Act. The parties stipulated that all medical bills have been paid or paid under Section 8(j). Neither party claims any credit for overpayment or underpayment of medical bills. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ORDER:

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week (maximum rate) for 30 weeks, because the injuries sustained caused the 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Robert M. Harris

Signature of Arbitrator

March 13, 2018
Date

MAR 13 2018

Joseph Hain v. NorthShore University Health System
11WC008828
Attachment to Arbitration Decision
Arbitrator's Finding of Fact and Conclusions of Law

On May 17, 2009, JOSEPH HAIN (Petitioner) was working for Respondent (NORTHSHORE UNIVERSITY HEALTH SYSTEM) as a registered nurse at Glenbrook Hospital working in the post-surgical recovery unit. Petitioner described his work duties as monitoring patients, transporting patients and assisting doctors in the care of patients. Petitioner described some of these duties involved as lifting patients and transferring patients, standing and walking.

Before May 17, 2009, Petitioner had never noticed anything unusual about his back, had never received any medical treatment or pain medicines for his back and was working full-time in his full-duty capacity as a nurse.

The parties stipulated that on May 17, 2009 Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. While lifting a heavy patient on that day, Petitioner noticed a twinge in his back and as the day progressed Petitioner noticed that the pain continued to get worse and eventually began radiating into his left leg.

On that same day of May 17, 2009, Petitioner was seen in the emergency department at Glenbrook Hospital. PX 1, pg. 140-145. Petitioner was examined by a Physician Assistant. Petitioner presented complaining of low back injury from lifting a patient that same day. PX 1, pg. 142. Hospital notes indicate, "Radiates down left leg." "Patient states he felt a twinge with the initial injury." History notes indicate: "This patient presents with a complaint of left buttocks pain with radiation into his left leg. Denies back pain. Does not want any pain medication at this time. The patient does not have a history of back problems." Neuro exam was normal. Flexion and extension of Petitioner's lumbar spine were limited due to pain. PX 1, pg. 143. Assessment was sciatica and Petitioner was recommended Norco and to follow up with employee health. PX 1, pg. 144-144.

On July 1, 2009, Petitioner was seen by Dr. Ivan Ciric, a neurosurgeon. PX 3, pg. 60. Dr. Ciric noted the accidental injuries of May 17, 2009 and noted that Petitioner was given a Medrol Dosepak with no improvement. PX 3, pg. 62. Dr. Ciric reported that Petitioner was given Prednisone from which there was some improvement, but that the improvement was not

sustained. PX 3, pg. 63. Dr. Ciric reviewed an MRI of May 24, 2009 and according to Dr. Ciric the MRI showed grade 1 degenerative spondylolisthesis at L4-L5 and diffuse, scattered degenerative changes with minimal broad-based disc bulges at several levels. PX 3, pg. 63. Dr. Ciric reported that Petitioner had foraminal stenosis at L4-L5 on the left side aggravated by his work-related injury and that there was foraminal stenosis as a consequence of the L4-L5 grade 1 spondylolisthesis that probably was also aggravated by the work-related injury. PX 3, pg. 63. Dr. Ciric referred Petitioner to Dr. Thomas Hudgins in the Physical Medicine/Rehabilitation Division at NorthShore for further care including a series of lumbar epidural steroid injections. PX 3, pg. 61.

On July 9, 2009 Petitioner presented for a visit with Dr. Hudgins for leg pain. Petitioner's pain score was 8. There was a referral for outpatient physical therapy. PX 2, pg. 26-27. Petitioner's diagnosis was spinal stenosis of the lumbar region. PX 3, pg. 4. Petitioner described his pain as sharp, radiating and stabbing and described difficulty standing, walking and sitting. PX 3, pg. 7-8.

On July 23, 2009, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 19 (per billing statement).

On August 10, 2009 Petitioner visited Dr. Hudgins for back pain. Petitioner's pain score was 3, the diagnosis was lumbago, and there was a referral for outpatient physical therapy. PX 2, pg. 24-25.

On August 13, 2009, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 22 (per billing statement).

On September 23, 2009 at a visit with Dr. Hudgins, The Petitioner's pain score was 2 in his buttocks and the reason for the visit was back pain and the diagnosis was lumbago. PX 2, pg. 22.

On January 26, 2010 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was lumbago. PX 3, pg. 20.

On February 26, 2010, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 26 (per billing statement).

On March 16, 2010 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was lumbago. PX 3, pg. 20.

On May 14, 2010, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 29 (per billing statement).

On June 1, 2010 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was spinal stenosis of the lumbar region. PX 3, pg. 23.

On October 18, 2010, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 29 (per billing statement).

On November 9, 2010 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was lumbago. PX 3, pg. 26.

On March 26, 2011 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was lumbago. PX 2, pg. 17.

On May 13, 2011, Petitioner underwent epidural steroid injection at Highland Park Hospital by Dr. Hudgins. PX 3, pg. 54.

On August 29, 2011, Petitioner was seen by Respondent's evaluating physician Dr. Andrew Zelby. RX 1. Dr. Zelby recounted Petitioner's history of medical treatment including the six epidural steroid injections above. RX 1, pg. 1. Petitioner continued to have pain in his low back exacerbated with prolonged sitting. RX 1, pg. 1. If Petitioner's report of no prior symptoms in his back was accurate, Dr. Zelby reported that Petitioner's work injury took a pre-existing asymptomatic degenerative condition and caused that condition to become symptomatic. RX 1, pg. 5. Dr. Zelby reported that Petitioner may continue to treat his condition periodically with epidural steroid injections. RX 1, pg. 5. Dr. Zelby opined Petitioner's ongoing complaints were no longer a result of his alleged work injury and has reached the point where Petitioner would have similar complaints regardless of Petitioner's alleged work injury. Dr. Zelby confirms Petitioner's treatment had not been excessive or unnecessary to that point and Dr. Zelby advised it would be reasonable for Petitioner to continue the course of treatment he had been undertaking. Dr. Zelby confirmed Petitioner was able to continue working within a full duty capacity. Dr. Zelby explained the nature of degenerative spondylosis and spondylolisthesis involves "episodic flareups of pain" and Petitioner "[was] reaching the point where his condition [was] becoming a manifestation of his underlying degenerative condition." Rx 1.

On September 30, 2011, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 35 (per billing statement).

On October 11, 2011 at a visit with Dr. Hudgins, the reason for the visit was back pain and the diagnosis was spinal stenosis of the lumbar region with neurogenic claudication. PX 3, pg. 29.

On February 24, 2012, Petitioner underwent transforaminal epidural injection. PX 4, pg. 13 (per billing statement).

On April 10, 2012 at a visit with Dr. Hudgins, the reason for the visit was follow up and the diagnosis was lumbago. PX 3, pg. 33. Dr. Hudgins ordered an MRI. PX 3, pg. 35.

On April 14, 2012, Petitioner underwent an infused MRI of the lumbar spine at Glenbrook Hospital. The MRI demonstrated: "Mildly progressive grade 1 degenerative anterolisthesis of L3 on L4 and L4 on L5; severe central spinal stenosis at L3/L4 and moderate biforaminal narrowing at this level; moderate central spinal stenoses at L4/L5 and moderate biforaminal narrowing; correlate clinically for possible bilateral L3, L4 and L5 radiculopathy." PX 1, pg. 35.

On May 4, 2012, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 42 (per billing statement).

On May 22, 2012 at a visit with Dr. Hudgins, the reason for the visit was follow up and the diagnosis was lumbago. PX 3, pg. 40.

On July 1, 2014 at a visit with Dr. Hudgins, the reason for the visit was follow up and the diagnosis was spinal stenosis of the lumbar region with neurogenic claudication. PX 3, pg. 44.

On September 14, 2015, Petitioner underwent epidural steroid injection by Dr. Hudgins. PX 4, pg. 62 (per billing statement).

On September 29, 2015 at a visit with Dr. Hudgins, the reason for the visit was epidural follow up and the diagnosis was degeneration of lumbar or lumbosacral intervertebral disc. PX 3, pg. 49. Pain score was 3 in the back. PX 3; pg. 53.

On May 20, 2016 and September 14, 2016, Petitioner underwent lumbar foraminal injections by Dr. Hudgins. PX 4, pg. 5 (per billing summary statement).

Petitioner claimed a period of temporary total disability (TTD) from May 18, 2009 through August 31, 2009 (15-1/7 weeks). Respondent claimed no responsibility for TTD after August 29, 2011 and claimed to have paid $13,071.78 in TTD benefits and $3305.40 in

temporary partial disability (TPD) benefits. Neither party claimed any underpayment or overpayment of TTD or TPD benefits.

Regarding Petitioner's current status, Petitioner testified he had taken a pain pill prior to testifying for the purpose of maintaining comfort. Petitioner returned to work for Respondent in his full-duty capacity as a recovery nurse after a few months and worked until about August 2013 when he was laid off. Petitioner now works as a travelling nurse a few days a month doing substantially the same duties as he did for Respondent. Petitioner testified he continued to work full duty after his release until a round of company-wide layoffs resulted in his termination. Petitioner described this as a "retirement" impliedly not by his own choosing, however, it was unrelated to the work injury. Petitioner testified since that time, he has worked for a nurse placement company, somewhat described as a "broker" where he is placed in certain jobs by a nurse staffing company. Petitioner explained these jobs usually last one or two days. Petitioner testified he has never turned down a potential placement due to pain in his low back. Petitioner testified he continues to take pain medications however has not undergone an epidural steroid injection in 2015. Petitioner testified he enjoys spending time with his grandchildren, which number a total of nine boys. He enjoys watching his high school aged grandsons play basketball however has difficulty at times with sitting during games. Petitioner testified he believes he may have had to sit out of some events because of his pain. Petitioner testified his pain medication, Vicodin, which he takes on a regimen, allows him to cope with the pain. Petitioner appeared to be in little to no distress during the hearing on February 22, 2018 and was advised he could make himself comfortable if he felt it necessary. Petitioner now notices pain in his back when he drives or sits for a long period of time. Petitioner notices pain in his back when he lifts and when he walks and stands for prolonged periods.

The parties agreed that all medical bills had been paid under Section 8(a) or Section 8(j).

CONCLUSIONS OF LAW

With respect to disputed Issue (F), is Petitioner's current condition of ill-being causally related to his injury, the Arbitrator finds and concludes as follows:

The Arbitrator concludes that the Petitioner's current condition of ill-being (indicated below) is causally connected to the stipulated accidental injuries sustained on May 17, 2009.

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).

Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

On July 1, 2009, Petitioner was seen by Dr. Ivan Ciric, a neurosurgeon. PX 3, pg. 60-61. Dr. Ciric opined after his physical examination and after based on his review of the May 24, 2009 lumbar spine MRI, that Petitioner had pre-existing degenerative lumbar spine conditions. Dr. Ciric then opined in his letter dated July 1, 2009, "In summary, it is my impression that Mr. Hain has foraminal stenosis at L4-5 on the left side, **aggravated by his work-related injury**. The foraminal stenosis is a consequence of the L4-L5 grade 1 spondylolisthesis that **probably was also aggravated by the work-related injury.**" PX 3, pg. 61. The Arbitrator places significant weight and credibility on these opinions from Petitioner's treating physician Dr. Ciric, whose opinions are sufficient to prove causation.

The Arbitrator also places significant weight and reliance on the opinions of Respondent's examining expert Dr. Zelby who examined Petitioner on August 29, 2011. Dr. Zelby opined (assuming Petitioner's "report of no prior symptoms in the back is accurate") Petitioner's **"work injury took a pre-existing but asymptomatic degenerative condition and caused that condition to become symptomatic."** (Resp. Ex. No. 1, p. 5). That is clear statement supporting causation. Dr. Zelby further indicated that **"...it appears that his degenerative condition became symptomatic as a consequence of his work injury..."**, another clear statement supporting causation. (Resp. Ex. No. 1, p. 5). These are the specific opinions from Dr. Zelby which the Arbitrator adopts.

The "chain of events" legal theory also supports a finding of causation.

It is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000).

A chain of events that demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability is sufficient evidence to prove a causal nexus between the accident and the employee's injury and an accident need only be a cause of the condition of ill being. *Schroeder v. IL Workers' Comp. Comm'n.*, 2017 IL App (4th) 160192WC, pars. 19 & 28.

In this case, the evidence indicates that Petitioner had underlying pre-existing degenerative lumbar spine conditions present before the accident, but which conditions were **asymptomatic** and did not prevent Petitioner from performing his usual job duties in an unrestricted manner (e.g., see Resp. Ex. No. 1, Dr. Zelby's report, page 5). Petitioner had no treatment to his low back prior to the accident. Petitioner took no pain medication for his low back prior to the accident. Therefore, Petitioner was in a condition of relative "good health" relating to his back prior to May 17, 2009 as is evidenced by Petitioner's credible testimony, his ability to work full-time and full-duty as a recovery nurse prior to that date and the total absence of any medical evidence to the contrary.

The parties stipulated that Petitioner sustained accidental injuries to his back on May 17, 2009. The medical records demonstrate that Petitioner's injury resulted in medical treatment and subsequent disability. Dr. Ciric, the treating physician, reported that Petitioner's accidental injuries aggravated his condition. Dr. Zelby, Respondent's Section 12 evaluator, also opined that Petitioner's stipulated accidental injuries caused his condition to become symptomatic.

The Arbitrator notes there has been no superceding, intervening accident to break the chain of causation.

With respect to disputed Issue (L), what is the nature and extent of Petitioner's injury, the Arbitrator finds and concludes as follows:

Because this accident occurred prior to the 2011 amendments to the Act, Section 8.1b does not apply to this claim.

Dr. Ciric's diagnosis was grade 1 spondylolisthesis at L4-L5 and diffuse, scattered degenerative changes with minimal broad-based disc bulges at several levels; and foraminal stenosis on the left side as a consequence of the L4-L5 grade 1 spondylolisthesis. These conditions were aggravated/exacerbated/accelerated as a result of the work accident. Dr. Hudgins diagnosed Petitioner with lumbago. Dr. Zelby also noted the aggravation of Petitioner's degenerative conditions as noted on the MRI.

Because of these lumbar conditions, Petitioner has undergone numerous epidural steroid injections, the last one in 2015. As late as September 2015, Dr. Hudgins reported that Petitioner was still complaining of pain. Petitioner last visited Dr. Hudgins just three weeks prior to this hearing, a strong indicator that his symptoms persist. Petitioner further testified that he takes Vicodin every day for pain, another strong indicator that his symptoms persist.

Lastly, Petitioner offered credible and unrebutted testimony that he continues to experience pain in his back performing certain activities, especially after lengthy periods. Petitioner testified he suffers constant pain in his low back radiating into his buttocks and lower thigh. Petitioner has limited sitting, standing and bending. After sitting for as long period, when Petitioner gets up, he feels low back pain and tingling into his right buttock.

Based on the above, the Arbitrator finds and concludes that Petitioner has sustained the permanent partial loss of use to the person as a whole pursuant to Section 8(d)2 of the Act to the extent of **6%** thereof, or 30 weeks (PPD rate $664.72).

Robert M. Harris

Robert M. Harris, Arbitrator

March 13, 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 McHENRY	)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sarah E. Herner,
Petitioner,

vs. No. 17 WC 28312

Monique C Cameron Thoroughbred Racing Stable, Inc.,
Respondent.

20 IWCC0087

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 duration of temporary total disability and the nature and extent of permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On the parties' Request for Hearing (AX1), Petitioner stipulated that she was entitled to 20-5/7 weeks of temporary total disability, from July 22, 2016 through December 13, 2016. Respondent agreed that Petitioner was entitled to temporary total disability, but maintained the duration was limited to 18-6/7 weeks with a termination date of November 30, 2016. The arbitrator found that both suggested end dates were erroneous. She relied upon a December 14, 2016 notation by Petitioner's physical therapist, stating that Petitioner would be returning to light duty work on December 16, 2016, as evidence of Petitioner's return to work date and concluded that Petitioner was entitled to 21 weeks of temporary total disability.

The Commission finds that Petitioner is bound by her statement in the Request for Hearing that she was entitled to 20-5/7 weeks of temporary total disability. Representations made in the Request for Hearing are binding on the parties, even if—as the arbitrator found in this case—the evidence supports an award for a longer period. *Walker v. Industrial Comm'n*, 345 Ill. App. 3d 1084, 1088, 804 N.E.2d 135, 148 (4th Dist. 2004); *Dent v. State of Illinois, Department of Corrections,* 2011 Ill. Wrk. Comp. LEXIS 510. For this reason, the Commission modifies the Decision of the Arbitrator by reducing the award of temporary total disability from 21 weeks to the 20-5/7 weeks stipulated by Petitioner in the Request for Hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 23, 2018, 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 $279.97 per week for a total of 20-5/7 weeks for the period from July 22, 2016 through December 13, 2016, that being the period of temporary total disability from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $4,620.00 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $252.00 per week for 83.5 weeks, because the injuries sustained caused a 50% loss of use of the left foot pursuant to §8(e) of the Act.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,300.00. 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: FEB 3 - 2020

Marc Parker

o-01/23/20
mp-dak
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNER, SARAH E Case# **17WC028312**

Employee/Petitioner

20IWCC0087

MONIQUE E CAMERON THOROUGHBRED RACING STABLE INC

Employer/Respondent

On 10/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0529 TUITE LAW
GREGORY E TUITE
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

0766 HENNESSY & ROACH PC
RYAN J McCARTHY
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **McHenry**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SARAH E. HERNER
Employee/Petitioner

Case # **17** WC **28312**

v.

Consolidated cases: ______

MONIQUE E. CAMERON THROUGHBRED RACING STABLE, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JESSICA A. HEGARTY**, Arbitrator of the Commission, in the city of **WOODSTOCK**, on **8/3/18**. 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. [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 **7/21/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Petitioner was **43** 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 $**4,620.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,620.00**.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $279.97/week for 21 weeks, commencing **7/22/2016 through 12/15/2016**, as provided in Section 8(b) of the Act.
- Respondent shall be given a credit of $**4,620.00** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**4,620.00**.
- Respondent shall pay Petitioner permanent partial disability benefits of $**252.00**/week for **83.5** weeks, because the injuries sustained caused a 50% loss of the left foot pursuant to 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.

Jessica A. Hegarty (signature)

Signature of Arbitrator

10-23-18

Date

ICArbDec p. 2

OCT 2 3 2018

BEFORE THE
ILLINOIS WORKERS COMPENSATION COMMISSION

STATE OF ILLINOIS)
)
COUNTY OF McHENRY)

SARAH E. HERNER,)
Petitioner,)
) No. 17 WC 28312
v.)
)
MONIQUE E. CAMERON THOROUGHBRED)
RACING STABLE, INC.,)
Respondent.)

20 I W C C 0 0 8 7

ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

On the day of the accident, Petitioner was concurrently employed by Monique Cameron Thoroughbred Racing Stable ("Respondent") and the Tall Corn Alpaca Farm. Respondent operated a racehorse breaking and training facility in Caledonia, Illinois where Petitioner's duties included exercising, galloping and running, at close to racing speed, an average of six horses on the racetrack per morning. (T. 10). Petitioner's other duties for Respondent involved hosing off the horses, putting them out to pasture, and cleaning up stalls. The job also required taking saddles off the horses and lifting bales of straw. (T. 11).

At the Tall Corn Alpaca Farm in Marengo, Illinois, Petitioner cleaned up after the animals

On July 21, 2016, while mounted on a horse she was training, Petitioner was thrown onto the sand track at Respondents' facility. Petitioner landed feet first on an incline between two tracks. She testified that upon impact she knew her left foot was broken because it was at a 90° angle. (T. 13).

Petitioner was transported by ambulance to Rockford Memorial Hospital, at which time a "complete extrusion of the distal tibia through the medial wound" was noted. (PX2/13). That same day, Dr. Jeffrey Earhart performed surgery including the following procedures:

1. Closed reduction with manipulation of left ankle dislocation.
2. Closed reduction with manipulation of left ankle trimalleolar fracture.
3. Removal of loose bodies of the left ankle joint.
4. Excisional debridement and irrigation of left open ankle fracture for devitalized fat, deep soft tissue and bone.
5. Open reduction and internal fixation of left medial malleolus fracture.
6. Application of multiplaner external fixator to left ankle.
7. Simple closure of traumatic laceration, 6 cm.

The postoperative diagnosis noted a left grade III open ankle fracture – dislocation.

Following surgery, Dr. Earhart advised Petitioner a second surgical procedure was necessary, open reduction and internal fixation of the lateral malleolus and syndesmosis when the soft tissue injury would allow. Petitioner was discharged from Rockford Memorial on July 24, 2016.

On July 28, 2016, Dr. Earhart performed the following outpatient procedures at St. Anthony Hospital:

1. Removal of external fixator left ankle.
2. Open reduction internal fixation left lateral malleolus.
3. Allograft bone grafting left fibula.
4. Open reduction internal fixation left ankle syndesmosis.
5. Excisional debridement and irrigation of pin sites times four for devitalized fat, deep soft Tissue and bone. (PX 2/13).

Petitioner was advised to bear no weight on her foot throughout the month of August. She then began physical therapy at Ortho Illinois. (PX 1/146) On September 23, 2016 Petitioner was given a special boot by her treating surgeon. She was unable to drive until October 14, 2016. On November 7, 2016, Petitioner was transitioned from regular therapy to work hardening which continued through December 21, 2016.

On November 30, 2016, Petitioner presented to Dr. Earhart at which time x-rays were taken. Upon review, the doctor noted concern as to nonunion of the fibula which was confirmed via CT scan on December 1, 2016. (PX 1/162). A bone stimulator was ordered and Petitioner was allowed to return to work with weight bearing as tolerated and a 25-pound lifting restriction. (PX 1/32).

Petitioner testified she returned to work for Respondent cleaning stalls and walking horses in December. (T. 23). She was not riding horses at the time. Petitioner wore an ASO brace. She testified she wore the brace at all times when working and when performing chores such as mowing and vacuuming. Petitioner testified she only worked for Respondent for a few weeks after her return to work.

On January 6, 2017, Dr. Earhart noted Petitioner was doing well despite continued radiographic evidence of left fibula nonunion in the left fibula. Petitioner was to continue with the bone stimulator. She would have a 25- pound weight restriction for two weeks, after which, all weight restrictions were lifted. She would continue wearing the ASO brace and return in 6 to 8 weeks for a re-evaluation and repeat x-rays. (Pet. Ex. 1, p. 13-15).

On February 17, 2017, Dr. Earhart reviewed the X-rays noting no radiographic signs of hardware failure at the distal fibula. Petitioner was advised to avoid at risk activities and stay below her pain threshold. The doctor recommended low-impact activities such as biking or swimming versus running or jumping. She was permitted to return to work without restrictions. Petitioner was to follow-up clinically and radiographically due to the bone loss at the fibula. Petitioner would continue with her bone stimulator. (Pet. Ex. 1, p. 9-11).

Petitioner was released from care by Dr. Earhart on April 19, 2017. X-rays taken at the last visit revealed a small medial bone loss within the distal fibula and a stable halo around the syndesmotic screw. The doctor indicated that surgical bone grafting may be needed in the future. (PX 1/7).

Petitioner testified she attempted to ride beginner lesson horses on two occasions after her medical release. She stated that she needed assistance and a platform to get off the horse. (T.31).

Petitioner has only worked at the alpaca farm since her release although she has sought work in other places such as factories and fast food restaurants.

With respect to her current condition, Petitioner limits her lifting to 20 pounds while working at the alpaca farm. The speed with which she can walk is slower since the accident because she now walks with a limp. She has lost the ability to perform recreational activities such as tennis, waterskiing and running on a treadmill.

When mowing her grass, she must go very slow because of her difficulty in traversing uneven ground. She takes Aleve liquid gels for pain and sleeps with her foot elevated on a pillow. (T. 33).

CONCLUSIONS OF LAW

(K) – TEMPORARY BENEFITS

Petitioner alleges temporary total disability from July 22, 2016 through December 13, 2016. Respondent disputes that time period, claiming Petitioner was disabled through November 30, 2016.

The Arbitrator finds that neither period is correct. While the medical records indicate that Petitioner was returned to limited duty by Dr. Earhart on November 30, 2016 and December 9, 2016, Petitioner testified that Monique Cameron did not accommodate Petitioner until sometime in December. (T. 23). The Arbitrator finds Petitioner's return to work date was on December 15, 2016 as noted by her therapist on that date which indicated, "the patient reports good tolerance to her program. She reports she thinks she will be ready to wrap up next week. She reports some anxiety about returning to work tomorrow." (PX 1/19). Based upon this record and Petitioner's testimony, the Arbitrator finds Petitioner was disabled from July 22, 2016 through December 15, 2016 for a total of 21 weeks.

(L) NATURE AND EXTENT OF THE INJURY

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.

1. The reported level of impairment pursuant to the AMA Guidelines:

Petitioner was sent by Respondent to Dr. Bryan Neal for an AMA impairment rating on March 14, 2018. Dr. Neal assigned an impairment rating of 22% lower extremity impairment, which converts to 9% whole body impairment. Dr. Neal noted her limp and diminished range of motion of the left foot. He noted that range of motion was "tight" when compared to right foot. The Arbitrator gives some weight to this factor.

2. The occupation of the employee:

At the time of her accident, Petitioner trained thoroughbred racehorses for the Respondent. Petitioner's duties included exercising, galloping and running, at close to racing speed, an average of six horses on the racetrack per morning. Petitioner testified she attempted to ride beginner lesson horses on two occasions after her medical release. She stated that she needed assistance and a platform to get off the horse on these occasions.

Although Petitioner was released to work "without restrictions", her treating surgeon advised her to avoid "at risk" and high impact activities involving her left leg and stay below her pain threshold. Petitioner is currently employed as a cleanup person at an alpaca farm. She cleans up after the animals by raking and filling a bucket using a shovel. She limits her lifting to 20 pounds. Based upon Petitioner's testimony, the observation of her gait, as well as Dr. Earhart's recommendation that Petitioner refrain from high impact activities involving the left leg, the Arbitrator finds that Petitioner can no longer pursue her former occupation. The Arbitrator gives greater weight to this factor.

3. The age of the employee at the time of the injury:

Petitioner was 43 years of age at the time of the injury. Based upon her relatively young age and her expected work life the Arbitrator notes that she must live and work with this disability for a number of working years. The Arbitrator gives greater weight to this factor.

4. The employee's future earning capacity:

As noted above, Petitioner can no longer pursue her occupation as a trainer of race horses. Although Petitioner was released to work "without restrictions", her treating surgeon advised her to avoid "at risk" and high impact activities involving her left leg and stay below her pain threshold. Petitioner did attempt to ride a horse on two occasions after her medical release. On both occasions, Petitioner required assistance as well as a platform in order to get off of the horse. Petitioner has only worked at the alpaca farm since her release although she has sought work in other places such as factories and fast food restaurants. The Arbitrator finds that Petitioner's future earning capacity may be adversely affected due to her physical limitations.

5. Evidence of disability corroborated by the treating medical records:

With respect to her current condition, Petitioner testified to the following:

- She limits her lifting to 20 pounds while working at the alpaca farm.;
- The speed with which she can walk is slower since the accident because she now walks with a limp;
- She has lost the ability to perform recreational activities such as tennis, waterskiing and running on a treadmill;
- When mowing her grass, she must go very slow because of her difficulty in traversing uneven ground;
- She takes Aleve liquid gels for pain and sleeps with her foot elevated on a pillow.

Records from Rockford Memorial Hospital on the accident date noted Petitioner suffered a "complete extrusion of the distal tibia through the medial wound." (PX2/13). Dr. Jeffrey Earhart performed surgery that included the following procedures:

1. Closed reduction with manipulation of left ankle dislocation.
2. Closed reduction with manipulation of left ankle trimalleolar fracture.
3. Removal of loose bodies of the left ankle joint.
4. Excisional debridement and irrigation of left open ankle fracture for devitalized fat, deep soft tissue and bone.
5. Open reduction and internal fixation of left medial malleolus fracture.
6. Application of multiplaner external fixator to left ankle.
7. Simple closure of traumatic laceration, 6 cm.

The postoperative diagnosis was left grade III open ankle fracture – dislocation.

On July 28, 2016, Dr. Earhart performed the following procedures:

1. Removal of external fixator left ankle.
2. Open reduction internal fixation left lateral malleolus.
3. Allograft bone grafting left fibula.
4. Open reduction internal fixation left ankle syndesmosis.
5. Excisional debridement and irrigation of pin sites times four for devitalized fat, deep soft Tissue and bone. (PX 2/13).

A CT scan, performed on December 1, 2016, indicated nonunion at the left fibula, diametaphysis. (PX 1/162). A bone stimulator was ordered.

On January 6, 2017, Dr. Earhart noted radiograph findings indicated incompletely healing at the fibula. Petitioner was released from care by Dr. Earhart on April 19, 2017. Petitioner told the doctor that she still had pain in the medial aspect of the ankle and that there was a continuing sensation of the ankle needing to be "popped". The pain level was 3/10 at rest and 7/10 with activity. The doctor noted that Ms. Herner walked with a limp. X-rays showed small medial bone loss within the distal fibula. In addition, there was a stable halo about the syndesmotic screw but no new loosening. The doctor indicated that surgical bone grafting may be needed in the future. (PX 1/7)

The Arbitrator finds Petitioner's testimony regarding her disability is corroborated by the treating medical records. Accordingly, greater weight will be given to this factor.

Further, the Arbitrator observed the Petitioner's foot with the ASO brace removed. There was a 3-inch scar just above the lateral ankle bone where the tibia had extruded from the leg after the accident. In addition, there was an 8 1/2-inch linear scar running upwards from the outside ankle bone. This was a result of the second surgery where a plate and screws were used to fixate the lower leg. The Arbitrator asked the Petitioner to walk down a hallway. The limp described in the treating medical records was evident.

Section 8.1 (b) states, "No single 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 a physician must be examined. The term "impairment" in relation to the AMA Guides to the Evaluation of Permanent Impairment 6th edition is not synonymous with the term "disability" as it relates to the ultimate permanent partial disability award.

Having considered all of the factors and based upon the totality of the credible evidence presented at trial, the Arbitrator finds that Petitioner has sustained a 50% loss of the left foot pursuant to 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AMALIA REYES,

Petitioner,

20IWCC0088

vs.

NO: 13 WC 07904

LABOR TEMPS Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, 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.

Petitioner filed an application for benefits asserting that she sustained a work injury on November 19, 2012 resulting in injuries to her lumbar spine, and right foot and ankle. At hearing the parties disputed causal connection, medical expenses, temporary total disability, and permanent partial disability.

Petitioner testified that on November 19, 2012 she was sorting letters that were coming out of a machine, placing them in boxes and putting the boxes on pallets. She was standing on a plastic mat that had been placed over a concrete floor. The mat on which she was standing was ripped and she twisted her right foot. She testified that she began to experience pain in her right foot, right knee, and lower back.

Petitioner initially received medical care from Concentra for her right foot and lower back pain. She was diagnosed with a lumbar sprain and right knee/foot sprain. A lumbar MRI was performed that revealed disc bulges at L2-3, L3-4, and a 5 mm. focal posterocentral disc

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protrusion at L4-5. Petitioner also continued to report right ankle pain. Dr. Bhatt at Concentra continued his diagnosis of lumbar strain. Petitioner received physical therapy and she was under 25 lb. work restrictions for lifting and pushing.

Petitioner continued treatment with Dr. Bhatt at Concentra until January 11, 2013. Dr. Bhatt's lumbar examination on the date showed full range of motion with negative straight leg raising and no signs of radiculopathy. He noted "trace occasional soreness" in the lower back. Dr. Bhatt diagnosed resolved lumbar strain and ongoing sprain/strain of the right ankle. He continued work restrictions and directed Petitioner to return in 5 days for follow-up. Petitioner never returned to Concentra.

Petitioner transferred her care to Marque Medicos commencing January 18, 2013. In the ensuing three months Petitioner received chiropractic attention, and pain management directed to her lumbar complaints. As her medical treatment at Marque Medicos continued she began reporting pain levels up to 7/10 in her lumbar spine. Petitioner was on 25 lb. lifting restriction on January 11, 2013 and was subsequently taken off work by Marque Medicos. Petitioner embarked on a prolonged course of treatment with Marque Medicos that continued through September 2015 involving physical therapy, pain management, chiropractic care, lumbar surgery and foot surgery.

On April 23, 2013 Petitioner presented to Dr. Mark Levin for a Section 12 evaluation at the request of Respondent. Dr. Levin reviewed the medical records and performed an examination. He subsequently reviewed the MRI films of the lumbar spine performed on December 12, 2012. He noted that the MRI showed degenerative signal changes in the lumbar spine from L3 to L5 with multi-level spondylosis and degenerative disc protrusion. Dr. Levin noted significantly that, "At L4-L5, there is a posterior central disc protrusion that does not impinge on the actual nerve roots." Dr. Levin opined that Petitioner's subjective complaints were out of proportion to the objective orthopedic pathology. Dr. Levin found Petitioner to be at MMI with regard to the condition of her lumbar spine.

The Arbitrator found that Petitioner met her burden of proof with regard to the injury to her right foot/ankle and awarded temporary total disability benefits commencing November 19, 2012 through July 28, 2014, reasonable and necessary medical expenses related to the treatment of the right foot/ankle and awarded loss of use of 25% of the right foot under Section 8(e) of the Act. The Commission affirms the Arbitrator's award as it relates to the right ankle/foot injury.

Additionally, the Arbitrator made an award relating to Petitioner's lumbar injury of medical benefits from November 19, 2012 through October 8, 2013. The Commission notes that Dr. Levin expressed the opinion detailed above that Petitioner was at MMI regarding her lumbar spine on April 23, 2013. The Commission finds the opinions expressed by Dr. Levin persuasive that Petitioner reached MMI with regard to her lumbar strain on April 23, 2013 and awards medical expenses incurred in the treatment of that condition to extend to April 23, 2013,

<u>Permanent Disability</u>

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

(v) evidence of disability corroborated by treating medical records

Based upon the medical records of Concentra Clinic, and the MRI of December 23, 2012 it appears to the Commission that Petitioner sustained a lumbar strain as a result of the November 19, 2012 work accident. The medical records from Concentra Clinic show that on that on January 11, 2013 Petitioner had a normal orthopedic examination with regard to her lumbar spine and required no further work restrictions or medical treatment. On January 18, 2013 Petitioner was noted to have trace residual soreness in her lumbar spine.

At the time of trial Petitioner testified that she had received no further treatment related to her lumbar spine since September 2015. The Commission finds that Petitioner as not sought further medical treatment since that time and that this factor weighs in favor of decreased disability.

Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds Petitioner sustained the loss of use of 7.5% of the person as a whole under Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2017, as modified above is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $151.07 per week for a period of 87.6 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 $151.07 per week for a period of 41.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 25% of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $151.07 for a period of 37.5 weeks, as provided by Section 8(d)2 of the Act, for the reason that the injuries to the lumbar spine caused the loss of use of 7.5% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses under §8(a) and 8.2 of the Act, incurred from November 19, 2012 to April 23, 2013 for Petitioner's lumbar condition.
Respondent shall pay reasonable and necessary medical expenses under Sections 8(a) and 8.2 of the Act incurred from November 19, 2012 through July 28, 2014 for Petitioner's foot/ankle condition; with the exception of the following which the Commission finds not to be medically necessary or appropriate:

a. History and physical with pre-operative labs prior to TFSI performed on March 13, 2013;
b. Four (4) physical therapy sessions between April 18, 2013 and April 23, 2013;
c. Transportation charges;

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d. Any chiropractic charges for office visits made during the physical therapy sessions.

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 $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: FEB 3 - 2020
o: 1/15/20
SJM/msb
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

SOIMCC0088

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

REYES, AMALIA
Employee/Petitioner

Case# **13WC007904**

LABOR TEMPS
Employer/Respondent

20IWCC0088

On 3/14/2017, 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 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:

1377 PARENTE & NOREM PC
MARTHA A NILES
221 N LASALLE ST 27TH FL
CHICAGO, IL 60601

2337 INMAN & FITZGIBBONS LTD
JACK SHANAHAN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **Kane**)

20 I W C C 0 0 8 8

- [ ] 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
AMENDED ARBITRATION DECISION

AMALIA REYES
Employee/Petitioner

v.

LABOR TEMPS
Employer/Respondent

Case # **13** WC **7904**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JESSICA A. HEGARTY**, Arbitrator of the Commission, in the city of **Geneva**, on **10/12/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 **11/19/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,873.72**; the average weekly wage was $ **226.61** .

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**2,786.79** for TTD, $**n/a** for TPD, $**n/a** for maintenance, and $**n/a** for other benefits, for a total credit of $**2,786.79**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act from:

1. November 19, 2012 through October 8, 2013 for Petitioner's lumbar condition.
2. November 19, 2012 through July 28, 2014 for Petitioner's foot/ankle condition; with the exception of the following which the Arbitrator has found not to be medically necessary and appropriate:
    a. HP with pre-op labs prior to the TFESI performed on March 13, 2013;
    b. 4 PT sessions between April 18, 2013 and April 23, 2013;
    c. Transportation charges;
    d. Any chiropractic charges for office visits made during Physical Therapy sessions.

TTD

Respondent shall pay Petitioner TTD benefits for the period commencing 11/20/12 through 7/28/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $2,786.79 for temporary total disability benefits that have been paid.

Permanent Partial Disability
Respondent shall pay Petitioner permanent partial disability benefits consistent with the Arbitrator's finding that the injuries sustained caused the 25% loss of the right foot, as provided in Section 8(e) of the Act.

Respondent shall further pay Petitioner permanent partial disability benefits consistent with the Arbitrator's finding that the injuries sustained to Petitioner's back caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

See Attached Addendum for the Arbitrator's analysis of the statutory factors with respect to the award of PPD.

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

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

3/13/17
Date

ICArbDec p. 2

MAR 14 2017

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AMALIA REYES,
Petitioner,

vs.

LABOR TEMPS,
Respondent.

No. 13 WC 7904

AMENDED
ADDENDUM TO THE DECISION OF THE ARBITRATOR

FINDINGS OF FACT

The parties stipulated on the issues of average weekly wage, employment, notice and accident. The only issues in dispute are causation TTD, the medical expenses and the nature and extent of the Petitioner's condition. (Arb. 1).

Petitioner worked for Labor Temps (Respondent), an employment agency, at a company called Freedom, where her job involved sorting letters and other items coming out of a machine. Petitioner would then fill a box with the items and place the box on a pallet. She stated she would fill up a box every 4 to 5 minutes, and the boxes ranged in weight very light up to 50 pounds. She had been performing that work for approximately a year and a half prior to the accident.

Petitioner testified that on November 19, 2012 there were additional workers in her work area which limited her ability to move. She was working very fast, standing on some plastic mats that were laid down to make standing on the concrete floor more comfortable. The mat she was standing on was ripped, and while she turned quickly to grab a cover for a box, her right foot twisted. Petitioner testified that she leaned onto a table so as not to fall, but felt her right foot turn. She continued working, but felt pain in her right foot, right knee and her lower back.

The records from Concentra (PX 1) confirm that Petitioner presented on the accident date with a history of stepping on a warped floor mat causing her to twist her right ankle. She complained of pain over the lateral aspect of the right ankle and foot with pain radiating to the lateral aspect of her right lower leg. The physical examination findings note swelling laterally and limited range of motion with pain in all directions. Petitioner was diagnosed with a sprain/strain of the ankle and a foot sprain. She was restricted to sitting work and was provided with crutches and a brace.

Petitioner returned to Concentra the following day with complaints of persistent ankle pain. She further complained of right lower back pain that radiated to the right hip area as well as right knee pain. The examination noted tenderness in the right lower lumbar paraspinals. Straight leg raising caused lower back

discomfort on the right side without radiculopathy. Examination of the right knee showed tenderness medially and laterally with swelling. Petitioner was diagnosed with a lumbar strain, a knee sprain/strain along with an ankle sprain/strain. Petitioner was scheduled for physical therapy and her restrictions were maintained. (PX 1)

On December 12, 2012, Petitioner underwent a lumbar MRI that found disc bulges at L2-L3, L3--L4, and a 5 mm focal posterocentral disc protrusion at L4-5 (PX 2). Dr. Bhatt maintained his diagnosis of a lumbar strain. (PX 1).

Petitioner followed up with Dr. Bhatt on December 28, 2012, and although she noted improvement, her complaints of pain in her right lumbar and right ankle persisted. Petitioner saw Dr. Bhatt one week later on January 4, 2013 reporting mild lower back pain with occasional tingling and medial pain in the right ankle that increased with pressure. Dr. Bhatt issued work restrictions of lifting and pushing no more than 25 pounds. (PX 1).

Petitioner was last seen by Dr. Bhatt at Concentra on January 11, 2013. The doctor noted "trace occasional soreness" in the lower back without radiculopathy. Petitioner still complained of mild pain in the medial aspect of the right ankle. Physical therapy was discontinued and she was instructed to engage in a home exercise program. Physical examination showed full range of motion without pain and negative straight leg raising. The ankle showed no edema or bruising and full range of motion without weakness. She had mild complaints medially. Dr. Bhatt diagnosed a resolved lumbar strain and ongoing sprain/strain of the ankle. Petitioner was to return in five days and her work restrictions were maintained. (PX 1).

Petitioner testified that she stopped treating at Concentra because her doctor informed her that treatment options had been exhausted. She testified that she was still ambulating with a cane.

She began treating with Marque Medicos, representing her first choice of physicians.

The Arbitrator has reviewed Petitioners' exhibits 2 (Marque Medicos), 3 (Dr. Kane), 4 (American Center for Spine and Neurosurgery – Dr. Erickson), 5 (Ambulatory Surgical Care Facility) and 6 (Dr. Harsoor). The Arbitrator estimates roughly 1000 pages of medical records among these providers, with many of the individual exhibits containing copies of records from the other exhibits listed above. The Arbitrator has reviewed these records and summarizes them as follows.

On Petitioner's first visit to Marque Medicos in Aurora on January 18, 2013, she was seen by Dr. Perez who noted complaints of low back, right leg and right ankle and foot pain. Petitioner described constant pain in her lower back, greater on the right side, radiating into her right buttock and right posterior thigh. She also complained of sharp pain in her right heel along with pain and swelling in her right ankle and constant numbness in her right foot, radiating into her big and second toes, and numbness in her right buttocks and thigh. She also felt that her right knee was going to give out and had stiffness and weakness in her right foot and ankle. Petitioner was assessed with a herniated lumbar disc and right ankle pain. Petitioner was referred to Dr. Engel for pain management and was provided light duty work restrictions. (PX 2).

Petitioner was seen by Dr. Engel at Medicos Pain and Surgical Specialists on January 24, 2013. On physical examination, Dr. Engel noted swelling in the right ankle with decreased range of motion. Straight leg raising was positive on the right at 30° and negative on the left. She was diagnosed a lumbar herniated disc with foot and ankle pain. Dr. Engel stated that x-rays of the right foot and ankle and her lumbar spine showed no fractures, and he was awaiting a radiologist's review of her lumbar MRI. (PX 2).

What follows thereafter takes Petitioner on a course of treatment that includes lumbar and right ankle surgery, physical therapy, chiropractic therapy and pain management services from different providers over the course of the next 21 months.

Lumbar spine

An EMG performed on February 15, 2013 showed acute denervation of the right S1 nerve root. (PX 2) On February 26, 2013, a positive straight leg test was noted. With respect to therapy, Petitioner had 13 sessions between January 28, 2013 and February 26, 2013. Therapy was discontinued due to lack of improvement.

On March 14, 2013, a right sided ESI was administered at L5-S1. On April 3, 2013 Dr. Engel recommended a neurosurgery consult to assess Petitioner for a disc herniation.

Petitioner underwent chiropractic treatment by Dr. Gattas for her lumbar spine on 12 occasions through April 24, 2013.

The Petitioner presented to Dr. Mark Levin on April 23, 2013 for an IME at the request of the Respondent. Dr. Levin had earlier completed a records review dated April 15, 2013 where he detailed Petitioner's treatment at Concentra and the first two months with Marque Medicos concluding that he would need to examine her in order to opine on causal connection, treatment and work ability. (RX 1).

At the April 23 exam, Petitioner reported to Dr. Levin that on November 19, 2012, she caught her right foot in a mat under a table. She heard a crack and her right foot became hot and swollen. About one and a half hours later, she could not walk due to the swelling. She noted her history at Concentra through early January, 2013, but stated this resulted in no improvement. She reported treating with Marque Medicos, undergoing chiropractic and physical therapy treatments three times a week, along with an epidural steroid injection on March 14, 2013 with no improvement. She was receiving therapy to both her right foot and ankle and her low back, and complained of low back pain on a level of 6–8/10. She had constant right medial ankle pain on a 7/10 basis. She reported 30% improvement in her symptoms since the initial injury. Dr. Levin performed an examination of Petitioner's cervical and lumbar spine, lower extremities and right ankle, and noted negative x-rays of the lumbar spine and the right foot. Following his examination and review of the records and diagnostic reports, Dr. Levin opined that the Petitioner's subjective pain complaints were out of proportion to the objective orthopedic pathology. He could find no objective orthopedic pathology requiring treatment for the work occurrence, but noted he would review the MRI studies. Dr. Levin found no objective pathology preventing the Petitioner from returning to her previous job. (RX 2, 4/23/13 rpt).

Dr. Levin subsequently reviewed the films from the MRI performed on December 12, 2012. In a follow up report on July 18, 2013, he noted degenerative signal changes of the lumbar spine from L3 to L5 with multilevel spondylosis and degenerative disc protrusion. "At L4–L5, there is a posterior central disc protrusion that does not impinge upon the actual nerve roots." He concluded that his prior opinions remained unchanged. (RX 2, 7/18/13 rpt.).

On April 24, 2013, Petitioner reported that the IME she had recently undergone at Respondent's request had increased her back pain. She was not seen for chiropractic care for about three months, though the report noted that April 24 was the "fourth out of six visits since last being evaluated by the physical therapist." The Arbitrator notes that virtually each of Dr. Gattas' exam notes contains a statistic like this, but there is no correlation as to which or whose evaluation this is being counted from, and they seem to randomly reset to another set of numbered visits throughout the records. (PX 2).

Petitioner next came under the care of neurosurgeon, Dr. Erickson whom she initially consulted with on April 15, 2013. Dr. Erickson read the lumbar MRI from December 12, 2012 to show a central disc herniation at L4–5 with no clear nerve compression. He noted that the epidural steroid injection that Dr. Engel had administered provided no lasting relief. Dr. Erickson noted he would not recommend surgery, but did recommend a second epidural steroid injection which he administered on April 29, 2013.

Petitioner underwent a sacral injection on May 15, 2013, and then a third lumbar injection on May 29, 2013 (PX 5). Petitioner returned to Dr. Erickson approximately a week later on June 7, 2013 when she reported right leg pain radiating to the right heel and top portion of her foot. She was back to using a cane and complained that her pain radiated down to the top of the foot on the right. Neither of the prior two injections provided any lasting relief. She now complained of leg pain worse than her back pain. (PX 4).On exam, paresthesias affecting the first, second and third toe were noted.

Dr. Erickson thus proposed a minimally invasive hemilaminectomy at L4–L5 on the right, believing that this disc was the source of her pain. He noted that she would be an excellent surgical candidate and that the surgery was related to the November 19, 2012 work injury. (PX 4).

Petitioner underwent the procedure on June 21, 2013 (PX 5), and followed up with Dr. Erickson on July 3, 2013, reporting a decrease in pain, and diminished paresthesias but persistent sciatic pain. Straight leg raising remained positive. Dr. Erickson asked her to consult physical therapy and replaced Norco with Tramadol. (PX 4). The Arbitrator notes that Petitioner did not follow up with Dr. Erickson thereafter for another eight months.

Petitioner saw Dr. Gattas on July 12, 2013 for chiropractic therapy. Over the next six weeks through August 30, 2013, Petitioner saw Dr. Gattas on 18 occasions. The records of chiropractic care and physical therapy overall in 2013 are devoid of much detail regarding Petitioner's subjective complaints or pain level, though starting in late July, 2013, her symptoms subjectively were improving.

On September 5, 2013, Dr. Engel noted that Petitioner had plateaued in physical therapy and prescribed an FCE.

On September 20, 2013, Petitioner participated in a FCE which the therapist deemed valid. (PX2; RX 6) The report concluded that Petitioner was capable of performing sedentary-light work with occasional standing during an 8-hour work day as well as a ten (10) pound lifting restriction. (PX 2).

Petitioner followed up one additional time with Dr. Engel on October 2, 2013, with increased complaints of pain to a 6/10 level, that she attributed to her participation in the FCE. Dr. Engel prescribed an MRI of her lumbar spine. The doctor noted that Petitioner would continue to treat with Dr. Erickson and Dr. Kane. (PX 2).

The lumbar MRI of October 8, 2013 showed post-surgical changes and no herniation or stenosis. The other levels appear roughly unchanged from the prior study (PX 2)

For reasons that are unclear, Petitioner followed up with neither Dr. Erickson nor Dr. Engel but presented to another chiropractor from Marque Medicos, Dr. Ramirez, on October 24, 2013. She complained of both lumbar spine and right foot pain, rating her low back pain as a 6/10. With regard to the back, Dr. Ramirez stated Petitioner would follow up with Dr. Erickson on November 6, 2013.

On November 6, 2013, Petitioner went back to Dr. Ramirez with low back complaints at a 7/10 with radiating pain into her right leg down to her right foot. She also complained of mild right foot pain. Dr. Ramirez discussed the MRI findings with Petitioner and stated that they revealed "enhancing granulation tissue on the right side" of the L4 – 5 disc. The doctor encouraged Petitioner to follow up with Dr. Erickson to review the findings, and continued her off work restrictions. (PX 2).

Petitioner went back to see Dr. Perez on January 24, 2014 with persistent pain in her low back area that radiated into her right leg. She now complained of constant numbness and tingling in the right leg, and had difficulty sleeping and performing simple household chores. Dr. Perez performed an examination, and noted that she would discontinue follow-up consultations with Dr. Engel since he was no longer affiliated with Marque Medicos. She was to follow-up with Dr. Kane for her foot problems, but no recommendation was made

as to future treatment for her low back. Her off work authorization was continued. (Id.).

Petitioner returned to Dr. Erickson on March 5, 2014. At that time, the doctor noted Petitioner underwent "successful" decompression at L4–5 on the right, and a functional capacity evaluation that placed her at the sedentary level with a 10-pound lifting restriction. He noted the recent lumbar MRI showed fibrosis but no clear disc herniation or any new findings. (PX 2). Nonetheless, Petitioner complained of low back pain at 8/10 and associated leg pain at 7/10. She complained of tingling in her toes and she was limping on the right side. Following an SSEP study which showed a finding of 0.9 standard deviations at L5 (PX 2, Diag Rpts), which Dr. Erickson noted was the same number he obtained preoperatively, he diagnosed recurrent L5 radiculopathy on the right and recommended a new course of epidural steroid injections, and possible surgery in the future. The Arbitrator notes this report is not contained in the subpoenaed records from Dr. Erickson submitted as Petitioner's Exhibit 4, but is among the records contained in Petitioner's Exhibit 2 from Marque Medicos.

Petitioner submitted as Exhibit 6 subpoenaed records from Dr. Harsoor. It is not clear how Petitioner came to Dr. Harsoor, though it appears it is because Dr. Engel was no longer with Medicos.

Petitioner first saw Dr. Harsoor on April 18, 2014, noting an onset of sudden pain at work in November 19, 2012. "Pain is constant, lasting all day. It is throbbing, sharp, tingling and numbness in quality." Petitioner also reported radiation to the right knee and foot along with tingling and numbness. The level of pain ranged from 5 to 8/10. "Patient is able to perform all activities of daily living but cannot lift heavy stuff [sic]. Pain behavior is positive for facial grimacing. She does not employ any physically." (PX 6). Following her examination and review of some medical records, Dr. Harsoor was to proceed with epidural steroid injections at L5–S1 per Dr. Erickson's recommendations. (PX 6). Petitioner saw Dr. Harsoor on two more occasions, each time complaining of a pain level of 8/10. (PX 6).

Petitioner then followed up with Dr. Erickson on August 27, September 17, October 8 and November 12, 2014. The Arbitrator again notes that the reports of these examinations were not contained in Petitioner's Exhibit 4, but rather in the Marque Medicos records (PX 2). Nevertheless, he noted the injections administered by Dr. Harsoor afforded only temporary relief. Petitioner's reports of back pain ranged from 5/10 to 8/10. He recommended a lumbar discography, which was done on September 26, 2014. (PX 5) Dr. Erickson reviewed the results of the test and noted that Petitioner experienced significant pain with each of the four discs injected. He therefore did not recommend surgery, though he stated that Petitioner has multilevel segmental disease underlying the mechanical back pain. (PX 2). Dr. Erickson discharged Petitioner from care on October 8, 2014.

The last treatment by Dr. Harsoor was on October 31, 2014. Petitioner reported low back pain at 7/10. Following a discussion of the medial branch block, which Petitioner refused, and a spinal cord stimulator, which Petitioner was going to consider, Dr. Harsoor likewise discharged Petitioner from care as she had reached MMI. (PX 6).

Petitioner, however, sought additional treatment with Rehab Dynamix, starting on January 6, 2015. She was seen for both back and ankle problems, rating her pain as a 7/10 in both areas. She was seen a total of 21 times in the 30 calendar days between January 6 and February 5, 2015, tending to note improvement from visit to visit but maintaining a pain level of 6/10 in the lumbar spine. On February 5, her progress was noted along with the statement that, "she will be having a lumbar injection next week." The provider of this injection is not identified, but otherwise Petitioner was discharged by the chiropractor, Dr. Bowden, to the care of pain management. Petitioner's Exhibit 7 also contains a July 1, 2015 MRI of the right ankle ordered by a Dr. Hedman. (PX 7).

Ankle treatment

The treatment to Petitioner's right foot and ankle followed a similar path of concurrent chiropractic and

physical therapy, along with treatment by a podiatrist, Dr. Kane, through August 2013.

Petitioner began treating with Dr. Kane, a podiatrist, starting on May 6, 2013 with complaints of a painful right foot and ankle following a work injury in November 19, 2012. Dr. Kane recommended immobilization with a fracture boot on the right foot and ordered an MRI. The diagnosis was to rule on a tendon tear of the right ankle and a contusion of the right foot and ankle. She was to continue the physical therapy that she had already begun and was to follow-up in two weeks. (PX 3).

The report of the May 16, 2013 MRI of the forefoot was negative for any "acute or chronic pathological process that would account for patient's forefoot symptomology." The ankle MRI showed evidence of a prior sprain at the anterior talofibular ligament (ATAF) and a previous transvers fracture of the third cuneiform bone (PX 5). Dr. Kane's summary of the MRI results on June 3, 2013 suggested a likely fracture of the dorsal aspect of the 3rd cuneiform, "in the process of healing," along with a ligamentous sprain or strain in the anterior talofibular ligament. Petitioner reported that the fracture boot had been helpful with her pain complaints, though upon removal, Dr. Kane noted swelling in the ankle. Petitioner had limited range of motion and complained of pain with activity. The doctor diagnosed posterior tibial tendinitis and contusion of the right foot and ankle, along with a partial tear of the ATAF ligament. Physical therapy was to continue along with use of the fracture boot. (PX 3).

Petitioner was seen three more times through August 26, 2013, at which time, Dr. Kane noted significant improvement in range of motion as well as muscle strength in the right foot. His diagnoses remained the same, and he recommended she wear a hi-top shoe for support.

Dr. Kane continued to see Petitioner almost monthly through March, 2014, though there was no additional therapy performed by Petitioner's providers during that time. Petitioner's subjective complaints had been mild, and Dr. Kane allowed her to perform moderate work duties with no use of ladders or unprotected heights.

On March 3, 2014, Petitioner had new complaints of sharp shooting pain radiating down her right leg to the ankle. She continued with these complaints, and by April 28, 2014, Dr. Kane recommended surgical repair of the ATAF ligament. Nonetheless, he maintained her work restrictions as noted above. (PX 3).

Petitioner underwent surgical repair of the ATAF ligament and the calcaneofibular ligament along with an excision of a bony chip fracture and repair of a tendon sheath tear on May 14, 2014. In the immediate follow-up report on May 19, Dr. Kane noted a "quick recovery" from the procedure, and recommended a surgical shoe. (PX 3).

Petitioner followed up routinely on three more occasions until July 28, 2014. At that time, Dr. Kane noted that she had tolerated the surgical procedure very well and had recovered quickly from it. She no longer had an antalgic gait, and after two more weeks of muscle strengthening therapy, he felt she would be at MMI for this injury.

The final diagnosis was anterior and calcaneofibular ligament ruptures and a peroneal tendon tear. She was capable of full duty without restrictions with regard to her foot, and was to return only as needed. (PX 3).

Following conclusion of her therapy, this was the last treatment for the right foot until Petitioner went to Rehab Dynamics in January, 2015. There, upon her initial visit on January 6, she complained of pain in the ankle on a level of 7/10. Following the chiropractic treatment and therapy through February 5, 2015, she noted the ankle pain was at 4/10. (PX 7). This is the last evidence of foot treatment in the records.

Respondent introduced two utilization reports into evidence, one assessing the treatment through the summer of 2013(RX 3), and the second addressing the treatment thereafter (RX 4). The first report, dated August 27, 2013, reviewed all but the Concentra treatment through the diagnostic studies ordered by Dr. Erickson prior to

surgery. Ten of the 13 therapeutic exercises for the back and 10 of the 15 therapeutic exercises for the right ankle were approved, along with a number of the diagnostic studies and initial injections. The report notes a discussion with Dr. Engel concerning these findings, and the noted area of disagreements and agreements with Dr. Engel on the reviewer's recommendations. (RX 3).

The Arbitrator notes that none of the treatment administered following the first utilization review was approved in the UR report dated December 15, 2014 (RX 4). This includes the low back and ankle surgeries, and all of the chiropractic and physical therapy and pain management treatment thereafter. The treatment reviewed included Dr. Harsoor's records through September 5, 2014, but was done before Petitioner appeared at Rehab Dynamix. Otherwise, all treatment prior to that and after the first report by the various providers was reviewed. (RX 4).

Petitioner testified that her back and foot are very painful. When asked to rate her pain on a scale of "1", meaning that she needs to take aspirin, and "10", which would require hospitalization, Petitioner stated her pain in her low back would be an 8 and the pain in her foot would be a 7. She testified she takes over-the-counter migraine medications for her back pain and ibuprofen for her foot pain.

Petitioner testified that she had been a laborer prior to this injury, and subsequent to the injury, she has only looked for work with the Respondent. She did attempt a housecleaning job in May, 2016, but only showed up for three shifts before she felt she could not do that work. She testified that her last contact with Respondent looking for work was approximately two before the trial, and they indicated they did not have any for her.

On cross-examination, Petitioner elaborated on her attempts to return to work with Respondent by stating that she has gone periodically and spoke with the "people in front" as to whether any work was available, but has always been told it is not. She identified both Laura and Dora as the people she would talk to, noting that her husband works for Respondent and she occasionally goes to pick up his paycheck for him. She testified that she remembers one occasion speaking with Liz Ochoa, the general manager of Labor Temps, about work, but that none was available.

Finally, Petitioner testified that the pain in her low back has not improved since before the surgery, and is in fact even worse when she has to be active or go upstairs. She likewise testified that the pain in her foot is the same today as it was before her surgery.

Petitioner rested and Respondent produced its General Manager, Liz Ochoa, to address Petitioner's return to work efforts with Respondent. Ms. Ochoa stated that as general manager, she is involved with work injury claims and light duty availability. She testified that while her clients cannot often accommodate restrictions to the extent that Petitioner had, there is typically work available at Labor Temps itself for its injured employees who are on such restrictions.

Ms. Ochoa remembered the one conversation Petitioner testified to having with her about returning to light duty work, but said that Petitioner produced an off-work statement rather than a light-duty statement from her doctor. She further testified that Laura and Dora are her assistants, and that if Petitioner had inquired of them about the availability of light duty work, they would have advised Liz of that as well. She testified at no time did Laura or Dora advise her that Petitioner inquired about work following November 19, 2012.

CONCLUSIONS OF LAW

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

Petitioner sustained an injury to her right foot and low back on November 19, 2012. With respect to Petitioner's *lumbar injury and her work related accident the Arbitrator finds a causal relationship through*

October 8, 2014 and further finds her right foot/ankle condition causally connected through July 28, 2014. Causal connection is apparent pursuant to the "chain of events" analysis. *Martin Young Enterprises, Inc. v. Industrial Com.* 51 Ill. 2d 149 (1972). The accident histories contained in the medical records describe consistent histories, specifically, that Petitioner was standing on a ripped plastic mat and while she turning to grab a cover for a box, twisted her right foot. Petitioner leaned onto a table so as not to fall, but felt her right foot turn. Complaints related to her right ankle/foot were noted at Concentra that same day. Petitioner returned to Concentra the day after her work injury with complaints related to her lower back. Her subjective complaints of pain and radiculopathy are corroborated by MRI taken less than a month following the accident that was significant for disc bulges at L2-3 and L3-4 as well as a 5 mm focal posterior central disc protrusion at L4-5. An EMG performed on February 15, 2013 noted a right S1 neuropathy. Following a course of conservative treatment including physical therapy and injections, her condition failed to improve. When Dr. Erickson saw Petitioner in June of 2013, she was using a cane to ambulate and complained of back pain that radiated to the top of her right foot and heel. Pursuant to his exam, the doctor noted parasthesias in Petitioner's first three toes and a positive straight leg test. Dr. Erickson thus proposed a minimally invasive hemilaminectomy at L4–L5 on the right, believing that this disc was the source of her pain. Petitioner engaged in follow-up treatment after the surgery and a valid FCE concluded that Petitioner was capable of performing sedentary-light work. The lumbar MRI of October 8, 2013 showed post-surgical changes and no herniation or stenosis. The other levels appear roughly unchanged from the prior study

Regarding Petitioner's right foot/ankle, MRI showed a cuneiform fracture and thickening of the lateral ligaments. She engaged in a course of conservative treatment, including injections and a fracture boot that failed to alleviate her symptoms. Petitioner underwent surgery on June 21, 2013 and followed up with Dr. Erickson on July 3, 2013. Although the records of chiropractic care and physical therapy overall in 2013 are devoid of much detail regarding Petitioner's subjective complaints or pain level, starting in late July, 2013, her symptoms subjectively were improving. At that time, Dr. Engel noted that Petitioner had plateaued in physical therapy and prescribed an FCE.

Petitioner's testimony regarding her symptoms is consistent with the medical chronology outlined in medical records. Petitioner had no lumbar or right foot/ankle complaints prior to his work injury and her complaints subsequent to the accident have been consistent

The Arbitrator finds the surgical recommendations credible based on the course of treatment reflected in the records. Conservative care consisting of various injections, pain medication, and physical therapy had been exhausted. Multiple physical exams revealed positive signs that were consistent with diagnostic testing.

Based on a careful review of the voluminous records documenting Petitioner's treatment, the Arbitrator finds a causal connection between Petitioner's lumbar injury and her work related accident through October 8, 2014 when her neurosurgeon released her from care. Regarding Petitioner's right ankle/foot condition, the Arbitrator finds a causal relationship to the November, 2012 accident though July 28, 2014 when she was released from care by Dr. Kane.

J) Whether the medical services provided were
reasonable and necessary

The Arbitrator incorporates the above findings on the issue of causal connection.

With respect to Respondent's Utilization Reviews, the Arbitrator notes that a great deal of Petitioner's treatment was approved. The Arbitrator too finds that much of the treatment provided for Petitioners lumbar back condition through October 8, 2013 and her foot/ankle condition though July 28, 2014 was medically necessary and appropriate with the exception of the following:

1. HP with pre-op labs prior to the TFESI performed on March 13, 2013: Petitioner was 38-years-old with no evidence of medical issues that would require pre-operative clearance including labs, EKG and chest-x-ray.

2. 4 PT sessions between April 18, 2013 and April 23, 2013: Petitioner already had 13 sessions of PT that failed to alleviate her symptoms. There is no evidence in the records that corroborate the medical necessity of these sessions.

3. Transportation: There is no evidence that Petitioner was homebound and unable to use private or public transport.

4. Any chiropractic office visit charges that are concurrent with any of Petitioner's physical therapy visits: There is no evidence to support the medical necessity of these visits which the Arbitrator deems are excessive and unnecessary. The Arbitrator notes that Petitioner's treating physician, Dr. Engel agreed that if a chiropractor charged for an office visit during the patient's physical therapy appointment it would be inappropriate. (RX 3)

K) Whether Petitioner is entitled to TTD

The Arbitrator incorporates the above findings as though fully set forth herein.

Petitioner was initially provided with restrictions from Concentra that Respondent was unable to accommodate. Petitioner was taken off of regular duty and placed on work restrictions on November 20, 2013. Although she has been released to work, Respondent failed to offer her any employment and Petitioner testified that she has repeatedly sought work through the Respondent as well as trying to work as a cleaning lady which she tried that for three days, but had to discontinue the work due to pain. That attempt was approximately two months ago.

Respondent's witness, Ms. Ochoa, testified that work was available within the Petitioner's restrictions and that the Petitioner had a failed to apply for any positions with the company. Specifically, she testified that sedentary work was available sorting cards, documents, etc. She testified that the Petitioner would have been eligible for that work and would not have needed to speak English in order to perform this work. In contrast, the Petitioner testified about regular efforts to obtain work through the Respondent. She specified several occasions where she met with individuals named Dora and Laura, as well as other individuals, all of whom Ms. Ochoa corroborated as front office employees. The Petitioner explained how she would frequently appear in the front office to obtain her husband's paycheck and would invariably request work at that time and would invariably be told none was available within her restrictions.

The implication of Ms. Ochoa's testimony is that there is work available, if not with the clients than with the Respondent directly. The Respondent is a staffing agency. If this work had been available all along, the Arbitrator finds it incredible that such work would not have been offered to the Petitioner when she was initially taken off of work. The Arbitrator finds that Petitioner's testimony is more credible on the issue of her efforts to return to work for the Respondent.

Consistent with the Arbitrator's findings with respect to causal connection and considering the evidence contained in the records as a whole, the Arbitrator awards temporary total disability benefits from November 20, 2013 up to and including July 28, 2014, at the rate of $226.61 per week. The Arbitrator further awards Respondent a credit in the amount of $2786.79 for previous temporary total disability payments.

L. The nature and extent of the injury

The Arbitrator incorporates herein her findings on the issue of causal connection.

In assessing the factors required pursuant to section 8b, of the Act, the Arbitrator notes as follows:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a mail sorting machine operator at the time of the accident. Given the fact that she is not able to return to work in her prior capacity as a result of said injury pursuant to the permanent lifting and standing restrictions, the Arbitrator assigns greater weight to this factor.

Regarding subsection (iii) of §8.1b(b), Petitioner was 39 of the date of injury and is only 41 at this point. Consequently, she will suffer the effects of this condition in her low back and in her foot/ankle for many years to come. Greater weight will be place on this factor by the Arbitrator

With respect to subsection (iv) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes a valid FCE performed on September 20, 2013 concluded that Petitioner was capable of performing sedentary-light work. Accordingly, The Arbitrator places greater weight on this factor.

For the foregoing reasons, the Arbitrator finds the Petitioner has lost 25% of the use of her right foot and ankle injury, and 20% of the use of the man as a whole for her low back injury.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua Rominski,

Petitioner,

vs. NO: 16 WC 12835

20IWCC0089

Service Drywall & Decorating,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, wages, medical expenses, TTD, prospective medical treatment, and "other", 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 34-year old journeyman carpenter, testified that his job duties with Respondent ranged "[f]rom rough framing to installing windows, backing for cabinets. We worked on the roof doing roof trusses, hanging drywall." (T.15). He noted that as a journeyman carpenter his job duties in general included "... interior systems, drywall studs, metal door frames, doors and hardware, ceiling grids, windows, commercial metal rafters on mid-rise buildings... Cabinets, crown molding base. All aspects of carpentry from rough to finished carpentry." (T.14).

Petitioner testified that on 2/9/16 he reported to the work site of the general contractor, W.E. O'Neil Construction. (T.24). He noted that prior to that date he had no pain in his left leg and that "[n]ever in my whole entire life have I had leg pain." (T.25). He also indicated that

prior to 2/9/16 his low back was "[e]xcellent" and that he had never had any treatment for same. (T.25-26). He stated that he "... had a slight fender bender several years ago [in 2011], and I had some minor physical therapy, approximately six visits worth", but he denied having any medical treatment for any portion of his back from 2012 through the first two months of 2016. (T.26). He also noted that he was working as a journeyman/carpenter in 2011 and that he did not miss any time from work as a result of this fender bender. (T.27).

Petitioner agreed that on 2/9/16 he turned right to descend the stairs and slipped and fell down eight to nine stairs on his butt and back. (T.27). He agreed that he reported his injury to a supervisor and sought medical treatment that day at Northwest Community Hospital where he was examined by Dr. Christian Daniels. (T.27-28).

In a Northwest Community Healthcare (NCH) progress note dated 2/9/16, Dr. Daniels recorded that "[t]oday at around 7:30 [Petitioner] was on the top step of some metal steps attached to the outside of the building. He went to go down the stairs and his left foot slipped on the stair and he fell down the entire stairs, [(]8-steps) on his buttocks/lower back pain. Now he is having lower back spasm, now having some mild left buttock pain & upper back of his thigh[.] Otherwise no radiation down his leg." (PX1). An assessment of lumbar spine and left hamstring strains was made at that time. (PX1). He agreed that Dr. Daniels prescribed medication, physical therapy and x-rays of his lumbar spine. (T.29).

Petitioner followed up at NCH on 2/19/16 at which time Dr. Daniels' assessment was left-sided low back pain without sciatica. (PX1). X-rays of the lumbar spine taken at that time were unremarkable. (PX1).

Petitioner was referred to physical therapy and was initially evaluated on 3/10/16. (PX1). He subsequently attended therapy sessions on 3/15/16, 3/18/16 and 3/22/16. (PX1). In a physical therapy progress note dated 3/24/16, it was recorded that the "[p]atient demonstrates very minimal changes or improvement. No worse but no significant increase in mobility or decrease in pain. Would recommend continued PT at this point." (PX1).

A lumbar MRI performed on 4/5/16 was interpreted as revealing degenerative disc disease at L5-S1. (PX1).

Petitioner indicated that he subsequently visited Dr. Samir Sharma at the Pain and Spine Institute. (T.30). He agreed that it would be a typographical error if Dr. Sharma's records mention incidents on 2/10/16 or 1/10/16. (T.31).

In an office note dated 5/13/16, Dr. Sharma recorded that Petitioner presented with lower back pain rated at 7 in intensity located primarily in the mid and lower lumbar spine radiating to the left posterior thigh. (PX2). He noted that "[t]his is an acute episode with no prior history of back pain. He states that the current episode of pain started after the injury, dated 2/10/2016 [sic]. The event which precipitated this pain was a fall down stairs. This occurred at work. Patient fell down 9 metal stairs on his buttocks; was seen by PCP who ordered 5 visits of therapy and ordered MRI... Associated symptoms include stiffness that occurs after prolong[ed] sitting, paravertebral muscle spasm and radicular left leg pain. He denies numbness in the lower leg or

weakness of the lower leg." (PX2). Dr. Sharma indicated that "Medical history is negative for history of significant low back pain; Pt did have mva with back pain several yrs prior which resolve[d] with 9 visits of therapy; MRI findings and imaging reviewed in detail with patient. Evidence of disc herniation at the left L5-S1 level(s)… neural foraminal narrowing of the Left L5-S1 vertebral levels; T2 high intensity signal consistent with annular disruption at the L5-S1; disc level(s)…" (PX2). Dr. Sharma referred Petitioner to physical therapy for evaluation of low back pain and imposed modified duty work restrictions which included maximum lifting/carrying of 10 lbs. and push/pull and lifting over shoulders limited to 4 hours. (PX2). These same restrictions, in addition to continued physical therapy, were referenced in office notes dated 6/17/16 and 7/15/16. (PX2).

Petitioner underwent therapy at ATI Physical Therapy from 5/19/16 through 7/14/16 and was discharged on 7/25/16 having attended 19 sessions. (PX7). The Commission notes that these records reflect continued complaints of low back pain by Petitioner throughout this period.

In an office note dated 7/15/16, Dr. Sharma recorded that the patient rated his lower back pain as an 8 and stated that "[h]is symptoms are worse since last visit … [He] has not found anything that helps relieve the pain… The patient has tried conservative therapy such as physical therapy and/or chiropractic therapy for 8 wks with increased pain; Patient feels sx have progressed in left LEX since last visit with inc pain/numbness; has trialed both nap/ibu w/o benefit…" (PX2). Dr. Sharma recommended a transforaminal ESI for therapeutic purposes given that "[t]he patient has radicular pain that is resistant to other therapeutic measures…" (PX2). The same modified duty restrictions were imposed at that time as well. (PX2).

Petitioner noted Dr. Sharma performed the first prescribed injection on 8/16/16. (T.33).

In an office note dated 9/16/16, Dr. Sharma recorded that the patient's lower back pain was rated a 7 in intensity and that "[h]is symptoms are improved initially, then worsened with deterioration of activities and levels of function… since last visit. He had a L5, S1 Transforaminal Epidural Steroid Injection last visit. The procedure provided a 60% relief of pain for 1 wk with return of pain after trying to do more activity at work…" (PX2).

Petitioner received a second epidural steroid injection on 9/27/16. (PX2).

Petitioner agreed that at the request of Respondent's insurance company he presented to Dr. Andrew Zelby on 9/30/16. (T.34). He noted that this exam took "[l]ess than five minutes." (T.34).

In a report dated 9/30/16, Dr. Zelby noted that he saw Petitioner in his office on that date for a §12 examination at the request of Respondent. (RX1). Following his examination and review of the records, Dr. Zelby diagnosed Petitioner with 1) mild lumbar spondylosis without radiculopathy, and 2) lumbar strain. (RX1). Dr. Zelby opined that "[o]bjectively [Petitioner] has a normal spine exam, with a reported sensory loss that is inconsistent with any abnormality in his lumbar spine. He has no jugular symptoms or findings on exam and his reported symptoms and his leg do not represent a radiculopathy. He also has nothing on his MRI that would result in his reported symptoms. Mr. Rominski sustained a lumbar strain as a consequence of his February 9,

2016 work injury. His treatment has been excessive and protracted for no identifiable medical reason. His injections were not reasonable or necessary irrespective of cause since Mr. Rominski has no condition in his spine that would be treated with injections. It is not surprising that Mr. Rominski reported no improvement in his subjective complaints after his injections since there is no relationship between the findings on his MRI and his subjective complaints. Mr. Rominski had a soft tissue injury and not an injury to the structural elements of his spine. His reported persistence and reported severity of symptoms are inconsistent with the objective medical findings and inconsistent with the natural history of his objective medical condition. There is no objective evidence to relate his ongoing subjective complaints to his reported incident at work in February 2016. Mr. Rominski requires no additional diagnostic studies or any further directed treatment for his spine irrespective of cause. He should be advised of the importance of a diligent, daily, self-directed range of motion, stretching and core strengthening exercise program both as a mainstay for long term control of his symptoms and also for the general health of his spine. Mr. Rominski was at maximum medical improvement for any infirmity to his spine arising as a consequence of his reported February 9, 2016 work injury by early May 2016 at the latest. He has been qualified to work without restrictions since that point at the latest, and he remains medically qualified to work full duty now. He is at no increased risk for injury with a return to full duty work. There is no medical basis to suggest that Mr. Rominski suffered any permanent disability as a result of his reported February 9, 2016 work injury." (RX1).

In an office note dated 10/28/16, Dr. Sharma stated Petitioner's symptoms were improved since the last visit and injection which he noted "... provided a 50% relief of pain for 2 wks with return of pain; leg pain has improved." (PX2). Petitioner agreed he received his third ESI at the time of this visit and that Dr. Sharma then referred him to Dr. Cary Templin for a surgical consult. (T.35).

In an office note dated 11/29/16, Dr. Templin recorded that Petitioner "... presents after a work-related injury that occurred on 01/10/2016 [sic]. Josh was walking out onto a set of stairs and had to turn to the right. When he did, his feet went out from under him and he slid down the stairs feet first on his back and has noted pain extending from the back and into the left leg since that time. Pain extends over the left hip girdle and down to the lateral thigh. He has done a 6-week course of therapy. He has done 3 injections with Dr. Sharma which have given him only temporary relief." (PX3). Dr. Templin's review of the x-rays and lumbar MRI "... show that there is mild degenerative change in the lumbar spine. There is noted to be degenerative disk change with a large annular tear at L5-S1 with a slightly rightward-more-than-leftward disk protrusion which abuts, but does not displace, the neural elements. It is more prominent to the right side. There is a small disk protrusion into the left L4-L5 foramen." (PX3). Following his exam, Dr. Templin recommended Petitioner "... re-enroll in physical therapy for 4-week course followed by a course of work conditioning. I would also recommend that he undergo a left SI joint injection to see if this benefits him. I will keep him on a 20-pound lifting restriction." (PX3).

On 12/15/16, Dr. Sharma performed a lumbar diagnostic medial nerve branch block at S1, S2 and S3. (PX2).

In an office note dated 1/10/17, Dr. Templin indicated that the patient "... states he did not notice significant relief..." following the SI joint injection on the left side by Dr. Sharma on 12/15/16 and that "[h]e continues to have pain that is primarily in his lower back with radiation into his left buttock and leg. It does not go below the knee." (PX3). Petitioner was instructed to follow up in one month and "... to bring his films to that visit for us to review. At that time, we can determine whether or not he may be a surgical candidate as he has been through epidurals, physical therapy, SI joint injections, and medications." (PX3).

In an office note dated 1/13/17, Dr. Sharma recorded that the procedure performed on 12/15/16 "... provided a 90% relief of pain 2 wks; overall still 40% improved..." (PX2).

In a Triune Health Group UR report dated 1/27/17, Dr. Steven Blum (board certified anesthesiologist with a sub-certification in pain medicine) non-certified the following procedures under review for medical necessity: 1) Flector 1.3% patch #60 prescribed 5/13/16; 2) physical therapy completed 5/19/16 – 7/25/16 to include all modalities; 3) L5, S1 Transforaminal Epidural Steroid Injection completed 9/27/16; 4) Lumbar Diagnostic Medial Nerve Block of the TP of Sacral ala S1, S2, S3 completed 12/15/16; 5) Tramadol 50 mg #30 prescribed on 9/16/16; and 6) proposed left sacroiliac joint injection under fluoroscopic guidance. (RX3).

In a Triune Health Group UR report dated 1/27/17, Dr. Gary Scott Shapiro (board certified orthopedic surgeon) non-certified the following procedures under review for medical necessity: 1) proposed left sacroiliac joint injection; and 2) any and all physical therapy completed beyond the 2 certified visits. (RX4).

Petitioner indicated that he has never presented to Dr. Blum or Dr. Shapiro, the above UR physicians, regarding this case. (T.46-47).

On 2/1/17, Dr. Sharma performed a sacro-iliac joint injection. (PX2).

In a Triune Health Group UR report dated 2/13/17, Dr. Safwan Barakat determined the following: 1) non-certification of proposed left sacroiliac joint injection; and partial certification of 2 physical therapy visits as ordered 1/10/17. (RX5).

In an office note dated 2/21/17, Dr. Templin recorded that the lumbar MRI "... demonstrates disc degeneration, annular tear and disc bulging at L5-S1. There is no significant central canal stenosis." (PX3). Dr. Templin noted that Petitioner was to "... follow up with Dr. Sharma in two weeks to discuss further intervention. We discussed that if he wishes to pursue potential surgery, we recommend a discogram prior to this, given his predominant lower back pain and his underlying degeneration. He will follow up afterwards." (PX3). Petitioner was also to continue with the previous work restrictions. (PX3).

In an office note dated 3/7/17, Dr. Sharma recorded that the patient's symptoms were improved since the last visit and that "[t]he procedure provided a 60% relief of pain for 2 wks with return of pain..." (PX2). Dr. Sharma noted that the "[p]atient was seen by spine surgeon who did rec lumbar discogram..." (PX2). Dr. Sharma noted that "[t]he patient will return for the following procedure: lumbar discogram Post-discogram CT scan to follow under fluoroscopic

guidance." (PX2).

On 3/27/17, Dr. Sharma performed a lumbar provocation discogram of the L4-L5, L5-S1 disc levels. (PX2). It was noted that concordant pain was identified at L5-S1. (PX2).

In an office note dated 4/4/17, Dr. Templin recorded that Petitioner "... has had back pain since a fall a year ago. At this point in time, he has had extensive nonoperative care including therapy, injections, medications, which have been unable to significantly reduce his pain to allow him to return to work. That being said, based on the findings of the CT portion of the diskogram, it appears that there is significant degenerative change to the L5-S1 disc with normal appearing L4-L5. If we see that there is no pain exacerbated by the L4-L5 level but significant pain at L5-S1, then one may consider a fusion of L5 S1 once I review Dr. Sharma's report from the diskogram. After discussing with the patient, should those be the findings of the provocative portion of the report, he would like to proceed with surgical intervention." (PX3). In addition, Dr. Templin noted that he reviewed the IME report of Dr. Zelby "... who indicated that Mr. Rominski suffered a lumbar strain with mild spondylosis, which certainly given the continued pain after a year of conservative treatment, does not seem to be the case." (PX3).

In an office note dated 4/10/17, Dr. Sharma recorded that the patient's symptoms were unchanged since his last visit and that the discogram resulted in a worsening of pain for a short time. (PX2). At that time, Dr. Sharma noted that "[p]atient's results were discussed with discogram with positive response at L4-S1; pt was seen by spine surgeon who did rec spine surgery however patient is considering 2nd opinion." (PX2). Dr. Sharma thereupon referred Petitioner to orthopedist Dr. Krzysztof Siemionow for evaluation and a second opinion. (PX2). He also continued to recommend modified duty. (PX2).

In a report dated 4/26/17, Dr. Siemionow recorded that the patient presented with low back pain radiating into the left lower extremity, and that "[h]e is here for a second opinion" regarding a recommendation for an anterior lumbar interbody fusion. (PX4). Dr. Siemionow noted that Petitioner "... denies having any problems with his lumbar spine requiring treatment before (02/10/16 [sic]). He has had spinal injections. He has taken medications for his current condition as a result of a (02/10/16 [sic]) work-related injury." (PX4). Dr. Siemionow's impression was "L5-S1 intervertebral disc degeneration and disc herniation with low back pain and left lower extremity radiculopathy." (PX4). He noted that his "... current recommendation is an anterior lumbar interbody fusion." (PX4).

In an office note dated 5/16/17, Dr. Sharma recorded that the "[p]atient was seen by 2nd opinion spine surgeon of which patient states was in agreement with surgery however corres[pondence] not available..." (PX2). Petitioner was to schedule a follow up visit in 4 weeks "... after physical therapy to assess benefit and discuss further treatment options..." (PX2).

Petitioner underwent a valid FCE at ATI Physical Therapy on 6/1/17 which demonstrated a physical demand level of LIGHT TO MEDIUM which was noted to be below the DOT level for his occupation. (PX7).

An MRI of the lumbar spine performed on 6/28/17 was interpreted as revealing "[s]pondylitic change of the lumbar spine at the level of L5-S1 with annular fissure formation of unknown chronicity. However there is no evidence for significant spinal stenosis or foraminal stenosis at any level." (PX3).

In a Triune Health Group UR report dated 8/15/17, Dr. Shapiro non-certified the following procedure under review for medical necessity: proposed anterior lumbar interbody fusion L5-S1 (assistant surgeon to perform approach) removing disc L5-S1 replacing with artificial disc filled with bone morphogenetic protein, posterior instrumentation at L5-S1 in a face down position. (RX6).

Petitioner was seen by Dr. Daniels on 8/28/17 for a pre-operative examination relative to the L5-S1 decompression procedure planned for 9/6/17. (PX1).

On 9/6/17, Petitioner underwent surgery at the hands of Dr. Templin in the form of 1) L5-S1 anterior lumbar interbody fusion; 2) application of interbody cage device, L5-S1; 3) anterior spinal instrumentation, L5-S1, using a Globus plate and screw system; 4) application of allograft bone fusion, L5-S1; and 5) neurophysiologic monitoring. (PX3). The pre and post-operative diagnosis was L5-S1 degenerative disc disease, discogenic low back pain, radiculopathy. (PX3).

In a Work Status Report dated 10/17/17, Dr. Templin took Petitioner off work completely. (PX3). Dr. Templin continued this off-work restriction in Work Status Reports dated 12/5/17 and 1/16/18. (PX3).

Petitioner agreed that he returned to Dr. Zelby at the request of the insurance company on 12/4/17. (T.43). He estimated that Dr. Zelby was in the room "[l]ess than the first [visit]. Maybe four minutes." (T.43).

In a report dated 12/4/17, Dr. Zelby noted that he saw Petitioner in his office on that date for another §12 exam. (RX1). He noted that Petitioner received additional therapy and injections and underwent an L5-S1 anterior fusion on 9/6/17 and that he "... feels that his low back pain is better and now his pain feels more like stiffness and discomfort although he has been very limited in his activities since surgery." (RX2). Following his examination and review of the records, Dr. Zelby diagnosed Petitioner with 1) mild lumbar spondylosis without radiculopathy, 2) lumbar strain, and 3) history of lumbar fusion. (RX1).

Dr. Zelby opined that "[o]bjectively [Petitioner] still has a normal spine exam and a normal neurologic exam. The opinions that I have already outlined concerning Mr. Rominski's injury and his spinal condition are unchanged since the bases for those conditions are unchanged. The fact that Mr. Rominski continued to report such significant pain in the context of the mild degeneration seen does not negate a diagnosis of a lumbar strain. It should indicate that the complaints of pain cannot be corroborated with any objective medical findings and while Mr. Rominski did have degenerative disc disease at L5-S1, the mild degeneration was a clear indication that this would not cause either the reported severity or reported persistence of pain that Mr. Rominski described. Pursuit of a fusion for the mild degenerative disc disease seen on Mr. Rominski's diagnostic studies exceeds the guidelines for the treatment of his objective

medical condition. Even with the described findings on discography, with such mild degeneration there is no reasonable expectation that such surgery will provide Mr. Rominski with meaningful and sustained relief of his complaints of pain. Because of that there was no medical basis to pursue the discogram. The discogram and surgery were not reasonable or necessary based on Mr. Rominski's objective medical condition and were not necessary as a consequence of his reported February 9, 2016 work injury… My opinions about Mr. Rominski's point of maximum medical improvement and ability to work as relates to his reported work injury from February 9, 2016 remain unchanged. At this point following the L5-S1 ALIF, a patient would typically begin physical therapy now. He should undergo 4-6 weeks of directed physical therapy followed by 4-6 weeks of work conditioning/hardening. He may return to light duty work after his first four weeks of postoperative physical therapy and return to regular duties after the physical therapy and work conditioning as outlined above. Mr. Rominski will be at maximum medical improvement for his surgical intervention by early March 2018 if x-rays indicate he has a solid arthrodesis at L5-S1. Any permanent restrictions that he may receive at the completion of the therapy program outlined above would not be necessary or more likely to become necessary as a consequence of his reported February 9, 2016 work injury." (RX2).

In an office note dated 12/5/17, Dr. Templin recorded that Petitioner was "… doing better than he was prior to surgery." (PX3). He noted that x-rays of the lumbar spine taken on that date demonstrate proper position, healing and alignment of the L5 to sacrum fusion with no evidence of loosening or subsidence and good restoration of disc height. (PX3). Petitioner was to start physical therapy with an eye towards advancing to a work conditioning program when able. (PX3).

Petitioner attended 35 therapy sessions at ATI Physical Therapy from 12/14/17 through 3/7/18. (PX7).

In an office note dated 1/16/18, Dr. Templin recorded that Petitioner was "… four months status post an anterior lumbar interbody fusion. He is doing well. He is continuing through physical therapy now and has made some progress… Pending his progress in therapy, we may transition him to work conditioning." (PX3).

In an office note dated 2/27/18, Dr. Templin recorded that Petitioner "… has been having some irritation of the left SI region in therapy, but overall doing well." (PX3). He noted that x-rays show "… there is a solid appearing fusion of L5-S1. No loosening, subsidence or migration." (PX3). Dr. Templin noted that Petitioner was to follow up with him in six weeks and that "[m]y plan right now is to transition him over the next couple weeks to work conditioning and in six weeks hopefully be close to placing him at maximum medical improvement… He remains off work pending work conditioning." (PX3).

Petitioner testified that prior to surgery his low back was "[a]wful. Daily pain, up at night, couldn't sleep." (T.44). He indicated that since surgery his low back is "… significantly better. I'm sleeping through the night. I'm more mobile and functioning through my daily life." (T.44-45). He noted that prior to the surgery he had pain and "… needle numbness to the knee" on a daily basis. (T.45). He stated that now "[i]t's significantly better than what it was. I do still have the continuous discomfort, but I can walk throughout the day versus before the surgery, I

could not." (T.45).

Petitioner was shown a check ledger at RX10. (T.49). He agreed that it shows he began work for Respondent on 1/23/16 and that he worked 16 hours that week. (T.49). He agreed that he worked 40 hours the following week, 1/30/16, and that he earned $1,644.47. (T.50). Likewise, he agreed he worked 37.5 hours the following week, 2/6/16, and earned $1,541.63 and that he worked 24 hours the week of 2/13/16, earning $986.64. (T.50).

Petitioner agreed that he incurred medical bills as a result of medical treatment and that he believed the bills admitted at PX8 are "... accurate as could be." (T.50-51).

Petitioner believed that he stopped working for Respondent "... sometime in October 2016 ... when they told me to sit home, to the best of my knowledge." (T.51-52). He indicated this occurred after his first examination with Dr. Zelby, and that he has not received a check since that time. (T.52).

Petitioner testified that CJ's Firewood is "... a small operation between my mother, my father, my brother-in-law, my girlfriend's son Christian. Basically getting logs and selling it in a bundle-type style on a rack at my parent's house in Mount Prospect." (T.52-53). He agreed that this operation was opened prior to his work injury. (T.53). When asked what this enterprise involves physically, Petitioner responded: "[b]efore the accident, we would process firewood and actually take logs and split them and season them for 18 months, and then you would, you know, deliver the firewood to different locations and make bundles that we would also sell at my parents." (T.53). Since the accident, he noted that "I've done it a couple of times, bundling it, maybe approximately five to six times. At this point, my parents have had to do 90 percent of it just to keep it kind of going to have 20 to $40 of an income for a week with that. I have a neighbor down the street from them as well that helps – occasionally will help them." (T.53). He indicated that prior to the accident he would bundle "[e]very other week to every three weekends. Saturdays." (T.54). He later agreed that he bundled firewood at CJ's Firewood five or six *times* post accident, not five or six *days*. (T.76-77). He also denied ever injuring his back and left leg working at CJ's Firewood, and is not making a claim for lost income from CJ's Firewood, noting that "[i]t's strictly basically a hobby-type business. It's not profitable per se." (T.54). He stated that since the accident his involvement in this business has been "... very minimal." (T.54).

On cross examination, Petitioner agreed that he worked for CJ's Firewood for about five or six times and that this included bundling firewood. (T.56). He noted that the bundles weigh 18 to 20 pounds and that "[i]t's all tree logs at this point. After my accident, all this wood has been seasoned for about two to three years at this point. So it's basically, it being put into my truck, primarily for my brother-in-law and transported to my parent's house, and at this point it would be put into a machine, and the machine actually processes the bundling. You just put the specific pieces of wood in it... And you remove the bundle and put it on a rack." (T.56-57). In describing the process, Petitioner testified that "[y]ou would just take approximately four to five individual pieces of firewood, put it onto a machine and use a foot pedal that would automatically spin the Saran Wrap around the firewood, and then at that point you would just remove the bundle and put it onto a rack." (T.58).

Petitioner agreed that he returned to work for Respondent through October 2016 and that he worked on average about 24 to 40 hours. (T.60). He also agreed that Dr. Sharma imposed light duty restrictions at office visits on 5/13/16, 6/17/16 and 7/15/16. (T.60-61).

Petitioner acknowledged that he has a Facebook account under his name and that he has taken photos and posted them on the internet. (T.62). Petitioner was shown RX11, which he agreed was the front page of his Facebook profile. (T.63). He noted that he "[o]casionally" posts photos, comments and statuses on his Facebook page and that he may have "[p]ossibly" posted pictures of jobs that he's done. (T.63). He recalled taking photos on 7/20/16 of a lot that he was going to flip. (T.64). He agreed that it says he was going to flip Joanne's lot. (T.66). He noted that the property was sold at $4,200 and he felt it could be sold at a price of $6,200 all cleaned up. (T.66-67). He agreed that he also "[p]ossibly" could have posted photos of another lot on 8/28/16. (T.67). Petitioner was shown RX11 and noted that "... would be the same piece of property." (T.67-68). He testified that "[m]y girlfriend purchased that piece of property at a Deed County Auction, and it was with the intent of her actually keeping it after the fact of thinking about it, and being in thought with her, she chose not to keep it. So we hired Tom Nauman out of Amboy to come in with his Bobcat and machinery to clear the lot to proceed to sell it, and I believe it's Nauman Excavating out of Amboy, Illinois." (T.69). He noted that he had two estimates for clearing the lot. (T.69).

On re-direct examination, Petitioner indicated that he has a scar below his belly button from the surgery. (T.73). He agreed that meant that in order to perform the surgery they had two surgeons and that they had to bypass his vital organs. (T.73). He also agreed that the lot shown in RX11-A (pp.1-2) was his girlfriend's. (T.73-74). He indicated that he did not do any work on the lot other than tie yellow ribbons around the trees that were saved, which he indicated was not outside his restrictions. (T.74). He stated that RX11-B (pp.1-6) shows "... a piece of property for camping. It's a seasonal campground." (T.75). He agreed that he took a photograph of it, and that it's the same property shown in RX11-A (pp.1-2). (T.75-76).

On further re-direct examination, Petitioner agreed Dr. Templin is currently recommending work conditioning, and that he had another visit with Dr. Templin he believed on 4/10 or 4/11/18. (T.78). He agreed he anticipates that Dr. Templin will recommend more work conditioning at that time. (T.78).

On further re-cross examination, Petitioner noted that he believed he had had two and a half weeks of work conditioning as of the date of arbitration (4/6/18). (T.80).

Conclusions of Law

It is well-settled that the Commission may infer causation from a sequence of lack of symptoms prior to an industrial accident, with symptom manifestation immediately following the accident. *Steak 'N Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC (3rd Dist. filed 11/17/16); citing *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 207-208; *United Coal Mining Co. v. Industrial Commission*, 318 Ill.App.3d 170, 175 (2000).

Furthermore, 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. *Kawa v. Illinois Workers' Compensation Commission*, 991 N.E.2d 430, 372 Ill. Dec. 123 (1st Dist. 2013); citing *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 63064, 442 N.E.2d 908, 911 (1982). The courts have found that this principle is nothing but a common-sense, factual inference. *Schroeder v. Illinois Workers' Compensation*, 79 N.E.2d 833, 839, 414 Ill. Dec. 198, 204, (4th Dist. 2017).

More to the point, the courts have held that "if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been." *Schroeder*, 79 N.E.2d at 839.

In the present case, Petitioner suffered an undisputed accident wherein he slipped and fell down eight to nine metal stairs and landed on his buttocks and back. The record also shows that Petitioner suffered no previous low back injuries, other than a self-described "slight fender bender" in 2011, which resolved with therapy. More importantly, he received no treatment for his low back from 2012 through February of 2016 and continued to work full duty as a journeyman carpenter without missing any time from work as a result of any low back complaints during the period leading up to the accident. In addition, he sought immediate treatment the day of the incident and subsequently underwent extensive physical therapy, during which time he continued to consistently complain of low back pain. Furthermore, at no point has he ever been accused by any of his treating and/or examining physicians of malingering or not giving a valid effort.

Dr. Sharma reviewed the MRI performed on 4/5/16 and found "[e]vidence of disc herniation at the left L5-S1 level(s)… neural foraminal narrowing of the Left L5-S1 vertebral levels; T2 high intensity signal consistent with annular disruption at the L5-S1; disc level(s)…" (PX2). Dr. Templin subsequently reviewed the same MRI and found "… mild degenerative change in the lumbar spine. There is noted to be degenerative disk change with a large annular tear at L5-S1 with a slightly rightward-more-than-leftward disk protrusion which abuts, but does not displace, the neural elements. It is more prominent to the right side. There is a small disk protrusion into the left L4-L5 foramen." (PX3). In addition, Dr. Templin ordered a discogram which identified concordant pain at L5-S1. (PX2). Furthermore, Dr. Siemionow, who Petitioner visited for a second opinion concerning the recommended fusion surgery, diagnosed Petitioner with "L5-S1 intervertebral disc degeneration and disc herniation with low back pain and left lower extremity radiculopathy." (PX4). Dr. Siemionow agreed with Dr. Templin's recommendation for an anterior lumbar interbody fusion. (PX4). Petitioner eventually underwent this procedure on 9/6/17. Petitioner testified that since surgery his low back feels "… significantly better. I'm sleeping through the night. I'm more mobile and functioning through my daily life." (T.44-45).

In sharp contrast to this evidence, Respondent's §12 examining physician, Dr. Zelby, maintains that Petitioner suffered nothing more than a "lumbar strain" as the result of the 2/9/16

work injury. (RX1). The Commission finds Dr. Zelby's opinion wholly unpersuasive given the totality of the evidence.

Therefore, based on the chain of events -- evidencing a lack of symptoms during the years leading up to the accident and the manifestation of debilitating symptoms immediately thereafter – as well as the medical records taken as a whole, the Commission finds that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being relative to his lower back is causally related to the accident on 2/9/16.

As a result, and in light of the above determination as to causation, the Commission finds that Petitioner is entitled to the reasonable and necessary medical expenses set forth in PX8 and PX9 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. Along these lines, the Commission finds the opinions of Dr. Zelby, to the effect that the treatment was "excessive and protracted", to be unsupported by the evidence. Likewise, the Commission has considered the opinions of the various utilization review doctors as to the certification of specific treatment modalities, including surgery, as set forth in their reports, and finds these opinions to be similarly unpersuasive, for the reasons set forth above.

In addition, having found causation, the Commission finds that Petitioner is entitled to prospective medical treatment in the form of work conditioning as prescribed by Dr. Templin.

Furthermore, with respect to TTD, the medical records show that on 5/13/16 Dr. Sharma imposed modified duty restrictions including maximum lifting/carrying of 10 lbs. and pushing/pulling/lifting over the shoulders limited to 4 hours. (PX2). The same restrictions were imposed by Dr. Sharma at the time of office visits on 6/17/16 and 7/15/16. (PX2). At the request of Respondent, Petitioner visited Dr. Zelby on 9/30/16 at which time the latter opined that Mr. Rominski was capable of returning to full duty work. (RX1). Petitioner testified that he worked for Respondent through October 2016, and that he has not received a TTD check since his first examination with Dr. Zelby. (T.52,60). He also testified that he believed he stopped working for Respondent "... sometime in October 2016... when they told me to sit home..." (T.51-52). The Commission notes that the parties submitted no specific testimony or other evidence to show exactly when Petitioner stopped working for Respondent or when Respondent ceased paying TTD. Based on the above, and the record taken as a whole, the Commission finds that Petitioner is entitled to temporary total disability benefits from 11/1/16, given Petitioner's testimony to the effect that he worked "through" October 2016, through 4/6/18, the date of arbitration, for a period of 74-4/7 weeks.

Finally, the Commission notes that Petitioner marked "wages" and "rate" as issues in dispute on review, but failed to address same in his brief. Likewise, Petitioner noted "Special Findigs [sic]" under "Other" on his Petition for Review, but specifically waived this issue at the time of oral argument. Therefore, these issues have been waived.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 8/1/18 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,062.00 per week for a period of 74-4/7 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 for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner medical expenses as set forth in PX8 and PX9 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 prospective medical treatment in the form of work conditioning as prescribed by Dr. Templin, 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.

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: FEB 5 - 2020
o:12/10/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stanley Haseltine,

Petitioner,

vs. NO: 13 WC 42502

City of Chicago Water Department ,

Respondent.

20IWCC0090

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 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 7, 2019, is hereby affirmed and adopted.

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

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

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

DATED: FEB 5 - 2020
o012320
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HASELTINE, STANLEY Case# **13WC042502**

Employee/Petitioner

CITY OF CHICAGO WATER DEPARTMENT

Employer/Respondent

20IWCC0090

On 3/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% 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:

0700 GREGORIO & MARCO
SEAN C STEC
2 N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
LAUREN A SERAFIN
140 S DEARBORN ST SUITE 700
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

STANLEY HASELTINE,
Employee/Petitioner
v.
CITY OF CHICAGO WATER DEPARTMENT
Employer/Respondent

Case # **13** WC **42502**

Consolidated cases: **n/a**

20 IWCC0090

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JULY 31, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **DECEMBER 6, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**75,972.00**; the average weekly wage was $**1,461.00**.

On the date of accident, Petitioner was **25** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**186,878.45** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**186,878.45**.

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

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

- The Arbitrator finds the Respondent shall pay Petitioner the sum of **$721.66** per week for a further period of **75 weeks,** as provided in **Section 8(d)2** of the Act, because the injury to the Petitioner caused a **15% loss of use of the person-as-a-whole**;

- The Arbitrator also finds the Respondent shall pay the Petitioner TTD benefits from December 7, 2013 through August 7, 2017. Furthermore, the Respondent shall have a credit in the amount of $186,878.45 for previously paid TTD benefits.;

- The Arbitrator denies the Petitioner's request for payment of medical bills after April 26, 2017. Furthermore, the Respondent shall receive a credit for all medical bills previously paid.; and,

- The Respondent shall pay those benefits that have accrued in a lump sum, 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

MARCH 7, 2019
Date

MAR 7 - 2019

STANLEY HASELTINE v. CITY OF CHICAGO WATER DEPARTMENT

13 WC 42502

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on July 31, 2018. The issues in dispute were causal connection, medical bills, TTD benefits, and the nature and extent of the injury, if any. Arbitrator's Exhibit 1. The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. Arbitrator's Exhibit (*hereinafter*, AX) 1.

FINDINGS OF FACT

The Petitioner testified that he worked for the City of Chicago, Water Department, as a laborer since approximately 2010. He testified that his first memory after his work injury was waking up at Northwestern Hospital. TX. 12. He does not remember the injury. Initially, the Petitioner reported that he sought treatment with Dr. Gireesan for an injury to his spinal cord, and then later began treatment for his neurologic complaints with Dr. Shepard. TX. 16.

In April of 2014, the Petitioner reported beginning treatment at Loyola Hospital because it was easier than driving downtown to Northwestern. TX. 17. At Loyola, he treated with Dr. Ghanayem, Dr. McCoyd, and Dr. Bajaj. *Id.* The Petitioner testified that he remembered first seeing Dr. Bajaj in April of 2014 and remembered beginning treatment at Rehabilitation Institute of Chicago around the same time. *Id.*

The Petitioner described his treatment for pain management therapy at the Rehabilitation Institute of Chicago five days a week, eight hours a day. TX 18. He also testified that he underwent speech therapy with Ms. Julie Phelan for about six months. The Petitioner also testified that he treated with Dr. Zost for blurred and double vision in October of 2014. TX. 18.

On December 1, 2015, the Petitioner testified that he underwent a surgical procedure with Dr. Anderson at Loyola to remove part of the nerves in his head. TX. 20. Since that date, the Petitioner reported having numbness and pain in the back of his head "all the time." TX. 21. In November of 2016, the Petitioner testified that he went to Michigan for a neurological

stimulator trial. However, because it did not work, he never underwent the permanent implant. TX. 22.

The Petitioner testified that after his work accident, he wakes up and goes to bed with head pain and goes to bed. TX. 27. He testified that he lies in bed all day, and his head feels like he is being "hit with a hammer." *Id.* His pain varies from constant 7/10 pain on a good day, and pain that is a 10/10 on a bad day. *Id.* He stated that he has approximately two good days and five bad days a week. *Id.*

The Petitioner testified that he remembered attending three Section 12 Examination appointments with Dr. Kohn, Dr. Glantz, and Dr. Weber. TX. 23. He also testified that on February 26, 2018, he saw a psychiatrist for nightmares, a fear of crowds, and a fear of dying. TX. 24.

With respect to Petitioner's vocational assessment, the Petitioner testified that he was interviewed by Kari Stafseth on October 31, 2017 and was truthful and honest with what he told her. TX. 25. He testified that he was not working since his accident, and he was recently approved to receive Social Security benefits. TX. 26.

With respect to his family life, the Petitioner stated that he has two children, three and five years of age, and his sister-in-law cares for them during the day as he is unable. TX. 28. He testified that he cannot watch television sports, or any programs with fast moving items on the television because it bothers him. The Petitioner testified that he only drives if he needs to pick up a prescription and his wife is at work. TX. 31.

On cross examination, the Petitioner testified that he was truthful and honest with what he told Dr. Bajaj and Dr. McCoyd during his examinations about his subjective complaints. TX. 32. He confirmed during his testimony that he was unable to care for his children, but also admitted he and his wife were able to conceive one child after his work injury. *Id.* He also testified that could not stand or sit for greater than ten minutes at a time. *Id.* When it was pointed out that the Petitioner had been sitting for greater than ten minutes at trial, he admitted that he was able to do so. *Id.* The Petitioner also testified that he could not lift greater than ten pounds. *Id.* Finally, he testified that he could not drive with fast moving traffic. TX. 33.

With respect to Petitioner's Vocamotive interview, the Petitioner confirmed that he told Ms. Stafseth he was unable to help around the house, and that he dropped out of high school. TX. 33. When presented with a copy of his resume that he submitted to the City of Chicago, however, he testified that he listed his educational background as not only having graduated high school but was attending classes at Joliet Junior College and working towards a bachelor's degree. TX. 34. When questioned whether the Petitioner took classes at Joliet Junior College,

he testified that he had not. TX. 35-36. When presented with a copy of his transcript reflected that he had, in fact, taken a class, he stated he did not know. The Petitioner testified that it was his name and date of birth on the transcript, and that the grade received in the class was an "A." TX. 38.

Surveillance was conducted by Bonnamy and Associates on three dates. Respondent's Ex. 6. On September 9, 2015, the Petitioner left his garage at 9:40am and began driving. Surveillance efforts were terminated due to Petitioner driving in a "circuitous fashion."

On September 19, 2015, surveillance was also conducted. Respondent's Ex. 6. On that date, the Petitioner drove in the morning at 8:35am, but the investigator lost the Petitioner while driving and returned to the Petitioner's home. At 10:46am, the Petitioner was found walking outside of his home, dressed in an "Illinois" tee-shirt, with another male. The Petitioner walks without appearing in any distress for approximately three hours. He is shown walking with a drill attached to his back jeans pocket. The Petitioner returns many times to the garbage cans outside in the alley and is shown breaking up large tree branches to fit into the garbage. He is bending, sweeping, walking, and carrying items until 1:42pm. The Petitioner confirmed that he was the individual depicted in the video footage.

On Wednesday, October 28, 2015, the Petitioner departed his home at 10:23 a.m. Respondent's Ex. 6. He drove to Hinsdale Illinois to enter a woman's clothing store. He drove thirty-three minutes home and returned at 12:33 p.m.

Respondent called Jim Kasper of Investigative Solutions to testify to his surveillance efforts. Jim Kasper testified that he conducted surveillance on three days and completed approximately thirty hours of investigation. TX. 45 Mr. Kasper testified that on the three days of investigation, he documented the Petitioner driving on highways and roads for roughly five hours. He testified that the Petitioner would drive to restaurants, shop at Home Depot for large plastic bins, push a shopping cart, and to drive his children to daycare. TX. 51. He described the Petitioner's driving as "aggressive" and travelling at very high speeds, sometimes as high as eighty-five miles per hour. TX. 54. He testified that in his many years of working as a private investigator, the Petitioner was one of the most aggressive drivers he saw. TX. 54. It was difficult for him to keep up with the Petitioner's driving.

Video clips from Mr. Kasper's investigation document the Petitioner driving through a McDonald's drive thru and dropping his children off at daycare. Respondent's Ex. 8. The Petitioner is shown to be walking without distress and carrying his one child while holding his other child's hand. At times, he lifts his five-year-old with one arm while carrying his other child in the other hand. Both children appear to be much greater than his alleged ten pound carrying limit.

Photographs of the investigation also document the Petitioner driving, carrying his children, pushing shopping carts, and entering stores. Respondent's Ex. 7.

The Petitioner's medical care began on the date of accident as he initially was taken to Northwestern via ambulance. After his initial hospitalization, the Petitioner visited Dr. Gireesan on December 26, 2013. Petitioner's Ex. 3 The Petitioner continued to complain of pain in the neck and upper back and reported headaches and blurred vision. CT scans of the cervical, lumbar and thoracic spine did not reveal any evidence of fractures or dislocations. He was referred to a neurologist for his headaches and blurred vision. He was diagnosed with a contusion of the back and neck.

The Petitioner visited Dr. Alan Shepard on January 22, 2014. Petitioner's Ex. 5. He presented oriented to person, place, problem and time. His recent and remote memory was noted to be intact. On examination, Petitioner's pupil examination was reported to be reactive to light and dark, his examination was "grossly normal" with a normal nerve and optic vessel appearance. The Petitioner, however, reported memory loss and headaches. The Petitioner did not report any photophobia or aura, and he did not report any trouble concentrating. He was diagnosed with post concussive syndrome, transient memory loss and headache. Dr. Shepard referred Petitioner to Speech Therapy due to his complaints.

The Petitioner returned to Dr. Gireesan on January 30, 2014. Petitioner's Ex. 3. He continued to complain of neck pain, left shoulder and lower back pain, but reported that he felt he was better able to move around since physical therapy. Dr. Gireesan again diagnosed the Petitioner with contusions of the back and neck. The Petitioner was referred to Dr. Ghanayem on April 3, 2014 for low back pain complaints. The Petitioner also visited Dr. Bajaj at Loyola. Petitioner's E. 7. The Petitioner discussed his treatment history with Dr. Bajaj and reported that therapy was helping, but his headaches remained a concern. Dr. Bajaj recommended a TENS unit and trial acupuncture.

By June 25, 2014, the Petitioner returned to Dr. Shepard. Petitioner's Ex. 5. The Petitioner reported headaches but reported no confusion and his memory was intact. Again, his examination was normal. Dr. Shepard referred the Petitioner to a pain clinic at Rehabilitation Institute of Chicago but decided to hold off on neurological testing because Petitioner's cognitive issues were improving. He also recommended the Petitioner resume physical therapy. Petitioner underwent an EMG on June 25, 2014. The exam was normal. Petitioner's Ex. 5

The Petitioner returned to Dr. Bajaj on July 30, 2014. Petitioner's Ex. 7 Dr. Bajaj documented Petitioner's ongoing complaints of pain and recommended neuropsychological testing.

The Petitioner was discharged from Rehabilitation of Chicago's Speech Therapy program on September 25, 2014. Petitioner's Ex. 9. The report documented that the Petitioner met his goals for auditory processing retention, and that the Petitioner was now able to utilize external memory aids and retention strategies. The report noted that the Petitioner demonstrated good comprehension follow-through and that his attention and concentration improved. He was recommended to continue a home exercise program to further enhance retention and concentration.

On September 26, 2014, the Petitioner underwent an evaluation at the Rehabilitation Institute of Chicago. Petitioner's Ex. 5. The therapist documented that the Petitioner did not "exhibit any obvious sensory impairment or loss of motor control that would affect performance on testing." Further, ***"he scored below the cutoff of one of the two embedded symptom validity measure and on one of two stand alone symptoms validity tests, indicating that he did not consistently give his best effort throughout the present evaluation. Because of these factors, taking some test scores at face value would give a low estimate of actual thinking abilities."*** Petitioner's Ex. 5, emphasis added. During the examination, it was noted that ***"Any cognitive impairment associated with the patient's concussion appears to be resolved."*** Further, ***"His erratic performance and memory is not due to concussion since impairment with such injuries resolves within days to weeks."*** The report further indicated, ***"There is not cognitive impairment that would prevent him from working in his previous position. However, due to Petitioner's psychiatric condition, he was recommended to undergo a pain management program to address "his expectation of persistent disability."*** Petitioner's Ex. 5, emphasis added. After reviewing the report, Dr. Shepard recommended the Petitioner undergo the interdisciplinary pain management program.

The Petitioner visited Dr. Zost for vision therapy. Petitioner's Ex. 10. Dr. Zost first examined the Petitioner on October 23, 2014. Dr. Zost noted on examination that Petitioner had 20/20 vision. His last visit with Dr. Zost was on April 8, 2014. While the Petitioner complained of pain, no abnormalities were listed on the chart note. Petitioner's Ex. 10.

The Petitioner last saw Dr. Shepard on December 11, 2014. Petitioner's Ex. 5. Despite his 20/20 visual examination with Dr. Zost, the Petitioner reported to Dr. Shepard that that he was told he may need glasses and Dr. Zost felt he had a "visual issue."

The Petitioner began treatment with Dr. McCoyd at Loyola on January 12, 2015. Petitioner's Ex. 6. The Petitioner discussed his prior treatment history with Dr. McCoyd and complained of posterior headaches. Dr. McCoyd documented that Petitioner had no evidence of thought disorder, normal attention and reasoning. Further, Petitioner's verbal expression, comprehension, repetition, reading and writing were intact. An MRI of the brain was ordered.

An MRI of the brain on January 12, 2015 was normal. After the normal findings on MRI, Dr. McCoyd recommended physical therapy.

Petitioner returned to Dr. McCoyd on March 30, 2015. Petitioner's Ex. 6. Dr. McCoyd noted that Petitioner's speech was fluent and clear, and his verbal comprehension and expression were intact. Nevertheless, Petitioner reported worsening headaches. Because of his headache complaints, Petitioner then underwent a bilateral occipital nerve decompression and neurectomy by Dr. Douglas Anderson at Loyola. Post-operatively, the Petitioner followed up with Dr. McCoyd and reported that the pain in the back of his head improved. Later, the Petitioner complained that the procedure made his condition worse and underwent a series of Botox injections. Dr. McCoyd noted that the Petitioner did not feel any relief from treatment.

After the failed Botox treatments, Dr. McCoyd prepared a treatment note on June 10, 2016 that noted that Petitioner's headaches were debilitating in nature and interfered with his ability to complete any reasonable essential job function and interfered with many routine activities of daily living. Petitioner's Ex. 6. He placed the Petitioner at maximum medical improvement. Dr. Bajaj also prepared a note on June 24, 2016 and noted that due to Petitioner's debilitating headaches, he was at maximum medical improvement and would require chronic pain management.

On December 19, 2016, Dr. Bajaj prepared an additional note that stated that the Petitioner suffered from constant daily pain, poor concentration, and had difficulty with normal everyday tasks. Petitioner's Ex. 7. The tasks included caring for his children, completing household chores, unable to sit or stand for ten minutes at a time without changing positions, unable to read or concentrate due to headaches and blurred vision. He could not lift greater than ten pounds, and has limitations in bending, squatting in repetitive motions. He could not interact in social situations and could not manage money.

Dr. McCoyd prepared an additional note on February 1, 2017, reconfirming that Petitioner had debilitating headaches that interfered with any reasonable essential job function and interfered with many routine activities of daily living. Petitioner's Ex. 6. The activities included Petitioner's ability to work, concentrate, work from heights, and drive at night or in heavy or fast-moving traffic.

During Dr. McCoyd's evidence deposition, he testified that if there was any evidence to suggest that the Petitioner was not being truthful with him regarding his physical capabilities and symptoms, it was possible his opinion would change regarding his permanent restrictions and total disability. Petitioner's Ex. 8, Page 46.

Respondent requested the Petitioner submit to a Section 12 Examination on April 26, 2017 with Dr. Glantz. Respondent's Ex. 2. Dr. Glantz performed a physical examination and

reviewed Petitioner's medical records. The Petitioner complained of head pain, blurred vision, headaches, memory problems, neck pain and back pain. During the examination, the Petitioner discussed his treatment history and current complaints. The Petitioner reported that although his physician told him not to drive, he did. Dr. Glantz diagnosed the Petitioner with a resolved concussion injury. He placed the Petitioner at neurological maximum medical improvement. Dr. Glantz reported that it was significant that at the time of accident, there was no acute bleeding in the brain, and the CT scan was normal. Even though the Petitioner displayed paralysis, there was no fracture in the spine or any bleeding within the spine based on the MRI findings. Further, when the Petitioner was examined acutely after his injury, he was regarded to be awake and alert and talkative and there were no deficits in the brain. When discussing the Petitioner's complaints, Dr. Glantz stated that the objective neurologic examination did not find any abnormality to substantiate his alleged symptoms. He noted the Petitioner was able to recall his treatment and was able to provide a history consistent with an individual who is mentally intact. There was no memory deficit noted. The Petitioner did not exhibit any evidence of photophobia or blurred vision upon examination. The headaches were noted to be subjective. Dr. Glantz also noted that it was not physiologically possible to have driving sensitivity so long post-accident. He believed that headaches were likely present for a few months after the work injury but resolved shortly thereafter.

Respondent also requested the Petitioner submit to another Section 12 Examination with Dr. Weber on August 7, 2017, to assess his cervical and lumbar spine. Respondent's Ex. 3. At the time of examination, the Petitioner explained his treatment history to Dr. Weber and discussed his current treatment program, medications and complaints. Dr. Weber diagnosed the Petitioner with a strain/contusion to his cervical and lumbar spine as a result of the injury. Dr. Weber provided the opinion that his cervical and lumbar strains were resolved, as there were no objective findings on the MRIs and his EMG was negative. She provided the opinion that no further testing or treatment was recommended and that he reached maximum medical improvement.

The Petitioner presented for a vocational evaluation with Kari Stafseth on October 31, 2017. Petitioner's Ex. 14. Ms. Stafseth prepared a report on November 7, 2017. *Id*. He reported having difficulties retaining information and had to write things down to remember them. He reported his biggest issue was his inability to care for his children. The Petitioner reported he had difficulties lifting his daughter, and he was not able to stoop, bend or kneel without pain. With respect to Petitioner's educational status, he reported that he dropped out of Plainfield South High School and took his "GED." He stated that he had not completed any junior college studies.

With respect to his vocational history, the Petitioner told Ms. Stafseth that he worked at Patten Construction as a Laborer prior to working for the City of Chicago. Aside from that job, he had no other work history.

Ms. Stafseth noted that the Petitioner was able to remain seated during the interview, and no pain behaviors were observed. The Petitioner maintained direct eye contact. Ms. Stafseth reviewed Petitioner's medical records and noted that the Petitioner reported difficulties with sleeping, driving and caring for his children, and daily activities.

Ms. Stafseth stated that if Dr. Weber and Dr. Glantz's opinions are accepted as accurate, then there would be no lost access to his usual and customary line of employment. If, however, Dr. McCoyd's opinion was correct that the Petitioner could not perform any daily activities, or concentrate, then there would be no stable labor market for the Petitioner.

During Ms. Stafseth's deposition, she testified that her testimony for a lack of a stable labor market was solely based on Dr. McCoyd's medical opinions being accurate. If the medical records of Dr. McCoyd were not accurate, then she testified her opinion would charge regarding Petitioner's employability.

Respondent submitted into evidence Petitioner's resume and Joliet Junior College transcript. Petitioner's resume reflected that he graduated Plainfield South High School and was "currently attending Joliet Junior College taking part time classes, working towards a bachelor's degree." Further, the Petitioner also had additional job history from what he told Ms. Stafseth. In addition to working at Patten Construction, he worked at Warehouse Specialist Incorporated. In that position, the Petitioner worked as a Trainer and Logistics team member, a forklift operator and prepared inbound and outbound fleet. Respondent's Ex. 4. Petitioner's Joliet Junior College transcript documented the Petitioner taking a Criminology class and received an "A" for the course. Respondent's Ex. 5

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

The Arbitrator finds that Petitioner's current condition of ill-being, as it relates to his head, cervical spine and lumbar spine is causally related to his work accident on December 6, 2013. The Arbitrator notes that Petitioner never had injured his head or cervical spine and never had received medical care of any kind for his head or cervical spine prior to December 6, 2013. TX. 12-13. The record also shows the Petitioner suffered a severe injury on December 6, 2013, when he was struck in the back of the head with a backhoe while working for Respondent. Petitioner's Ex. 1.

The Arbitrator further notes that immediately after his work injury, Petitioner was admitted to Northwestern Memorial Hospital where he was treated for severe traumatic injuries to his head, cervical spine and lumbar spine on an inpatient basis from December 6, 2013 through December 11, 2013. During his hospitalization, Petitioner was treated for complaints of pain in his cervical and lumbar spine as well as headaches and blurred vision. Petitioner's Ex. 2.

The Arbitrator recognizes that proof of the state of good health of the Petitioner prior to and down to the time of injury, and then change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. *Spector Freight System, Inc. v. Industrial Commission*, 93 Ill. 2d 507, 513, 445 N.E.2d 280, 67 Ill. Dec. 800 (1983). Based on this analysis, the Arbitrator finds the Petitioner has established a causal connection between his current condition of ill-being, as it relates to his head, cervical spine and lumbar spine, and his work accident on December 6, 2013.

Issue J: *Medical bills*

However, the Arbitrator finds the Petitioner did not meet his burden of proof to support the need for ongoing treatment after April 26, 2017. In support of this decision, the Arbitrator finds as follows:

Section 8(a) of the Workers' Compensation Act provides that an 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." 820 ILCS 305/8(a). The Arbitrator finds that Petitioner did not meet this burden based on Dr. McCoyd's recommendation for ongoing treatment after reaching maximum medical improvement as his testimony is not credible.

The Arbitrator gives greater weight to Dr. Glantz's opinions that no additional treatment was necessary after his April 26, 2017 Section 12 examination. Dr. Glantz based his medical opinion on the fact that Petitioner had reached maximum medical improvement and did not require any treatment. Therefore, no further care or treatment was necessary.

Based on the evidence outlined above, the Arbitrator finds that Petitioner did not meet his burden of proof regarding the reasonableness and necessity of Petitioner's treatment and therefore, denies Respondent's liability for payment of the outstanding medical bill.

Issue K: *TTD*

Because the Arbitrator finds that Petitioner is capable of full duty work and reached maximum medical improvement as of Dr. Weber's August 7, 2017 Section 12 examination, the Arbitrator finds that Respondent properly issued temporary total disability benefits up until that date, and no additional benefits are due and owing.

Issue L: *Nature and extent of injury*

Initially, the Arbitrator notes the Petitioner is seeking an Order for permanent and total disability benefits. The Petitioner bears the burden of proving every aspect of his claim by a preponderance of the evidence. Hutson v. Indus. Comm'n, 223 Ill App. 3d 706, 714 (5th Dist. 1992). "Liability under the Workmen's Compensation Act may not be based on imagination, speculation, or conjecture, but must have a foundation of facts established by a preponderance of the evidence..." *Shell Petroleum Corp. v. Indus. Comm'n*, 366 Ill. 642, 650 (1937). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Revere Paint & Varnish Corp. v. Indus. Comm'n*, 41 Ill.2d. 59, 63 (1968). Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. *Spankroy v. Alesky*, 45 Ill. App.3d 432, 436 (1st Dis. 1977).

There are three ways to establish one as permanently and totally disabled. He can do so through a preponderance of medical evidence; a showing of a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in his circumstance. *Valley Mould & Iron Co. v. Indus. Comm'n*, 84 Ill.2d 538 (1981).

It is well within the purview of the Commission to determine what weight to give testimony and resolve conflicts in the evidence, particularly medical opinion evidence. *Hosteny v. Illinois Workers' Compensation Comm'n,* 397 Ill.App.3d 665, 675 (2009); *Fickas v. Industrial Comm'n,* 308 Ill.App.3d 1037, 1041 (1999). Moreover, medical opinion testimony is often a critical component of odd-lot analysis. *Freeman United Coal Mining Co. v. Industrial Comm'n,* 318 Ill.App.3d 170, 178 (2000).

Here, the Petitioner alleges that he is medically permanently and totally disabled as of September 2, 2016. The Arbitrator finds Respondent's medical opinions from Dr. Glantz and Dr. Weber more persuasive. The basis for the decision is due to the Dr. McCoyd's complete reliance on Petitioner's subjective complaints when making his medical opinions, and the Petitioner's lack of credibility with those complaints. The Arbitrator finds Respondent's surveillance footage and other evidence more credible than Petitioner's testimony and medical evidence presented at trial. When all objective evidence completely contradicts Petitioner's subjective complaints, it is impossible for the Arbitrator to find in favor of the Petitioner.

The Arbitrator did not find Petitioner's testimony at trial credible. Petitioner testified that he is in constant pain, and five days a week, he lays in bed all day with pain at a 10/10. He testified that he was truthful and honest with what he told his physicians, including: not being able to lift greater than ten pounds, not being able to sit or stand for more than ten minutes at a time, not being able to drive due to moving cars making him dizzy, not being able to concentrate or care for his children. Despite Petitioner's testimony that on his best day, the pain is a 7/10 and he still could not perform usual activities of daily living, he was able to sit in an unpadded chair in the courtroom well beyond ten minutes, without alternating standing and sitting, and without any apparent distress. The Arbitrator does not find Petitioner's testimony believable.

At trial, the Petitioner was able to recall his medical history without difficulty, concentrate and read evidence presented to him by Respondent, speak coherently and follow the progression of the line of questioning presented to him. Further, the Arbitrator finds it interesting that shortly after Petitioner's work injury, he was able to grow his family by conceiving another child.

Despite the Petitioner testifying that he was truthful with what he told Ms. Stafseth about dropping out of high school, the Petitioner confirmed he reported not only completing high school on his resume, but also was enrolled in a junior college. When asked whether the Petitioner completed any junior college courses, he replied that he had not. Even when presented with Petitioner's Joliet Junior College transcript, the Petitioner would not admit that he had taken a course there. The Petitioner confirmed that his information, including date of birth, was his on the transcript. Lastly, Ms. Stafseth was not aware that the Petitioner had

additional transferrable skills from the Warehouse Specialist Incorporated position he previously held.

The Arbitrator finds that the vocational counselor could not have made a credible opinion regarding Petitioner's labor market when they were provided with untruthful and inaccurate information.

Petitioner's credibility is further diminished considering the surveillance presented at trial. The Petitioner testified that he was truthful with what he told his physicians about his pain complaints, his capabilities and how he spends each day. The medical reflects the Petitioner reported that he could not drive because of blurred vision, could not care for his children alone, could not concentrate, lift greater than ten pounds, and spent most of his days in bed with pain 10/10. In contrast, the surveillance footage documented the Petitioner living a normal life and taking care of his children.

In the surveillance footage from Bonnamy and Associates, the Petitioner is shown working alongside an individual in his garage, with a drill hanging from his back jeans pocket. He is seen bending, squatting, walking, sweeping and carrying large branches to break apart. Although his activity inside the garage is not able to be seen, he was walking and standing for much greater than ten minutes. Further, having a drill attached to his jeans pocket demonstrates that he was performing work in the garage that required a power tool. It should be noted that around this time, the Petitioner visited Dr. McCoyd on October 16, 2015 and reported increased headache pain and that he experienced these every day without relief.

Additionally, the surveillance footage shown from Investigative Solutions and the testimony of Jim Kasper depicts a much different picture of how the Petitioner testified he spends his time off work. Surveillance was taken in February of 2017. Around this time, the Petitioner told Dr. Bajaj on December 19, 2016 that he could not concentrate, could not care for his children, could not lift objects greater than ten pounds, or complete daily activities. Further, on February 1, 2017, Petitioner told Dr. McCoyd that he could not work or drive due to vision problems with fast moving traffic. However, Jim Kasper testified that on the three days he investigated the Petitioner, the Petitioner drove approximately 170 miles and at least five hours and was one of the most aggressive drivers he ever investigated. Mr. Kasper's digital speedometer documented the Petitioner driving up to eighty-five miles an hour.

Additionally, Mr. Kasper reported the Petitioner would drive his children to day care, drop them off, drive around, and complete various errands. Trips included going to McDonald's drive-thru, Home Depot, or a store. The Arbitrator notes this testimony was in direct contradiction to the Petitioner's testimony that he only drove to pick up a pain prescription if his wife was not home, and the medical records documenting the Petitioner reporting he could

not drive due to fast moving traffic. The video footage from Investigative Solutions also documents the Petitioner lifting one his children with one arm, the child clearly weighing greater than ten pounds. It also shows him caring for his children without his sister in-law. The Arbitrator find that's Petitioner's testimony is visibly contradicted by the video footage.

Because of Petitioner's lack of credibility, the Arbitrator also finds the opinions of Dr. Glantz and Dr. Weber more credible than those of Dr. McCoyd and Dr. Bajaj. After reviewing the testimony in the deposition transcript of Dr. McCoyd, he bases his opinions on permanent and total disability on Petitioner's subjective headache pain. Dr. McCoyd testified that he could change his opinion on permanent and total disability if evidence was presented to suggest the Petitioner was not being truthful. The Arbitrator also notes that Dr. McCoyd also testified that Petitioner could return to some type of work, in the event the job could work around his subjective complaints of pain. A finding that Petitioner is capable of working, even if accommodated, is contradictory to a finding of permanent and total disability. If an employee can perform some form of employment without seriously endangering health or life, he or she is not entitled to a total disability award. *A.M.T.C. of Illinois, Inc. v. Indus. Comm'n*, 77 Ill.2d 482 (1979).

Instead, the Arbitrator finds Dr. Glantz's opinion that Petitioner can perform full duty work credible. Dr. Glantz based his opinion that the Petitioner was capable of full duty work on Petitioner's physical examination and medical reports. Dr. Glantz relied upon the objective neurologic examination to formulate his opinions, as well as his evaluation of Petitioner's mental functioning. Dr. Glantz notes that the Petitioner was able to recall his treatment and provide his history that is consistent with someone mentally intact. The Petitioner also did not display any blurred vision or photophobia. Petitioner's daily activities evidence on surveillance footage and his testimony at trial all support Dr. Glantz's opinions.

The Arbitrator also finds it interesting that Petitioner's treating physicians completely disregard the Petitioner's capabilities on examination when making their opinion regarding permanent and total disability. Specifically, Dr. McCoyd and Dr. Bajaj both comment on Petitioner's capabilities and comprehension nearly up until their permanent and total disability opinions. Dr. McCoyd reports Petitioner's "normal attention and reasoning," and "verbal expression, comprehension, repetition, reading and writing being intact" in nearly every medical record. Further, Petitioner's "immediate recall and remote memory were intact." "Visual activity and field are intact and no positional or diurnal variation" were noted in Dr. McCoyd's initial January 12, 2015 visit. Petitioner's physicians disregard Petitioner's invalid efforts documented by the Rehabilitation Institute of Chicago and only rely on what the Petitioner told them he is feeling. The Arbitrator finds it impossible to conclude that their

opinions are credible when they ignore evidence that is entirely contrary to their opinions on Petitioner's disability.

The Arbitrator also relies on the fact that Petitioner successfully completed Speech Therapy at Rehabilitation Institute of Chicago, and all other physicians noted Petitioner's intact mental capabilities in the records to support his opinion. Lastly, Petitioner's own testimony serves as evidence of Petitioner's mental faculties being intact. Dr. McCoyd testified that the sole basis for his opinions was Petitioner's subjective complaints of headaches, which do not comport with the evidence presented at trial, and therefore is not persuasive.

Because the Petitioner did not meet his burden of proof to establish himself as medically permanently and totally disabled, he would have to meet his burden of proof by establishing he was disabled under an odd-lot theory, or through a diligent but unsuccessful job search. The Arbitrator finds that the Petitioner was not able to meet his burden of proof under either scenario.

Under the odd-lot theory, a claimant must establish that he is unable to perform services except for those that are so limited in quantity, dependability, or quality that there is no reasonable stable market for his skills. *A.M.T.C. of Illinois, Inc. v. Industrial Comm'n,* 77 Ill.2d 482, 487 (1979). It is the claimant's burden to prove that he is so incapacitated from working, that he is unable to be regularly employed in any well-known branch of the labor market. *Ceco Corp. v. Industrial Comm'n,* 95 Ill.2d 278, 286 (1983). A claimant can establish this by showing either: (1) a diligent, yet, unsuccessful job search; or (2) that his age, training, education, experience, and physical condition prevent him from engaging in stable and continuous employment. *Westin Hotel v. Industrial Comm'n,* 372 Ill.App.3d 527, 544 (2007).

The Arbitrator finds that the Vocational Assessment from Ms. Stafseth not credible. Ms. Stafseth testified that she based her opinions on a lack of a stable market on Petitioner's subjective complaints of pain and Dr. McCoyd's medical evidence only. Because the Arbitrator finds Dr. McCoyd's testimony unpersuasive and Petitioner's subjective complaints not credible, Ms. Stafseth's testimony cannot be provided any weight.

Further, the Arbitrator notes that Ms. Stafseth was not provided with truthful information of Petitioner's prior work and educational history, further making her findings not credible, should she have relied on any of this information. In addition to the Petitioner reporting not completing high school or taking any junior college courses, the Petitioner testified that he had only one job prior to working for Respondent. Petitioner's resume expressly refutes that statement as he also worked at Warehouse Specialists Incorporated. The Arbitrators finds that the Petitioner withheld information to Ms. Stafseth to support his case.

Lastly, the Petitioner testified that he had not searched for any jobs since his injury, and therefore, did not meet his burden of proof to establish permanent and total disability under an odd lot theory of liability. At trial, Petitioner offered no job logs, nor any evidence that he searched for any employment. Rather, he reported that he had not looked for any job during his Vocational Assessment. The Arbitrator finds that Petitioner failed to offer enough evidence of a diligent, but unsuccessful job search.

When all objective evidence completely contradicts Petitioner's subjective complaints, it is impossible for the Arbitrator to find in favor of the Petitioner. The Arbitrator finds that Petitioner did not meet his burden of proof by a preponderance of the evidence that he was permanently and totally disabled, neither through Dr. McCoyd's opinions, his testimony, nor through an unsuccessful job search and vocational assessment. Therefore, the Arbitrator denies Petitioner's request for permanent and total disability benefits.

Instead, the Arbitrator finds that because of Petitioner's work injury, he sustained a concussion injury, subjective headaches, and bilateral occipital neurectomies. He reached maximum medical improvement on April 26, 2017 and was capable of full duty work. With respect to his lumbar and cervical spine, the Petitioner sustained a diagnosis of lumbar and cervical sprain/strains, reached maximum medical improvement, and was capable of full duty work as of August 7, 2017. Accordingly, his request for permanent and total disability benefits is denied.

The Arbitrator now must determine if the Petitioner is entitled to permanency under Section 8(d)2 of the Act. Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment from (a) above;
(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.

(See 820 ILCS 305/8.1b)

With regards to factor (i) of Section 8.1b of the Act:

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence by either party. As such, the Arbitrator gives **no weight** to this factor.

With regards to factor (ii) of Section 8.1b of the Act:

ii. The Arbitrator finds the Petitioner was employed by the Respondent as a Laborer at the time of his December 6, 2013, accident. The Petitioner testified he has not returned to work Respondent as a Laborer, or in any other employment position. The Arbitrator therefore gives ***moderate weight*** to this factor.

With regards to factor (iii) of Section 8.1b of the Act:

iii. The Arbitrator notes that the Petitioner was 25 years old at the time of the accident. (*AX* 1). The Arbitrator therefore gives ***some weight*** to this factor.

With regards to factor (iv) of Section 8.1b of the Act:

iv. The Arbitrator notes that the Petitioner has not returned to work for the Respondent in his previous position as a Laborer. However, the record lacks credible testimony and/or credible evidence as to his future earnings capacity. As such, the Arbitrator therefore gives ***no weight*** to this factor.

With regards to factor (v) of Section 8.1b of the Act:

v. Evidence of disability corroborated by the treating medical records finds that the Petitioner suffered an injury to his head, cervical spine, and lumbar spine that necessitated medical care. Due to these injuries, he suffered a concussion, subjective headaches, and bilateral occipital neurectomies. Although the Petitioner testified he continues to experience headaches and other cervical and lumbar symptoms, the Arbitrator has found the Petitioner's testimony not to be credible. Nonetheless, due to the Petitioner's medically documented injuries, the Arbitrator therefore gives ***significant weight*** to this factor.

Based on the above factors, and the whole record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of an **15% loss of use of the person-as-a-whole** pursuant to Section 8(d)2 and Section 8.1b of the Act.

Signature of Arbitrator

MARCH 7, 2019
Date

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ELEUTERIO VALDEZ, Petitioner vs. ADVANCED MOVING & STORAGE, LALAGOS, JAMES, INDIVIDUAL AND AS OWNER OF ADVANCED MOVING & STORAGE AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND, Respondent	)	No. 08WC 012126

ORDER

This matter having come to be heard on Petitioner's Motion to Adjudicate Respondent's Review, due notice having been given and the Commission being duly advised in the premises, it is hereby ordered as follows:

1. That the Decision of Arbitrator in this matter dated November 25, 2019, be and hereby is corrected to read as follows......

   "In the year preceding the injury, the Petitioner earned $29,120.00; the Average Weekly Wage was $560.00"

2. That there are no further issues pending on review in this matter.

Therefore, Respondent's Review is hereby dismissed.

Dated 2/6/2020

D. Douglas McCarthy
Commissioner Douglas McCarthy

FEB 6 - 2020

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KAREN SUKNOVICH,

Petitioner,

20IWCC0091

vs.

NO: 17 WC 037956

CHILD LINK, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Decision of the Arbitrator is modified only to strike the second paragraph within the **Order** section that reads, "The Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to the motor vehicle accident on June 16, 2017" and replace it with the following sentence, "As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 2018, is hereby affirmed and adopted as modified.

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

SOIMCC0061

20IWCC0091

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

Pursuant to §19(f)(2) of the Act, no bond for removal of the cause to the Circuit Court by Respondent is required as the Commission did not enter 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: FEB 6 - 2020
KAD/mav
O: 12/10/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

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

SUKNOVICH, KAREN
Employee/Petitioner

Case# **17WC037956**

20IWCC0091

CHILD LINK INC
Employer/Respondent

On 6/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0500 LAW OFFICES OF CURTIS S BURKE
218 N JEFFERSON ST
SUITE 401
CHICAGO, IL 60661

1120 BRADY CONNOLLY & MASUDA PC
KELLY E KAMSTRA
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)

Karen Suknovich
Employee/Petitioner

v.

Child Link, Inc.
Employer/Respondent

Case # **17** WC **37956**

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 **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **March 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. [ ] 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 ______

20IWCC0091

FINDINGS

On the date of accident, **June 16, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**43,264.00**; the average weekly wage was $**832.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**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 Petitioner failed to prove by a preponderance of the evidence that an accident occurred arising out of and in the course of her employment with the Respondent.

The Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to the motor vehicle accident on June 16, 2017.

As such, Petitioner is not entitled to the payment of requested medical bills, or temporary total disability 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.

Tiffany Kay

Signature of Arbitrator

6/24/18
Date

ICArbDec19(b)

JUN 26 2018

PROCEDURAL HISTORY

This matter was pursued under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") by Karen Suknovich (hereinafter "Petitioner") and sought relief from the Child Link Inc. (hereinafter "Respondent"). The matter was originally scheduled to be heard before Arbitrator Douglas Steffenson (hereinafter "Arbitrator Steffenson") on March 29, 2018 in Chicago, Illinois. However, Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay") covered Arbitrator Steffenson's trial call on March 29, 2018. Therefore, by agreement of both parties, this matter was tried before Arbitrator Kay and the decision rendered by Arbitrator Kay. Arbitrator Kay has examined the submitted records.

FINDINGS OF FACT

The parties proceeded to hearing on March 29, 2018, with disputed issues as to whether the Petitioner sustained accidental injuries that arose out of and in the course of employment, whether the current condition of ill-being is causally connected to her injury, whether the Respondent is liable for unpaid medical bills, and whether the Petitioner is entitled to Temporary Total Disability benefits. (Arb.X.1)

The parties stipulated that Respondent was operating under the Act on June 16, 2017 (Arb. X.1) The parties stipulated that the date of the accident was June 16, 2017 and that Petitioner and Respondent had a relationship of employee and employer. (Arb.X.1) The parties also stipulated that Petitioner worked for Respondent on this date as an agency registered nurse, notice of the accident was given to the Respondent on June 16, 2017, Petitioner was 53 years of age on the date of the accident, single and with 1 dependent child. (Arb.X.1) The stipulated average weekly wage, calculated pursuant to Section 10 of the Act, was $832.00. (Arb.X.1)

ARBITRATORS SUMMARY OF TESTIMONY

The Petitioner, Karen Suknovich, was the first witness to testify. Petitioner testified that the President and CEO of Respondent is Ms. Malia Arnett (hereinafter "Ms. Arnett"). Petitioner and Ms. Malia Arnett (hereinafter "Ms. Arnett") live in the same neighborhood and have several friends in common. (T.23) Petitioner described her relationship with Ms. Arnett as one of acquaintances, prior to working for Respondent, that developed into them socializing and discussing work outside of the office. (T.23) Petitioner testified that she and Ms. Arnett attend concerts outside of work, visit each other at their homes, go after work and grab a bite to eat, and have traveled together. (T.23) Ms. Arnett confirmed this, testifying that she knew Petitioner prior to hiring her. (T.118) Ms. Arnett stated that she and Petitioner were also members of a lot of social groups in the neighborhood such as Recipe Club and a Theater group. (T.118) Ms. Arnett testified that she has known Petitioner for about 10 years and thought of her as a friend. (T.118)

Petitioner testified that Respondent is a Social Service agency that contracts with DCFS for Youth in Care, Foster Care and Adoptions. (T.15) Petitioner is a registered nurse who has been licensed since 1991. (T.10) As a requirement to maintain her license, she must re-certify every 2 to 3 years. (T.10) Petitioner mentioned to Ms. Arnett that she needed to get back into the workforce. In result, Ms. Arnett hired Petitioner to work full-time for Respondent in September of 2015, but prior to that, for approximately a year-and-a-half she was a contract employee. (T.15) Ms. Arnett testified that Petitioner worked approximately 25-30 hours a week. (T.122) Petitioner testified that her general duties included "looking at medical records of the children in our care, meeting with their case workers, and trying to decide if their medical issues were being handled properly and

appropriately." (T.17) Petitioner testified that she would accompany the children to their doctors' visits, visit them in the hospital, ensure their foster parents were handling their health issues appropriately, and monitor their medication logs. (T.17) Additionally, she testified that she would provide life skills classes to the foster children and in-service classes for the Respondent's employees. (T.18) Occasionally, she would also accompany Ms. Arnett to visit legislatures on behalf of Respondent. (T.18)

Petitioner testified that on June 16, 2017 she was employed by the Respondent as a registered nurse. On June 16, 2017, Respondent held one of its regular weekly management meetings. Petitioner testified that the meeting became very contentious that day. (T.20) Once the meeting ended, Ms. Arnett approached Petitioner at her desk and said "I need to get out of here, and I want to talk to you about what happened. Let's go, get your purse, let's go." (T.21) In contrast, Ms. Arnett testified that the management meeting was not contentious and the only reason for leaving the office with Petitioner was to have lunch, discuss their after-work plans, and go shopping at Marshalls. (T.124-127) Petitioner and Ms. Arnett left alone together. Ms. Arnett drove her car and Petitioner rode with her as her only passenger. Petitioner said they drove around for a while before ending up at Potbelly's restaurant. (T.22) Petitioner testified that prior to the June 16, 2017 accident, it was not customary for her and Ms. Arnett to go to lunch or shop together during work hours. (T.23) However, Petitioner testified that this occasion was not the first time Ms. Arnett consulted her outside of work to discuss work issues. (T.24)

Petitioner testified that during their off-site meeting at Potbelly's, Ms. Arnett ate lunch but Petitioner did not eat anything. (T.19) Ms. Arnett testified that after eating at Potbelly's she and the Petitioner walked over to Marshalls to find something to wear and a bag for their trip the following weekend. (T.127-128) Ms. Arnett stated that Petitioner was complaining about her back hurting, due to a new exercise routine, and wanted to leave. Petitioner denied going to Marshall's with Ms. Arnett. Petitioner testified that after the off-site meeting, while heading back to the office, they were involved in the car accident. (T.19) Ms. Arnett was driving and Petitioner was a passenger in the car during the accident. (T.24) Petitioner stated that "they were stopped at a red light and out of nowhere, there was a heavy jolt to the car." (T.25) Petitioner testified that they were rear-ended by a large Ram like truck. (T.25) In contrast, Ms. Arnett testified that they were involved in the accident after shopping at Marshalls (T.130-132) They were sitting at a stop light and she felt a bump and she asked Petitioner "Did something happen?" (T.131). After the impact, Petitioner testified that she felt pain in her neck, lower back, was disoriented and loss consciousness briefly for a period of time. (T.25, 26) Petitioner testified that prior to accident in June of 2017, she had no prior medical treatment for either her neck or back. (T.27)

Petitioner testified that after the impact, she did not inspect Ms. Arnett's vehicle, but the other vehicle was inoperable with his bumper pushed into his front tires. (T.26) In contrast, Ms. Arnett testified that both vehicles involved in the accident were operable and able to drive away from the scene of the crash. (T.133) Petitioner testified that they waited almost 2 hours for the police to arrive. Once the police arrived, Petitioner testified that she told them her neck and back was injured. (T.27) Petitioner testified that the police offered to call an ambulance for her but she refused because she felt she could "shake it off" and wanted to see her own physician. (T.28) After the police came, Petitioner and Ms. Arnett returned to the office. When they arrived at the office, Petitioner stated that they encountered three of Respondent's employees in the parking lot. (T.29) Petitioner identified the employees as Ms. Angela Jones-Street (hereinafter "Ms. Jones-Street"), Ms. Pamela Cooper and Mr. Mike Bickel. (T.29) Petitioner stated that she was having difficulty exiting the car so Mr. Bickel approached and helped her exit the car and into the building. (T.30) Petitioner said while she was entering the building she saw Ms. Barnett speaking with Ms. Jones-Street. Petitioner testified that she was having pain in her lower back, severe spasms and trouble walking. Petitioner retrieved several items from her office and then left the office. (T.31) Petitioner testified that she was able to drive herself home.

In contrast, Ms. Arnett testified that after the police arrived she dropped Petitioner back off at the office. (T.131) Ms. Arnett testified that there was no one in the parking lot when they arrived after the accident. (T.135) Petitioner exited her car without any difficulty. (T.135) Ms. Arnett did acknowledge Ms. Jones-Street as a former employee of Respondent. (T.135) However, in contrast to Petitioner's testimony, Ms. Arnett testified that she did not recall having a conversation with her in Respondent's parking lot on the day of the accident. (T.135-136) Ms. Arnett testified that around 7:00pm that evening Petitioner text her to see if she wanted to go out for drinks that evening. (T.128)

Petitioner testified that once she arrived home she experienced severe pain, spasms, pain down her left leg, stiffness in her neck and pain going down her left arm. (T.32) Petitioner took some over the counter pain medication and assumed it would be better in the morning. (T.32) Petitioner stated that she woke up at 2:00am in the morning with the inability to feel her hands and began to panic. (T.32) She took more pain medication and laid back down and then sought medical attention on the morning of June 17, 2017. (T.33)

Ms. Jones-Street was called to the stand to testify on behalf of the Petitioner. She testified that she was employed by Respondent from September 2004 until August 24, 2017. (T.97) She stated that she held many job titles but at the time she left she was a Senior Adolescent Child Welfare Specialist. (T.98) Her job duties included the placement of children from the ages of 13 to 21, who were in the care of the State of Illinois foster care. (T.98) She testified that she resigned from her position with Respondent in August of 2017 on good terms. She characterized her relationship with Petitioner as just "work friends" that did not socialize outside of the office. (T.108) She testified that during the time she worked with Petitioner she knew her to be pleasant, polite, professional and honest. (T.101-103) When asked about her thoughts of Ms. Arnett, she stated that she found her to be "very mean-spirited and manipulative". (T.112) Additionally, she testified that in regard to Petitioner and Ms. Arnett occasionally going to lunch, it was uncommon because Petitioner worked part-time. (T.110) She testified that Petitioner came into work between 9:00am and 10:00am and she would leave between 2:00pm and 3:00pm. (T.110)

Ms. Jones-Street testified that on June 16, 2017, as she and three of her other colleagues were leaving work at Respondent, they entered the parking lot and saw Ms. Arnett driving at a high speed into the lot. (T.104) She stated Ms. Arnett pulled up next to them, she thought to say goodbye, but said "Karen and I were at a meeting and on our way back and some idiot hit my car." (T.104) She said she replied "Are you all okay?", and she was like, "well, I'm fine but Karen hurt her back." (T.104) Ms. Jones-Street said while she was having this conversation with Ms. Arnett, her other colleague, Mr. Mike Bickel, held Petitioner's arm and helped her get out of the vehicle and walk into the building. (T.104-106) She testified that after the accident her next communication with the Petitioner was in November of 2017. (T.109) She said she sent a text message to the Petitioner to see how she was doing. During this conversation, Petitioner asked Ms. Jones-Street if she would mind writing a statement about the incident. (T.114) Ms. Jones-Street told Petitioner she would only write what she heard. (T.114) Petitioner also asked her if she would be okay with testifying and she agreed. She stated today [at trial] is her first time seeing the Petitioner since the day of the accident in person.

Ms. Arnett was the only witness called to the stand to testify on behalf of the Respondent. She testified that she is the CEO of Respondent. (T.117) She founded Respondent about 15 years ago in 2004. (T.117) As CEO, her responsibilities are to oversee the operation of the company and several programs that they have contracts with. She does some fundraising and development of their donor base. (T.117) The Respondent has approximately 48 to 49 employees. Ms. Arnett said she hired Petitioner in September of 2015 as a consulting nurse. (T.119) Petitioner's job was to look at the children who had asthma or more pervasive things that needed support and then educate the case managers and foster parents about the condition. (T.120) She testified that Petitioner was also responsible for articulating her recommendations into reports but she was not doing this in a

timely manner. (T.120) Ms. Arnett testified that Petitioner worked 25 to 30 hours a week. In contrast to Petitioner's testimony, she testified that she never encouraged Petitioner to inaccurately report her time with Respondent. (T.122)

On the morning of the accident, June 16, 2017, Ms. Arnett testified that she saw the Petitioner and they discussed their plans for the evening. (T.123) She said she saw her again at their weekly management meeting, where all the team members come together and they talk about the week and how it wrapped up. (T.123) Petitioner testified that it was a contentious meeting. (T.20) In contrast, Ms. Arnett testified that there was nothing unusual about the meeting and that nothing stood out about it to her. (T.124) She testified that after the meeting, and after she wrapped up some calls and emails, it was about 1:00-1:30pm and she was starving and needed to get out of the office. She testified that she also needed to determine what her afternoon plans were with Petitioner and their friends so they could make the reservations. (T.123) Ms. Arnett went over to the Petitioner's desk and said "Hey, let's get out of her and grab something to eat, check out the Escape Room, so that Mary can make the reservation." (T.124) They left and drove over to Potbelly's. While at lunch, they got online and did some searches to see what their different options were regarding the Escape Room. (T.126) She stated that they did not discuss any business related to Respondent at Potbelly's. (T.130) Ms. Arnett testified that they left Potbelly's and went to Marshall's to pick up something to wear for their trip to Memphis the next weekend. (T. 128) They ended up ending cutting the shopping a little short because Petitioner started complaining about her back hurting due to new workout routine she started. (T.128) She testified that they did not discuss any business nor purchase anything related to Respondent at Marshall's. (T.130) The two left Marshall's and headed to Ms. Arnett's car and began heading back to the office.

Ms. Arnett testified that she was at a full stop, about 5 or 6 cars back, at a light on Canal Street when she felt a bump. (T.131) Ms. Arnett testified when she felt the bump she asked Petitioner "Did something happen?" (T.131) The truck behind her hit into her driver's side bumper. (T.132) When the police arrived a police report was filed and she was asked if they needed medical attention. (T.132, PX1) Ms. Arnett testified that neither her or Petitioner accepted medical attention. (T.133) She stated that the truck that hit them was able to drive away from the scene of the crash. (T.133) She testified that their plan for the evening was de-railed and they sat there for an hour-and-a half waiting on the police. Afterwards, Ms. Arnett ended up dropping Petitioner off at the office. (T.131) She testified that once in the parking lot, Petitioner exited her car without any difficulty. (T.135) She denied having a conversation in the parking lot with Ms. Jones-Street. (T.136) Ms. Arnett testified that around 7:00pm, Petitioner text her asking her if she wanted to get drinks. (T.131)

Ms. Arnett testified that she was not informed about the Petitioner's injuries and her claims of their relation to the accident until later. (T.136) She stated she became aware after she told Petitioner she needed to come back to work, leave or she would have to get Cobra to pay for her own health care. (T.136) She testified that she did not receive off work slips until July. (T.136) She stated that she found out Petitioner was claiming her injuries were work related in August from some of their neighborhood friends. (T.137) Petitioner returned to Respondent in January after she was released from her doctor. (T.137) Petitioner returned to the same position, duties and pay that she was at before leaving. (T.141) Ms. Arnett testified that Respondent is capable of making accommodations for employees with work restrictions. (T.142-143) Ms. Arnett testified that Petitioner is still an employee of Respondent and was never terminated. (T.138) Ms. Arnett testified that she and Petitioner were together the past three weekends prior to trial and continue to socialize. (T.144)

SUMMARY OF PETITIONER'S MEDICAL TREATMENT

On the morning of June 17, 2017, Petitioner went to Hinsdale Orthopedics Urgent Care Center (hereinafter "Hinsdale") and received medical attention from Dr. Judith Lin (hereinafter "Dr. Lin"). (T.33) Petitioner complained of neck pain that radiated down her arms and caused her hands to tingle. (P.X2) Petitioner also complained of pain going down her left leg. She denied, among other things, any double vision, frequent headaches, insomnia, confusion/memory loss, and anxiety. (P.X2) Dr. Lin completed a physical examination of Petitioner's head and neck and found Petitioner demonstrated normal atraumatic cephalic with limited cervical range of motion. An examination of Petitioner's cervical spine revealed paraspinal tenderness with no fracture or masses. An x-ray of the lumbar spine revealed degenerative disc disease at L5-S1 with no lumbar fracture or dislocation. The x-ray of the cervical spine revealed some degenerative disc disease with spondylosis primarily at C5-C6 with no fractures or dislocations. Dr. Lin noted normal cervical alignment, maintained in flexion and extension. (P.X2) Dr. Lin's overall assessment was a cervical and lumbar strain. (P.X.2p2) Dr. Lin ordered MRI's, at the Petitioner's request, of both her cervical and lumbar spine that were to be reviewed by Dr. Ashraf Darwish (hereinafter "Dr. Darwish"). (P.X2p2).

On June 21, 2017, the cervical and lumbar MRI's were completed. The lumbar spine revealed edema of the pars and pedicles of L5 on both the right and left consistent with stress reactions with disc space narrowing and bulging of the L5-S1 disc. Additionally, there was mild to moderate central canal and moderate bilateral foraminal narrowing. (P.X2) The cervical MRI revealed no cervical fractures, no dislocations, and a left protrusion of disc and disc/osteophyte complex at C5-C6 complicated by facet anthropathy. (P.X2) On June 22, 2017, Petitioner returned to Hinsdale Orthopedics for a follow-up with Dr. Darwish. Petitioner complained of muscle pain, stiffness/swelling of joints, joint pain and trouble walking. Additionally, Petitioner complained of numbness and tingling but denied confusion/memory loss, anxiety and insomnia. (P.X2) Dr. Darwish reviewed the X-Ray and MRI's and diagnosed Petitioner with sprain of ligaments of lumbar and cervical spine, low back pain, cervical disc disorder with radiculopathy, and mid-cervical region radiculopathy. (P.X2) Dr. Darwish recommended conservative management including physical therapy for both the cervical and lumbar spine. He also referred Petitioner to Dr. Khan for cervical epidural steroid injections at C5 6 and C6 7. He instructed the Petitioner to follow-up with him in 6 weeks for re-evaluation. Additionally, he stated that no surgical intervention was needed at that time. (P.X2) Petitioner testified that she never went and saw Dr. Khan for the epidural steroid injections because she wanted to see a neurosurgeon before she proceeded with that procedure. (T.36)

On June 30, 2017, Petitioner went to West Suburban Neurosurgical Associates (hereinafter "Suburban"), and was seen by Dr. Robert Peter Kazan (hereinafter "Dr. Kazan"). Petitioner testified that she was familiar with Dr. Kazan because she had a friend who had seen him for a cervical neck injury. (T.38) Petitioner was familiar with his reputation just from being a nurse. (T.38) Petitioner reported to Dr. Kazan that she was in a car accident where the car was stopped and hit from behind by a 4 door Ram truck that dislodged the bumper off the convertible partially and pushed the convertible mechanism into the back seat. (P.X3) Petitioner told Dr. Kazan she thought the truck was going approximately 30mph and not drivable after the accident. Dr. Kazan concluded that this was a "substantial rear-end collision". Petitioner told Dr. Kazan that she went home that day and sometime in the middle of the night developed paresthesias in both shoulders and hands. (P.X3) Dr. Kazan examined Petitioner and concluded that the rear-end collision caused symptomatic bilateral paresthesias and weakness in the left arm consisting of biceps and triceps weakness. Dr. Kazan recommended that Petitioner start physical therapy, gave her a prescription to do home cervical traction 30 minutes daily with 6-8 pounds. He told her to return to see him in 2 weeks to see if the measures he recommended improved her symptoms. (P.X3)

On July 7, 2017, Petitioner went back to Suburban for a follow-up appointment with Dr. Kazan. Petitioner complained of parathesias in both arms and requested to try a Medrol Dosepak. Dr. Kazan prescribed the Medrol Dosepak and recommended that she make an appointment to see Dr. Ning Sun (hereinafter "Dr. Sun") in Neurology to have an EMG of both upper extremities. Dr. Kazan ordered the EMG to see if there was any objective radiculopathy. Dr. Kazan requested to see Petitioner after the EMG was performed. (P.X3) On July 14, 2017, Petitioner went to Dupage Neurological Associates, S.C. (hereinafter "Dupage") and was seen by Dr. Sun for an EMG and NCV. Petitioner complained of cervical radiculopathy and cervical dystonia. Additionally, Petitioner testified that during this visit she also complained of some memory issues and headaches. (T.40) Petitioner testified that Dr. Sun conducted some testing and told her she had suffered a traumatic brain injury. (T.41) During the accident Petitioner stated that she suffered from memory impairment and that she experienced headaches from her neck spasms immediately after the accident. (T.41) Petitioner testified that she did not recall mentioning these complaints or symptoms to any of her previous doctors. (T.41) The Arbitrator notes that the records provided into evidence regarding the appointment on July 24, 2017 do not reflect Dr. Sun stating the Petitioner had a traumatic brain injury. In addition, the report also does not reflect the Petitioner complaining of memory impairment or headaches resulting from neck spasms.

On July 24, 2017, Petitioner returned to Dr. Kazan who noted that Petitioner had a positive EMG done by Dr. Sun. The EMG found left cervical radiculopathy at C5-6 and C6-7. Dr. Kazan found that the results from the EMG matched the x-ray report exactly. He recommended several more weeks of conservative therapy. If there was no response to the daily traction and physical therapy he stated that she may need 2 level foraminotomies, C5-6 and C6-7 on the left. (P.X3) On August 14, 2017, Petitioner was seen by Dr. Kazan for a follow-up visit. Petitioner complained of tremendous radicular pain down her left leg to the foot with paresthesias. She also complained of weakness in her anterior tibialis muscle, her left quadriceps reflex was absent, and her pain level was reported as a 10 out of 10. (P.X3) Petitioner states that her lumbar symptoms were more prominent than her previous complaints regarding her back. Dr. Kazan ordered an MRI to be done that day at Salt Creek Medical Imaging and a prescription for Medrol Dosepak to control the pain until she could see his associate Dr. Stanley Fronczak (hereinafter "Dr. Fronczak"). (P.X3) Dr. Kazan stated that if a large disc herniation was present, Dr. Fronczak would undoubtedly recommend surgical treatment. (P.X3)

On August 15, 2017, Petitioner was seen by Dr. Fronczak in a follow-up neurosurgical evaluation following her examination by Dr. Kazan. Dr. Fronczak reviewed Petitioner's MRI study and in a letter reported that he found a left lateral recess posterior to L4 measuring 8.7mm representing a herniated and extruded disk fragment superiorly at the L4-L5 level with a fragment. (P.X3) In comparison to the prior MRI study that was performed on June 21, 2017 at Hinsdale, Dr. Fronczak opined that the extrusion was new. Dr. Fronczak noted that Petitioner was in an accident on June 16, 2017 and was complaining of discomfort in her back and neck. He also noted that "apparently her symptoms appeared to resolve but nevertheless she was continuing to undergo therapy and take medications for both complaints." (P.X3) Petitioner reported to Dr. Fronczak that on August 9, 2017 she felt mild to moderate back discomfort with radiation into her buttock as far distally as the left thigh. Petitioner saw Dr. Sun and underwent a series of injections into the right mid and low back. The injections consisted of cortisone and lidocaine and were placed in her musculature. Dr. Fronczak recommended the Petitioner continue her Medrol Dosepak and increased her Norco tablet dosage due to her presenting a multiplicity of aggravating factors he felt were related to disk extrusion, generalized spasm and muscle cramping in her back, buttock and anterior and posterior thigh surfaces. (P.X3) Dr. Fronczak also recommended that she continue on Flexeril and given her improvement, he anticipated if her pain could be controlled, some of her additional symptoms may resolve to the extent they can then evaluate her radiculopathy. He noted that symptomatic disk herniations improve gradually over time as long as the person can tolerate their painful complaints. (P.X3)

On August 17, 2017 Petitioner returned to see Dr. Fronczak for a neurological evaluation. Petitioner complained of severe pain on the left with weightbearing, weakness of hip flexion, abduction and adduction. Petitioner complained of still experiencing spasms involving the quadriceps and numbness extending distally beyond the knee. Dr. Fronczak noted that the Petitioner had severe pain with attempted weightbearing far in excess of what one would expect purely as a result of disk herniation. He reviewed her MRI studies and found a disk bulge at L2-L3 level. However, he noted that it was right-sided which did not explain the Petitioner's symptoms. He ordered an MRI study of the hip to rule out any pathology, and if no cause was found regarding the Petitioner's symptoms, he suggested an epidural steroid injection. (P.X3) On August 18, 2017, Petitioner was contacted by Dr. Fronczak to inform her of the results to her MRI of the left hip. The MRI demonstrated findings consistent with a possible gluteus medius muscle tear, trochanteric edema and possible mild trochanteric bursitis. Dr. Fronczak contacted Dr. Barfield at Hinsdale Orthopedics and spoke with his assistant, Ms. Cindy Galindo. He arranged for Petitioner to be seen that morning. He felt Petitioner required physical therapy and modalities to diminish the pain involving the left hip region. (P.X3)

On August 22, 2017 the Petitioner underwent an epidural steroid injection. On August 24, 2017, Dr. Fronczak called Petitioner to see if she received any relief from the epidural steroid injection. Petitioner complained of difficulty walking but in general more relief. Petitioner did not have any new complaints other than her previous issues with ambulance. Dr. Fronczak told her to follow-up with Dr. Kazan on August 25, 2017. On August 25, 2017, Petitioner was seen by Dr. Kazan and he reviewed her MRI scan. Dr. Kazan opined that there was an extruded disc impacted into the foremen and that was why she had the L5 weakness of her foot extensors and her big toe as well as numbness in the L5 distribution. Dr. Kazan noted that Petitioner had improved with the epidural injections and had another one scheduled with Dr. Barfield. However, if she did not improve any further, he would go ahead and operate on her to remove the fragment in the foramen. On September 11, 2017, Petitioner saw Dr. Vincent Traynelis (hereinafter "Dr. Traynelis") at Rush. Dr. Traynelis told Petitioner that she should have a lumbar diskectomy. His recommendation was due to her complaints of continued weakness of her anterior tibialis, big toe, and numbness in the L5 nerve distribution. (P.X3) He scheduled the surgery for September 21, 2017 at Advocate Good Samaritan Hospital (hereinafter "Advocate Hospital") for lumbar diskectomy on the left at the L4-5. (P.X3)

On September 20, 2017, Dr. Kazan performed a left L4-L5 hemilamintomy, discectomy and foraminotomy on Petitioner at Advocate Hospital. There were no reported complications to the surgery. On September 29, 2017, Petitioner had a follow-up appointment with Dr. Kazan. Petitioner reported no pain in her left leg, greater strength in her toes, and numbness in her foot. Dr. Kazan removed her sutures and sent her to physical therapy at ATI to increase her foot strength. On October 30, 2017, Petitioner returned to Dr. Kazan for a follow-up appointment. He reported that she had regained tremendous strength in her left foot and anterior tibial muscle. Petitioner had one more physical therapy sessions scheduled. Petitioner still complained of some numbness and tingling. Dr, Kazan felt these issues would improve. He noted some cervical issues and an EMG that showed some irritability on the left at C5, C6 and C7. Dr. Sun was still treating her with steroid injections and Botox. Dr. Kazan recommended another EMG early next year to see if there was any worsening to determine a need for cervical surgery. (P.X3) On January 29, 2018, Petitioner had a follow-up appointment with Dr. Kazan. At this appointment she complained of numbness in her left thumb, index and middle finger. Dr. Kazan informed Petitioner that she was eligible to have 2 level foraminotomies, left C5-6 & C 6-7. On February 21, 2018, Petitioner underwent 2 level foraminotomies, left C5-6 & C 6-7 surgery at Advocate Hospital. (P.X3) Petitioner returned to Dr. Kazan for follow-up appointments on March 2nd and March 16, 2018. On the March 16, 2018 appointment Dr. Kazan reported that she had no radicular pain, some paraspinal burning, sharp muscular pain to the left and below the incision and some numbness in her fingers. Petitioner reported to still be unable to look down comfortably. Dr. Kazan opined that she could not work at the time and scheduled a follow-up appointment in 2 weeks. Petitioner's last doctor appointment with Dr. Kazan was on March 16, 2018.

Petitioner admitted medical documentation and off-work slips taking her off work from July 14, 2017 through January 8, 2018 and from February 21, 2018 until March 29, 2018 (hearing date). (P.X5,6) Petitioner was released back to work on January 8, 2018 without any restrictions but "as tolerated". (T.58) Petitioner continued to be off work and had a follow up visit scheduled with Dr. Kazan on April 2, 2018 (T. 11, 71) At the time of the hearing, Petitioner was not released to return to work. (T.71) Petitioner has not received any Temporary Total Disability or Medical payments from Respondent. (T.67-68, 71-73)

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment:

The Petitioner, Karen Suknovich, was the first witness of the three witnesses to testify at trial. There were many discrepancies between the Petitioner's testimony, subjective complaints, and the non-rebutted exhibits entered into evidence. In regard to the actual accident, Petitioner testified that after the impact, the other vehicle was inoperable with his bumper pushed into his front tires. (T.26) In addition, on June 30, 2017, Petitioner went to Suburban and was seen by Dr. Kazan. Petitioner told Dr. Kazan she thought the truck was going approximately 30mph when it impacted Ms. Arnett's car and that it was not drivable after the accident. (P.X3) Petitioner also stated that the truck dislodged the bumper off the convertible partially and pushed the convertible mechanism into the back seat. (P.X3) Dr. Kazan concluded that this was a "substantial rear-end collision". (P.X3)

Petitioner's testimony and statements were directly contradicted by Ms. Arnett's testimony. Ms. Arnett testified that both vehicles involved in the accident were operable and able to drive away from the scene of the crash. (T.133) This was supported by the police report submitted into evidence by the Petitioner. (P.X1) The report states that neither vehicle was towed due to the crash. In addition, the officer noted in his narrative that both vehicles sustained minor damage. (P.X1) Petitioner's statements are also contradicted by the pictures of the back of Ms. Arnett's vehicle at the scene of the accident. (R.X2) The bumper of her car is attached. (R.X2) The Petitioner did not rebut or object to the picture of the vehicles being entered into evidence.

Petitioner testified that after the impact she felt pain in her neck, lower back, was disoriented and loss consciousness briefly for a period of time. (T.25, 26) Petitioner testified that once the police arrived they offered to call an ambulance for her but she refused because she felt she could "shake it off" and wanted to see her own physician. (T.28) Despite Petitioner's "loss of consciousness briefly for a period of time", Petitioner testified that once she arrived at the office, had to be helped out of the car and into the building, she drove herself home. (T.31) Petitioner told Dr. Kazan that she went home that day and sometime in the middle of the night developed paresthesias in both shoulders and hands. (P.X3) On June 17, 2017, Petitioner went to Hinsdale Urgent Care and complained to Dr. Lin she was experiencing neck pain that radiated down her arms and caused her hands to tingle. (P.X2) Petitioner also complained of pain going down her left leg. (T.33) On June 22, 2017, Petitioner returned to Hinsdale Orthopedics for a follow-up with Dr. Darwish. On this visit Petitioner complained of muscle pain, stiffness/swelling of joints, joint pain and trouble walking.

The extensiveness of Petitioner's complaints the days after the accident were contradicted by Ms. Arnett's testimony. Ms. Arnett testified that the evening after the accident, Petitioner was texting her to see if she wanted to go out for drinks. (T.131) In addition, Ms. Arnett testified that the next weekend (June 23-25,

2017) Petitioner attended a three-day birthday party with a bunch of their friends in Nashville, Tennessee. (T.146) The trip consisted of them walking from bar to bar. (T.146) Ms. Arnett testified that Petitioner did not complain of any pain and seemed to have no difficulty walking from bar to bar in her wedge heels. (T.147) In support of this testimony, the Respondent entered a picture of Ms. Arnett, Petitioner, and their friends in Nashville, Tennessee on the birthday trip. (R.X3) This testimony was unrebutted and there was no objection to entering the aforementioned picture into evidence.

Petitioner was seen on July 14, 2017, at Dupage by Dr. Sun for an EMG and NCV. At this appointment Petitioner complained that almost immediately after the accident she was experiencing headaches from neck spasms. (T.41) Petitioner also complained of a foggy mind, being forgetful, being moody and being confused. (T.86) However, none of the medical records submitted into evidence reflect these complaints to any of her prior physicians. Petitioner supported this finding by testifying that she had never complained of these symptoms prior to her appointment with Dr. Sun. (T.41) However, on cross-examination, Petitioner contradicted her testimony during the direct examination, by stating that she had reported her confusion, headaches, and memory issues to Dr. Kazan prior to seeing Dr. Sun. (T.87) The Arbitrator notes that Petitioner's medical records reflect her denying these same complaints during her earlier doctor visits. (P.X2)

Overall, due to the discrepancies and contradictions between the Petitioner's testimony, medical records, exhibits admitted into evidence and conflicting testimony the Arbitrator finds the Petitioner's testimony to not be credible.

Ms. Jones-Street also testified on behalf of the Petitioner. She testified that she had a conversation with Ms. Arnett in the parking lot of Respondent following the accident. (T.104) She testified that Ms. Arnett told her, that while leaving a meeting, her car was rear-ended. (T.104) When asked if anyone else heard this conversation she testified that no one else overheard it. Additionally, she testified that their co-worker Mike Bickel, held Petitioner's arm and had to help her exit the vehicle to walk into the office building. (T.104-106) She testified that after the accident her next communication with the Petitioner was in November of 2017. (T.109) She said she sent a text message to the Petitioner to see how she was doing. During this conversation, Petitioner asked Ms. Jones-Street if she would mind writing a statement about the incident. (T.114) Ms. Jones-Street testified that she told Petitioner that "I would only write what I heard, that was it." (T.114) Ms. Arnett denied not only that this conversation between her an Ms. Jones Street occurred, but that there was any one else present in the parking lot when she returned with Petitioner from the accident. (T.135) The credibility of Ms. Jones Street was called into question during cross-examination when she disclosed she had been disciplined at Respondent prior to her resignation. Also, when asked her thoughts about Ms. Arnett she testified that she felt she was "mean spirited, controlling and manipulative." (T. 112) Overall, the Arbitrator found Ms. Jones-Street's testimony and credibility to be questionable.

Ms. Arnett was the only witness to testify on behalf of the Respondent. Overall, the Arbitrator found Ms. Arnett's testimony to be credible. Ms. Arnett testified, and it was unrebutted, that she and Petitioner were friends. (T. 118-119) She established that she and Petitioner had common friends outside of work, were in several social groups together, and traveled together. She testified that on the day of the accident, June 16, 2017, she was not discussing any work matters with Petitioner but merely having lunch. (T. 123) She testified that after lunch they went to shop at Marshall's and ended up leaving early due to the Petitioner complaining of issues with her back due to a new work-out routine. (T.128) Petitioner's medical records reflect that she reported working out regularly. (PX2)

Ms. Arnett testified that on her way back to the office with Petitioner they were involved in a minor rear-end collision. (T.131) She testified that both cars were operable after the accident. (T.133) This testimony was

supported by the police report from the accident stating that the crash was minor and that both vehicles were operable afterwards. (T.132) In addition, it stated that neither vehicle required a tow from the accident scene. (P.X1) She testified that she was unaware that Petitioner had been injured. (T.136) Ms. Arnett testified that once they arrived at the office Petitioner got in her own vehicle and left. (T.135) She also testified that Petitioner text her that evening around 7:00pm for drinks. (T.131) To support Ms. Arnett's lack of knowledge of Petitioner's claimed injuries, she testified that Petitioner went on a 3 day birthday trip to Memphis [also referred to as Nashville] with her and a group of friends the next weekend. (T. 146) On the trip they walked from bar to bar and at no time did she hear the Petitioner complain of pain or any issues related to the accident. This testimony was supported by a picture of Petitioner, Ms. Arnett, and their friends from the weekend trip. (R.X3) This exhibit was entered into evidence unrebutted and without an objection. (R.X3)

Ms. Arnett testified to first receiving an off work slip from Petitioner in July 2017. (T. 136). She was not informed that Petitioner was claiming her injury was work related at this time. (T. 137). In fact, Ms. Arnett testified that she was not aware that Petitioner was claiming a work-related injury until September of 2017. When asked whether she had questions regarding Petitioner not returning to work for several weeks following the accident, Ms. Arnett testified that to her knowledge, Petitioner had a planned vacation to California. (T. 182). This went unrebutted at trial. Overall, the Arbitrator found Ms. Arnett's testimony to be credible.

With respect to issue (C) whether an accident occurred that arose out of and in the course of employment with Respondent, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that her accident arose out of and in the course of her employment. "A claimant bears the burden of proving by a preponderance of the evidence that his 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, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

First, the Petitioner has the burden of proving by a preponderance of the evidence that the accident arose out of her employment with Respondent. The Illinois Supreme court held, "for an injury to have arisen out of the employment, the risk of injury must be a risk peculiar to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of his employment ...A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling his duties ...If the injury results from a hazard to which the employee would have been equally exposed apart from the employment, then it does not arise out of it. *Orsini v. Industrial Commission*, 117 Ill.2d 38, 509 N.E.2d 1005, 1008-1009, 109 Ill. Dec. 166 (1987).

Here, Petitioner has established that she and Ms. Arnett, CEO and Supervisor of Respondent, were in a car accident on June 16, 2017. (P.X1) Petitioner testified that the two left the office and had a work-related meeting at Potbelly's following their weekly office meeting. (T.21, 24) Petitioner relies solely on her testimony to establish that work-related business was discussed at this meeting. No evidence was produced on behalf of the Petitioner to support this testimony. In contrast, Ms. Arnett claims their meeting was not in fact a work-related meeting but merely a lunch. (T.124-127) Regardless of whether there was a meeting at Potbelly's or merely a lunch, both Petitioner and Respondent agree that the accident occurred after their interaction at Potbelly's and during their commute back to Respondent. Therefore, their meeting and whether it was related to business with the Respondent is irrelevant. The actual accident occurred after the meeting and while Petitioner and Ms. Arnett were commuting back to the office.

The motor-vehicle accident that Petitioner was involved in during her commute back to the office was not a risk peculiar to her work with Respondent. Additionally, Petitioner was not exposed to any greater risk than any other general public person traveling along that same road by reason of her employment with Respondent. Petitioner also failed to prove that she was doing something she had to do in order to fulfill her duties as an employee of Respondent. Conflicting testimony was provided from the Petitioner and Ms. Arnett regarding Petitioner being aware of where she was going and why she was going. Petitioner testified that she was unaware of where they were going and was just told to come along. However, Ms. Arnett testified that she said to Petitioner "Hey, let's get out of here and grab something to eat, check out the Escape Room, so that Mary can make the reservation." (T.124) The conflicting testimony raises a credibility issue that Petitioner did not provide evidence to rebut. The Arbitrator finds that the Petitioner's involvement in the car accident was a hazard that Petitioner would have been equally exposed to apart from her employment with Respondent.

Precedent case law provides that accidents that occur when an employee is traveling to and from work do not generally arise out of or occur in the course of employment. However, if the employee is classified as a "traveling employee", an exception exists. Here, Petitioner provided no evidence or arguments to support that she was a traveling employee whose job duties required her to travel away from Respondent's premises. Mere commuting is not encompassed in the traveling employee doctrine. Petitioner failed to prove that in this case she was a traveling employee.

The issue of whether the injury occurred in the course of Petitioner's employment largely comes down to a credibility determination of whether the testimony of Petitioner or the testimony of Ms. Arnett should carry more weight. Due to the aforementioned contradictions found between Petitioner's testimony, subjective complaints, and the non-rebutted exhibits entered into evidence Petitioner's testimony was found to not be credible. Notwithstanding the credibility issues, in order for an injury to be compensable, the Petitioner has to prove that the injury arose out of and was in the course of the employment. Petitioner failed to prove by a preponderance of the evidence that her injury arose out of her employment with Respondent. Therefore, an issue of whether the injury was in the course of employment is moot.

With respect to issue (F), (J), and (L) the Arbitrator finds as follows:

As a finding has been made that the Petitioner's accident did not arise out of and in the course of her employment with Respondent, the other disputed issues are moot.

Tiffany Kay

6/ 24 /18

Signature of Arbitrator

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CALEB LALONDE

Petitioner,

vs. NO: 15 WC 22191

VILLAGE OF NILES FIRE DEPARTMENT,

Respondent.

20IWCC0092

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 the nature and extent of permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With regard to the nature and extent of the Petitioner's injury, the Commission views the evidence differently than the Arbitrator.

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established under §8.1b of the Act using, in part, the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most

> current edition of the American Medical Associations' "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment. *829 ILCS 305/8.1b(a) (West 2013)*.

Pursuant to §8.1b(a) of the Act, the Respondent engaged the services of Dr. Mark Levin who provided an AMA Impairment Rating of 5% impairment of an upper extremity, equivalent to 3% whole person impairment. The Arbitrator gave little weight to Dr. Levin's Impairment Rating and based this determination on his interpretation that the wrong section of the AMA Guides was used in arriving at this Impairment Rating. The Arbitrator noted that Dr. Levin did not perform the alternative rating using a loss of range of motion impairment as outlined in §15.7 of the Upper Extremity Chapter, a procedure that "may have resulted in a higher impairment rating than the 5% impairment he determined." (Arb. Dec. p. 7) A closer reading of the record, however, confirms Dr. Levin used §15.7 Range of Motion Impairment after he considered Petitioner's residual loss of motion and determined that would be the best criteria to use to rate him. (RX1, pp. 15-16, DX2, p. 5)

Dr. Levin testified that when issuing the AMA impairment rating, one option is to arrive at it through the diagnosis, but for Petitioner, he chose alternatively to use the §15.7 Range of Motion Impairment "because if you were just to use the regular table, that would not take into account that this gentleman does have some minor restricted motion in two planes, therefore the better rating was to give him the more benefit of a higher rating under the range of motion impairment section." (RX1, pp. 15-16)

The Commission notes Dr. Levin specifically utilized the "rule of liberality" and he testified that, "if one does not give him the liberality, he actually should have a zero percent upper extremity impairment." (RX1, 47)

The Commission also notes that on cross-examination, Dr. Levin testified that the Petitioner did the warm-ups before the range of motion test. Typically he has participants do warm-ups three times, but he documented only the last motion despite the fact that the AMA Guides "says you should do it three times and document three times." (RX1, pp. 53-54) Dr. Levin explained that "that's part of the warm-up and that's how I always have done it." "...So you're allowed to use the last one, which (if) anything, should give you the best recording of what the motion is." (RX1, pp. 54-55)

Petitioner's attorney then queried whether it was true that the AMA book "says that you average out all three test scores?" Dr. Levin responded, "They average out all three, but you want to give them the highest value which is what he's given on the last visit on the last exam....no, they aren't all averaged out because you want to give him what his functional last one is. So the last one is what was used." (RX1, p 56) The Commission finds that Dr. Levin's range of motion calculation was not documented in accordance with the AMA Guides.

Further, the Commission agrees that §8.1b(b) applies, however, disagrees with the Arbitrator's determination of permanent partial disability. Therefore, the Commission strikes the Arbitrator's evaluation of Petitioner's permanent partial disability pursuant to §8.1b(b) of the Act, under the Conclusions of Law, and substitutes the following:

According to §8.1b(b) of the Act, for injuries that occur after September 1, 2011, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) The reported level of impairment pursuant to AMA guidelines;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by the treating medical records.

In considering the degree to which Petitioner is permanently partially disabled as a result of the work-related accident, the Commission weighs the five factors in §8.1b(b) of the Act as follows:

(i) At his deposition, Dr. Levin testified that he examined the Petitioner, took a history from him, and performed x-rays on his left shoulder on February 28, 2017. Petitioner reported to Dr. Levin that he was a weightlifter, significant because he had a very muscular trapezial area and upper extremity which allowed him to regain his strength. Dr. Levin testified that Petitioner, "...had had excellent strength and physique from his body building." (RX1, pp. 11-12) Dr. Levin authored a report of the history, physical exam, review of records, radiographic studies and an AMA impairment rating that he provided from the visit on February 28, 2017. (RX1, p. 8) Dr. Levin testified consistent with his report, that he provided an AMA Impairment Rating of 5% impairment of an upper extremity, equivalent to 3% whole person impairment. (RX1, pp. 18, 19, DepX2, p. 6) Dr. Levin testified that he used §15. 7 Range of Motion Impairment to arrive at his impairment rating, after consideration of other criteria, but documented only the last one of the three range of motion tests. He did not average the results of the three tests despite the fact that the "book says you should do it three times and document three times." (RX1, pp. 53-56) The Commission assigns this factor little weight.

(ii) Petitioner was, and continues to be, employed as a firefighter/paramedic and was released to work with no restrictions. Petitioner testified his job requires him to perform very strenuous activities on a routine basis, such as lifting and carrying heavy pieces of equipment such as ladders, hoses, and extrication tools. He must perform repetitive overhead activities when doing salvage and overhaul work after a structure fire has been extinguished in order to determine if the fire is completely extinguished. He must respond to emergency situations where he has to lift and move disabled or injured persons quickly or to assist other paramedics carry a person on a stretcher down flights of stairs to an ambulance. He has not ever declined overtime, ambulance runs or refused to fight fires, and he continues to use all the tools of a firefighter. This factor is assigned greater weight.

(iii) Petitioner was 25 years old at the time of his work accident. Petitioner testified that he wanted to work "at least until 2044," when he could "pension off." (T, p. 20) Thus Petitioner intends to work approximately 27 years from the date of the arbitration

hearing as a firefighter. This factor is assigned greater weight.

(iv) There is no evidence of reduced future earning capacity in the record thus this factor is assigned no weight.

(v) Regarding evidence of disability corroborated by the treating medical records, as a result of the work-related accident of May 28, 2015, Petitioner was diagnosed with left shoulder instability with joint dislocation and he underwent an arthroscopic left shoulder subacromial decompression, open capsular suture plication, interval closure and synovectomy on August 17, 2015. (PX2, PX3) Petitioner underwent physical therapy beginning August 2015 and advanced to work conditioning on February 9, 2016, with his last work conditioning appointment on March 1, 2016. In his pre-test subjective notes, he reported the lowest functional pain score in the last 30 days is 0/10, worst functional pain score in last 30 days is 0/10, and current functional pain score is 0/10. At that time, performance relative to his job demands was 94.12% (16/17 job demands met). He demonstrated the ability to function at the Heavy Physical Demand Level of work as demonstrated by a 70 pound 2-hand occasional lift from floor to waist. The parties stipulated Petitioner was entitled to TTD for 40-/17 weeks, for the period June 2, 2015 through March 8, 2016 and Petitioner received full pay pursuant to PEDA. (ARBX1) Dr. Visotsky released Petitioner to return to work without restrictions on March 8, 2016. On September 13, 2016, Petitioner's shoulder was slightly tender to palpation with subjective pain along the biceps labral area and tightness on glenohumeral internal rotation. Dr. Visotsky determined that Petitioner was at MMI on September 13, 2016 and he was again released to full-duty work with no restrictions. Petitioner testified that he has not seen Dr. Visotsky or received any further treatment since being released in September 2016. Based on the treating medical records, this factor is assigned moderate weight.

Having weighed the evidence and analyzed the §8.1b(b) factors, the Commission finds Petitioner sustained a 10% loss of use of the person as a whole under §8(d)2.

Finally, the Commission corrects scriveners' errors in the Arbitrator's Decision on page six, in the first sentence in the first full paragraph, wherein it should read "He noted Dr. Visotsky's [not "Lisotsky's"] full-duty release." Also on page six, the last sentence in the second paragraph, should read, "Dr. Levin noted Petitioner's [not "Petitioner"] muscular trapezii and upper extremities." On page 7, the citation should read "§8.1b(b)" [not "§8.1(b)b"]. (Arb. Dec. pp. 6, 7)

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of 15% loss of use of a person-as-a-whole as provided in §8(d)2 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the

reason that the injuries sustained caused a 10% loss of use of a person-as-a-whole.

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

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

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

DATED: FEB 7 - 2020
KAD/bsd
O:121019
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LaLONDE, CALEB T
Employee/Petitioner

Case# **15WC022191**

VILLAGE OF NILES-FIRE DEPARTMENT
Employer/Respondent

20IWCC0092

On 5/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.00% 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:

1497 MORICI FIGLIOLI & ASSOCIATES
CAROL A VIRGILIO
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

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

20 I W C C 0 0 9 2

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

Caleb T. LaLonde
Employee/Petitioner

Case # **15** WC **22191**

v.

Consolidated cases: ______

Village of Niles-Fire Department
Employer/Respondent

20IWCC0092

An *Application for Adjustment 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 **August 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [x] What is the nature and extent of the injury?

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On **5/28/2015**, 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 $**95,005.04**; the average weekly wage was $**1,827.02**.

On the date of accident, Petitioner was **25** 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 because Petitioner received full pay pursuant to PEDA, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0.** The parties stipulated that there is no claim for overpayment or underpayment of TTD.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$735.37/week** for **75** weeks, because the injuries sustained caused a **15% loss of a person-as-a-whole,** as provided in §8(d)2 of the Act.

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

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

Signature of Arbitrator

May 8, 2018
Date

MAY 8 - 2018

Caleb T. LaLonde v. Village of Niles-Fire Department
15 WC 22191

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

FINDINGS OF FACT

Petitioner Caleb LaLonde has been employed by Respondent Village of Niles Fire Department as a firefighter/paramedic since July 2013. Petitioner testified that as a firefighter/paramedic he responds to all calls for fire suppression, such as house and other structure fires, vehicle fires, and any other types of fires along with responding to activated fire alarms. He also responds to other types of emergency calls such as scenes of automobile accidents and to assist in transporting sick or injured individuals. When performing these various activities, he has to frequently carry heavy ladders, equipment such as hoses, and extrication equipment and tools, which involve overhead activities. Additionally, when assisting the ambulance crews he is required to lift and carry stretchers with heavy individuals to the ambulance for transport. He also does on-going strenuous training activities that require lifting heavy firefighting equipment and in the realm of fire rescue training exercises, the pulling and carrying of fellow firefighters.

Petitioner testified that he was able to perform all job duties required of a firefighter/paramedic for Respondent without difficulty and had never injured his left shoulder before May 28, 2015. On that date Petitioner was participating in a water rescue training exercise at Oasis Water Park in Niles, Illinois. Petitioner testified that he along with his fellow firefighters were in a boat and were required to lift and pull his fellow firefighters out of the water and into the boat. As he was lifting a firefighter out of the water with his left arm, he felt an immediate sharp pain in his left shoulder. He stated that it felt like a ripping sensation. Petitioner is left-hand dominant.

Petitioner reported his injury to his chief. He was initially sent to Advocate Occupational Health-Niles Center (Advocate) for treatment on May 28 (PX #1). Petitioner reported how the accident occurred and his left shoulder was examined. On exam left shoulder range of motion was limited by pain. Petitioner was diagnosed with a left shoulder strain and prescribed rest, ice, and pain medication.

Petitioner treated at Advocate from May 28 through June 11, 2015. Petitioner was placed on restricted duty from June 3 to June 11, 2015. On the last visit, June 11, Petitioner reported that he was seeing an "ortho" who took him off work. Petitioner was

discharged to follow up with his "ortho."

Petitioner consulted orthopedist Dr. Jeffrey Visotsky with Illinois Bone and Joint Institute on June 9, 2015 (PX #2). Dr. Visotsky took a detailed history of Petitioner's accident and treatment. Dr. Visotsky suspected a left shoulder labral tear and recommended an MRI arthrogram of the left shoulder. The June 16, 2015 MRI arthrogram showed a labral tear. On June 23, 2015 Dr. Visotsky confirmed the labral tear. He then recommended a course of physical therapy.

Petitioner began a course of physical therapy at Accelerated Physical Therapy (PX #4) on June 23, 2015 and was discharged from the program on July 21, 2015. Petitioner testified that he plateaued during physical therapy and was still experiencing pain and discomfort in his left shoulder in addition to diminished range of motion. Petitioner next saw Dr. Visotsky on July 21, 2015 who recommended arthroscopic anterior labral repair surgery due to his continued pain and discomfort, diminished range of motion, left shoulder instability, and an unsuccessful course of physical therapy.

Dr. Visotsky performed an arthroscopic left shoulder subacromial decompression and left shoulder open capsular suture plication and interval closure on August 17, 2015 (PX #2 & PX #3). Dr. Visotsky found a tear between the supraspinatus and subscapularis with interval widening. He also performed a synovectomy. Dr. Visotky's pre-operative diagnosis of left shoulder instability with joint dislocation was confirmed by the procedure. On August 21, 2015, Dr. Visotsky recommended a minimum of 3 months of physical therapy, which could be extended up to 6 months due to Petitioner's physically demanding job as a firefighter/paramedic.

Petitioner began a post-surgical course of physical therapy at Accelerated Physical Therapy and continued to follow-up with Dr. Visotsky. Petitioner testified that his strength and range of motion was improving, however he still reported tightness with internal rotation and tenderness and weakness in his left arm and shoulder. Petitioner continued with a structured physical therapy program at the recommendation of Dr. Visotsky. Due to Petitioner's progress, Dr. Visotsky advanced Petitioner to work conditioning on February 9, 2016.

Petitioner was continued in physical therapy due to continuing symptoms of left shoulder tenderness. Petitioner's final visit with Dr. Visotsky was September 13, 2016. Dr. Visotsky determined that Petitioner was at MMI. However, Petitioner testified that he still has pain along the left biceps and the labral area. He further testified that he has not seen Dr. Visotsky or received any further treatment since being released in September 2016.

Petitioner testified that at the present time, he continues to experience problems with his left shoulder. He testified that he continues to perform his same work activities as before the accident. Petitioner testified that his work primarily consists of patient care, working with patients in emergency situations. He carries patients on cots and stretchers. As far as firefighting duties, Petitioner testified that most of his activities consist of training drills. He agreed that he continues to use all the tools of a firefighter, and participates in most drills. He testified that he does not ever decline to respond to fire or ambulance calls. He has not refused any work shifts because of his shoulder condition.

Petitioner testified that since his return to work, he is more cautious at work. He testified that he relies on other members of his team to help him more than he did before his accident. He testified that he tries to use his right hand and arm more while pushing and pulling cots, swinging an axe, and when "pulling" ceilings with a pole.

Petitioner testified that he is limited in his nonoccupational pursuits. He also testified that certain recreational activities are difficult to perform such as playing a full round of golf or throwing a sixteen inch softball, which were activities he was able to perform prior to his work accident. Petitioner also testified that when he scrubs walls, his left shoulder fatigues quickly. He tries not to lift to high shelves.

Petitioner testified that he intends on working for Respondent as a firefighter/paramedic until he retires. He has no reason to believe that his job stability with Respondent has been impacted by his injury. Petitioner testified he has received pay raises since his accident. Petitioner testified that he does not work overtime as much as he did before the accident, although he acknowledged that this was due to a general decline in overtime availability. Petitioner testified that he still works overtime whenever it is offered. Petitioner testified that he has not refused to go on any ambulance runs because of his shoulder condition. He testified that he has not refused any work shifts because of his shoulder condition.

Petitioner is currently 28 years old and intends on working until 2044, when he can receive his full pension. Petitioner further testified that although the firefighters are not offered overtime as frequently as they were before his accident, he still notices weakness and fatigue in his left arm and shoulder after performing overtime work after his full shift.

Petitioner was examined by orthopedist Dr. Mark Levin at Respondent's request pursuant to §12 of the Act on February 28, 2017 (Evd Dep X#2). Petitioner gave his work history as a firefighter/paramedic and the history of his work accident. Petitioner filled out a History of Present Illness with a Pain Diagram and a QuickDASH Outcome

Measure. In addition to a clinical examination Dr. Levin reviewed the First Report of Injury, Supervisor's Report, records from Advocate Occupational Health, records from Athletico, records from Dr. Visotsky, the June 16, 2015 MRI arthrogram report, and records from Accelerated Rehab/Athletico PT. Dr. Levin had x-rays of the left shoulder performed.

Dr. Levin noted Dr. Visotsky's surgical repair of the left shoulder torn labrum. He noted Dr. Lisotsky's full duty release. Petitioner reported pulling and pain with overhead activity with his left shoulder. The pain extends down into the biceps. Petitioner expressed concerns that he may continue to have problems with his shoulder. Petitioner reported that he cannot throw a ball or play golf or play Frisbee, although he was able to do his normal job.

On exam Dr. Levin noted reduced and painful range of motion in the left shoulder compared to the right. Petitioner complained of pain on palpation of the left trapezius. There was no pain on palpation over the AC or SC joints. There were no abnormal findings on examination of the cervical spine. Dr. Levin noted Petitioner muscular trapezii and upper extremities.

Dr. Levin opined that Petitioner was at MMI (Dep #2). He further opined that Petitioner was capable of working full duty and that he did not require further orthopedic intervention. In addition, Dr. Levin provided an AMA Impairment rating of 5% impairment of an upper extremity, equivalent to 3% whole person impairment.

Dr. Levin gave his evidence deposition June 28, 2017 (RX #1). He testified to being a board-certified orthopedic surgeon. He described himself as a community based orthopedist. He refreshed his memory from his narrative IME report of February 28, 2017 (Dep X#2), the History of Present Illness (Dep #3), and the QuickDASH Outcome Measure (Dep #4).

Dr. Levin reiterated the findings he noted in his narrative report of February 28, 2017. He acknowledged the "rule of liberality', which requires the examiner to use a higher level of impairment assessment to the benefit of the examinee. He further explained the process of assessing impairment using AMA Guidelines. Dr. Levin noted that Petitioner's diminished left shoulder motion in two planes was minor. He acknowledged that Dr. Visotsky's diagnosis was correct and that surgery was appropriate.

Dr. Levin confirmed his 5% impairment of an upper extremity, which was equivalent to 3% whole person impairment. On cross-examination Dr. Levin acknowledged that about 90% of the IMEs he performs are for the defense and that

more than 90% of AMA impairment ratings are for the defense. He would not speculate whether Petitioner's impairment could increase with the passage of time. He admitted that in this case, another impairment rating could be done using a loss of range of motion impairment rating as outlined in §15.7 of the Upper Extremity Chapter. Dr. Levin did not to perform this alternate impairment rating procedure even though Petitioner exhibited a loss of range of motion of the left shoulder and that the alternative rating procedure may have resulted in an impairment rating higher than the 5% impairment he determined.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's proved that his current condition of ill-being is causally related to the work accident he sustained on May 28, 2015. Petitioner's credible testimony regarding the current condition in his left shoulder is supported by the medical evidence submitted at trial, including the opinions of Respondent's §12 examining physician, Dr. Mark Levin.

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

The Arbitrator evaluated Petitioner's permanent partial disability in accord with §8.1(b)b of the Act:

(i) Respondent's §12 examining physician, Dr. Mark Levin, concluded that Petitioner had a 5% impairment of the upper extremity based on the 6th Edition of AMA Guidelines. Dr. Levin acknowledged that he was aware of the "rule of liberality" which requires a physician to utilize the impairment rating method that would result in the highest impairment rating. He also admitted that in this case, another impairment rating could be done using a loss of range of motion impairment rating as outlined in §15.7 of the Upper Extremity Chapter. Dr. Levin did not to perform this alternate impairment rating procedure even though Petitioner had exhibited a loss of range of motion of the left shoulder and that the alternative rating procedure may have resulted in a higher impairment rating than the 5% impairment he determined. Given this, the Arbitrator gives little weight to this impairment rating.

(ii) Petitioner's occupation as a firefighter/paramedic requires him to perform very strenuous activities on a routine basis, such as lifting and carrying heavy pieces of equipment such as ladders, hoses, and extrication tools. He must perform repetitive overhead activities when doing salvage and overhaul work after a structure fire has been extinguished in order to determine if the fire is completely extinguished. He must respond to

emergency situations where he has to lift and move disabled or injured persons quickly or to assist other paramedics carry a person on a stretcher down flights of stairs to an ambulance. Petitioner's limitations with his left shoulder have a significant impact his off-duty activities and his ability to perform his work activities. The Arbitrator gives great weight to this factor which increases the value of permanent partial disability.

(iii) Petitioner was 25 years old at the time of his work accident. He had a statistical life expectancy of 52.8 years. Petitioner will have to suffer from his limitations and pain for the remainder of his life, with the possibility those complaints worsening with advancing age. The Arbitrator gives great weight to this factor which increases the value of permanent partial disability.

(iv) Petitioner has returned to full duty work as a firefighter/paramedic. He testified that he has not declined or refused any work assignment. He testified that he intends to continue working for Respondent until his scheduled retirement. There was no evidence that Petitioner's injury has adversely affected his earning capacity. The evidence demonstrated that Petitioner will be able to continue working as a firefighter/paramedic. Therefore, the Arbitrator gives great weight to this factor which diminishes the value permanent partial disability.

(v) Petitioner clearly suffered a left shoulder labral tear which required surgical repair after failed conservative care. He underwent post-surgical physical therapy and work-hardening which permitted him to achieve MMI and return to full duty work. Petitioner has not had any medical care for his injury since his release by Dr. Visotsky in September 2016. The Arbitrator gives great weight to this factor which increases the value of permanent partial disability.

Based all the evidence, including evaluation of the above five factors, the Arbitrator finds that Petitioner has sustained a permanent partial loss of use of a person-as-a-whole to the extent of 15%, 75 weeks, pursuant to §8(d)2 of the Act.

[signature]

Steven J. Fruth, Arbitrator

May 8, 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Miguel Hernandez,

Petitioner,

20IWCC0093

vs.

NO: 18 WC 25035

Montana Metal Products, LLC,

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, temporary disability, medical and choice of medical provider 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 16, 2019, is hereby affirmed and adopted.

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

20IWCC0093

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 $22,900. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 7 - 2020
o1/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0093

HERNANDEZ, MIGUEL Case# **18WC025035**
Employee/Petitioner

MONTANA METAL PRODUCTS LLC
Employer/Respondent

On 1/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% 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:

1922 STEVEN B SALK & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

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

20IWCC0093

STATE OF ILLINOIS)

)

COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Miguel Hernandez
Employee/Petitioner

Case # 18 WC 25035

v.

Consolidated cases: ____________

Montana Metal Products, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, arbitrator of the Workers' Comp. Comm'n, in the city of **Chicago** on **11/19/2018**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was the 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 the petitioner's employment by the respondent?

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

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

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

G. [ ] What were the petitioner's earnings?

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

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

J. [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 the respondent?

N. [ ] Is the respondent due any credit?

O. [x] Other **Choice of doctors**

20IWCC0093

FINDINGS

- On **5/15/2018**, the respondent **Montana Metal Products, LLC** *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- Petitioner's current condition of ill-being *is* causally related to the accident.
- In the year preceding the injury, the petitioner earned $ **33,566.52** the average weekly wage was $ **645.51**
- On the date of accident, Petitioner was **55** years of age, *single* with **0** dependent children.
- Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credits of $**0.00**.
- Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

- Respondent shall pay to the Petitioner reasonable and necessary medical services of $**16,159.91****, as provided in Section 8(a) and subject to Section 8.2 of the Act.
- Respondent shall pay Petitioner temporary total disability benefits of $**430.34**/week for **15-4/7** weeks, commencing **8/3/2018** and carrying through **11/19/2018**, in accordance with Section 8(b) of the Act.
- Respondent shall authorize and pay for the arthroscopic surgery to repair Petitioner's left knee medial meniscus, which Dr. Silver has recommended, as provided in Section 8(a) of the Act.

** less $62.50 for non-emergency transportation (taxi) to Dr. Silver's office (Pet. Ex. No. 9)

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 2.46% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Brian T. Cronin (signature) — 1-15-2019

Signature of arbitrator — Date

JAN 16 2019

Miguel Hernandez v. Montana Metal Products, LLC
18 WC 25035

FINDINGS OF FACT

Miguel Hernandez ("Petitioner") testified that he was employed by Montana Metals ("Respondent") on May 15, 2018. Petitioner testified via a Spanish-English interpreter.

Petitioner testified his job duties included spray painting. As part of his job, he would stand on a metal table while he worked because the (assembly) line is higher. Petitioner testified that at about 3:30 p.m., near the end of his shift, he slipped and fell off a metal table that was approximately two feet high while spray painting. Petitioner testified that he fell because of the dust that was landing on the table and the table was smooth. Petitioner testified he hit his knee on the floor and "went forward." Petitioner testified his clothes were torn and he felt pain in his knee and back "by (his) waist ... in the middle." The pain was located above his belt line, below the center of his back and on the left side.

Petitioner testified that a co-worker named "Isai" witnessed the incident. Petitioner testified he told his supervisor "Eugene" about the occurrence. Petitioner testified he did not seek medical treatment on the day of the slip and fall because he thought it was something "light." Petitioner testified he continued to work full duty through June 18, 2018. Petitioner further testified that he never felt pain like this to his knee or back before. Petitioner testified that he did not take any pain medication for these symptoms during that month.

Petitioner testified that on June 18, 2018, he was not feeling well. His knee, back and "body" were bothering him. So, he went to Human Resources at Respondent and told them he wanted to see a doctor. They sent to Advocate Occupational Health Center

in Elk Grove Village (Advocate) by that day. At Advocate, Petitioner gave the following "DESCRIPTION OF ACCIDENT": "I was paiting (sic) and I slipped to the ground which caused me to hit my knee. I twisted my body and landed on my left side of the body. My back, left knee and hip hurt." (Pet. Ex. No. 1, p. 5). Ramon Castillo, M.D., at Advocate examined him and ordered x-rays. Petitioner exhibited tenderness to palpation along the lumbosacral area and pain was reproducible with extreme bending. The left knee had tenderness along the inferior patellar area. X-rays were negative for fractures but did show some degenerative arthritis. Dr. Castillo prescribed Ibuprofen and instructed him to remain off work that day and to then return to work with a 20-lb. lifting restriction (Pet. Ex. No. 1, pp. 2-7) Dr. Castillo diagnosed him with (1) Strain of muscle, fascia, and tendon of lower back, initial encounter, and (2) Sprain of other specified parts of left knee, initial encounter. (Id. at 6.)

Respondent was able to accommodate the work restrictions.

Petitioner followed up with Dr. Castillo several times. Dr. Castillo prescribed physical therapy, which Petitioner did. Petitioner attended therapy at ATI Physical Therapy from July 2, 2018 through July 22, 2018. (Pet. Ex. No. 2). Petitioner testified that the physical therapy did not help.

On July 20, 2018, Dr. Castillo ordered an MRI of the left knee and of the lumbar spine. (Pet. Ex. No. 1, p. 21).

The MRI of the left knee taken at Bright Light Medical Imaging on July 29, 2018 showed an oblique tear of the posterior horn body junction of the medical meniscus with chondromalacia. The MRI of the lumbar spine showed a disc bulge at L4-5 and multilevel lumbar spondylosis (Pet. Ex. No. 3).

On August 2, 2018, Petitioner sought treatment from orthopedic surgeon Ronald L. Silver, M.D. Dr. Silver took a history from Petitioner: while working as a painter, he "tripped on a stair on May 15, 2018 and fell striking and twisting his left knee and injuring his lower back." Dr. Silver noted mild effusion, joint line tenderness and painful range of motion. Dr. Silver took Petitioner off work and ordered prescription anti-inflammatory medications, Lidocaine and Terocin patches, and Protonix for GERD symptoms. Dr. Silver also prescribed physical therapy and wanted to see the MRI films. Dr. Silver referred Petitioner to Dr. Alkhudari for treatment of Petitioner's back pain (Pet. Ex. No. 5, pp. 1-12).

Petitioner started physical therapy at Dr. Silver's clinic on August 2, 2018.

On August 7, 2018, Dr. Silver reviewed the MRI film of the left knee and diagnosed a torn medial meniscus and recommended arthroscopic surgery. Dr. Silver also stated that the need for the surgery was caused by Petitioner's May 15, 2018 work accident (Pet. Ex. No. 4, p. 13).

Dr. Silver continued to treat the Petitioner through the hearing date, continued to keep the Petitioner off work and continued to recommend arthroscopic repair of the torn medial meniscus of Petitioner's left knee (Pet. Ex. No. 4).

Petitioner also saw Azzam Alkhudari, M.D., at Northwest Chicago Medical Center for treatment of his back. (Pet. Ex. No. 5). Dr. Alkhudari first examined Petitioner on August 6, 2018. He took a history from Petitioner that his low back pain "started after a work-related injury on 05/15/2018" when he "was painting and he fell off on his left side." Dr. Alkhudari next wrote: "He hit his left head and left knee. He continued working initially on that day, then the pain start (sic) worsening after that." Petitioner's voiced current

complaints of constant, throbbing lower back pain that started on 05/15/2018 that has worsened in the last week. (Pet. Ex. No. 5, p. 2). Upon examining Petitioner, Dr. Alkhudari found a negative straight leg raising test bilaterally, but a positive Patrick's sign bilaterally, lumbar facet joint tenderness from L3 to L5-S1, mild SI joint tenderness, and decreased range of motion. (Pet. Ex. No. 5, p. 3).

Dr. Alkhudari wrote the following regarding the findings for the 07/29/2018 MRI of the lumbar spine: "Significant for multilevel lumbar spondylosis. No findings suggestive of definitive etiology of current pain symptoms. Facet joint from L3-L4, L4-L5 and L5-S1, no significant canal or foraminal stenosis." (Pet. Ex. No. 5, p. 3). Dr. Alkhudari assessed Petitioner with the following: "Acute nociceptive low back pain after work-related injury attributed mainly to lumbar facet arthropathy." (Pet. Ex. No. 5, p. 3). Dr. Alkhudari recommended diagnostic lumbar facet joint injections. He also recommended continued physical therapy, but deferred to Dr. Silver on the medications (Pet. Ex. No. 5, pp. 1-4).

Dr. Alkhudari performed bilateral lumbar facet medial branch injections at L3, L4 and L5 on August 18, 2018 (Pet. Ex. No. 5, pp. 5-8). At a follow-up appointment on August 27, 2018, Petitioner complained of only 60% pain relief for a few days before the pain worsened and he was having new radicular pain to his ankles. Dr. Alkhudari recommended a radiofrequency ablation (Pet. Ex. No. 5, pp. 9-10).

Petitioner returned to Dr. Alkhudari on October 1, 2018 with continuing complaints of throbbing axial low back pain that radiates to bilateral lower extremities down to his bilateral feet as well as complaints of intermittent paresthesia in the lower extremity. Petitioner stated that the prescribed ice machine helped a lot with the pain. Dr. Alkhudari assessed Petitioner with the following: "Acute nociceptive with neuropathic component

low back pain after work-related injury attributed to lumbar facet arthropathy, and new lumbar radiculopathy." Dr. Alkhudari again recommended the radiofrequency ablation (Pet. Ex. No. 5, pp. 11-14). Dr. Alkhudari also referred Petitioner to Anis O. Mekhail, M.D., an orthopedic surgeon at Parkview Orthopaedic Group.

Petitioner was examined by Dr. Mekhail on October 25, 2018. He gave Dr. Mekhail a history of falling over the side of a metal table when he was spray painting on May 15, 2018. Petitioner's current complaints consisted of low back pain that sometimes goes down the left leg. Dr. Mekhail did not think that Petitioner was a surgical candidate, but he did recommend that Petitioner complete a full course of physical therapy for the back, which he had not done. Dr. Mekhail thought Petitioner might be able to go back to a light-duty job for the back but kept him off work until he sees his treating physician. (Pet. Ex. No. 6, p. 1).

On October 10, 2018, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner presented himself to orthopedic surgeon Lawrence Lieber, M.D., for an examination. (Resp. Ex. No. 2). Dr. Lieber took a history: on May 15, 2018, while working for Respondent, Mr. Hernandez slipped and fell from a two-foot platform on which he was standing, which caused him to twist and injure his lower back and strike his left knee on the metal floor. Upon examining Petitioner, Dr. Lieber noted a surgical scar on Petitioner's left knee. Dr. Lieber wrote that Petitioner shows significant restricted range of motion and pain about the knee area with difficulty ambulating, which is not consistent with his underlying degenerative change. He wrote that Petitioner also shows significant stiffness and inability to ambulate without noted antalgic gait due to low back pain, which is also inconsistent with the objective abnormalities present. Dr. Lieber diagnosed Petitioner with

degenerative lumbar disc disease, chondromalacia and degenerative joint disease of the left knee. He opined that neither diagnosis had any relationship to the May 15, 2018 accident. He also opined that Petitioner was not a surgical candidate for his knee, did not need facet injections to his spine, did not need a Game Ready Ice Machine for his back, did not need any topical medications for his back or his knee and that Petitioner was at maximum medical improvement and could return to full-duty work. (Resp. Ex. No. 2).

On October 18, 2018, Dr. Silver wrote a note to CCMSI, Respondent's third-party administrator. In that note, Dr. Silver reiterates that the MRI shows an oblique tear of the posterior horn body of the medial meniscus. Dr. Silver states that Dr. Lieber mischaracterized the MRI. Dr. Silver also states that there is no evidence that the meniscal tear is degenerative as this type of tear is usually the result of trauma and not representative of degeneration. Dr. Silver did state that the MRI of the knee did show some degenerative changes that were asymptomatic prior to the accident of May 15, 2018. This represented a permanent exacerbation and acceleration of pre-existing, asymptomatic, degenerative changes in addition to his torn medial meniscus from the work injury (Pet. Ex. No. 4, p. 26).

Dr. Silver then stated that Dr. Lieber's opinions that Petitioner's problems were due to arthritis makes no sense because Petitioner would have been symptomatic before the accident (Pet. Ex. No. 4, pp. 26-27).

Dr. Silver opined Petitioner is not at MMI and needs surgery, and that his exams continue to demonstrate effusion, medial and lateral joint line tenderness, positive McMurray test and painful range of motion. Dr. Silver stated that Petitioner needs continued physical therapy and that adding topical drugs helped to reduce inflammation

and reduce oral opioid medication (Pet. Ex. No. 4, pp. 26-27).

Petitioner testified that he wants to have the surgery as recommended by Dr. Silver. He has pain and swelling in his left knee and that it is aggravated by walking and going up and down stairs. His back continues to hurt and he has to change positions frequently. The ice machine does give him some temporary relief. Petitioner has been off work since he saw Dr. Silver on August 2, 2018. No TTD has been paid and $26,184.13 in unpaid non-fee-scheduled bills were submitted into evidence. Respondent submitted proof of payment of some medical bills, but those payments are reflected in the bills submitted by the Petitioner (Pet. Ex. Nos. 7-12 and Resp. Ex. No. 1).

Proofs were closed on November 19, 2018.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all the elements of his claim (*O'Dette v. Indus. Comm'n,* 79 Ill.2d 249, 253 (1980)) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill.2d 52, 63 (1998).

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

The Arbitrator finds that an accident occurred on May 15, 2018 that arose out of and in the course of Petitioner's employment by Respondent.

Petitioner testified that co-worker Isai witnessed the accident and that Petitioner

reported it to supervisor Eugene after it occurred. Neither man was called to testify.

Although Dr. Silver's history of accident slightly differs from other histories, the weight of the evidence indicates that on May 15, 2018, while working as a painter for Respondent and standing on a metal platform, Petitioner slipped and fell from such platform to the floor and injured his left knee and low back.

Additionally, after the accident, Respondent modified each of the metal platforms by securing a rubber mat atop it presumably to make it less slippery. Such remedial measure would suggest that an accidental injury occurred, and that Respondent was aware of it.

Although Respondent pointed out that Petitioner's blood tests taken 2½ months post-accident showed that Petitioner had traces of the anti-anxiety medication Clonazepam in his system, there is no indication that the drug was in his system on May 15, 2018.

Based on the foregoing, the Arbitrator finds that on May 15, 2018, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

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

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner's current condition of ill being is causally related to the injury.

Respondent argues that since Petitioner did not seek treatment in over a month,

that his current condition of ill-being is not causally related to the alleged accident of May 15, 2018. Petitioner continued to work for Respondent during that month.

There is no evidence that Petitioner sustained a non-work-related intervening injury during that month.

There is no evidence that prior to May 15, 2018, Petitioner voiced complaints of, or sought treatment for, his left knee or low back.

In this case, the Arbitrator finds the opinions of Dr. Silver to be more persuasive than those of Dr. Lieber. Dr. Silver testified that an oblique tear is the type of tear that typically is the result of trauma, not degeneration.

With regard to Petitioner's low back condition, Dr. Lieber states: "MRI of the lumbar spine from my review shows no evidence of any acute disc herniation."

It is true that Dr. Alkhudari does not offer a formal causal connection opinion, and that Ernest Laney, M.D., the radiologist who interpreted the lumbar spine MR images, opined there are no findings to suggest a definitive etiology of Petitioner's current symptoms. Yet, on October 1, 2018, Dr. Alkhudari diagnosed Petitioner with the following: "Acute nociceptive with neuropathic component low back pain after work-related injury attributed to lumbar facet arthropathy, and new lumbar radiculopathy."

Petitioner complained to Dr. Mekhail of low back pain that sometimes goes down the left leg.

The Arbitrator finds Petitioner to be credible.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being of his left knee and low back are causally related to the accident of May 15, 2018, and that Petitioner is entitled to receive prospective medical care in the form of

arthroscopic surgery to repair the medical meniscus tear of his left knee, which Dr. Silver has recommended.

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

The Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary. The Arbitrator further finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

$26,184.13 in medical bills has not been paid. This amount is prior to the application of the Illinois Workers' Compensation fee schedule.

After applying the fee schedule, the Arbitrator awards the following bills and amounts to be paid by Respondent to Petitioner:

1.	ATI Physical Therapy (This is after giving the Respondent credit for the amounts previously paid) (Pet. Ex. No. 7)	$307.09
2.	Bright Light Medical Imaging (Pet. Ex. No. 8)	$2,538.00
3.	Orthopedic Specialists of the North Shore (Pet. Ex. No. 9)	$407.67
4.	Comprehensive Pain Care Center (Pet. Ex. No. 10)	$3,764.41
5.	Northwest Chicago Medical (Pet. Ex. No. 11)	$8,042.36
6.	Dr. Desai Virendra, M.D. (Pet. Ex. No. 12)	$1,100.38

Total amount of fee-scheduled bills **$16,159.91****

** less $62.50 for non-emergency transportation (taxi) to Dr. Silver's office (Pet. Ex. No. 9)

L. What temporary total disability benefits are in dispute?

The Arbitrator finds that Petitioner is entitled to 15-4/7 weeks of temporary total disability benefits from August 3, 2018 through the hearing date of November 19, 2018 at the rate of $430.34 per week.

The Arbitrator finds that on August 2, 2018, Dr. Silver examined Petitioner, took him off work, and has kept the Petitioner off work since that time. Therefore, Petitioner is entitled to temporary total disability benefits for the aforementioned period.

O. Choice of Doctors.

The Arbitrator finds that Petitioner is on his first choice of doctors.

The Respondent sent Petitioner to Advocate Occupational Health where he saw Dr. Castillo. Dr. Castillo ordered the physical therapy that Petitioner had at ATI Physical Therapy. Dr. Castillo also ordered the MRI that Petitioner had on July 29, 2018 at Bright Light Medical Imaging. (The Arbitrator notes that ATI Physical Therapy still has a partially unpaid bill and Bright Light Medical Imaging has a completely unpaid bill). The Arbitrator finds that Advocate Occupational Health, Dr. Castillo, ATI and Bright Light Medical Imaging are in Respondent's chain of medical providers.

The next chain of medical providers is Petitioner's first choice of doctors. The Petitioner first saw Dr. Silver on August 2, 2018. Dr. Silver then referred Petitioner to Dr. Alkhudari, who injected Petitioner at Northwest Chicago Medical, Ltd. Desai Virendra, M.D., administered the anesthesia during the August 18, 2018 injection. Dr. Alkhudari

later referred Petitioner to Dr. Mekhail who examined Petitioner on October 25, 2018. Therefore, all of those doctors are within Petitioner's first choice of doctors and their chain of referrals.

Brian T. Cronin
Arbitrator

1-15-2019
Date

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF LASALLE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vernon House,
Petitioner,

20IWCC0094

vs.

NOS: 12 WC6283; 12WC31860

Illinois Department of Transportation,
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 temporary disability, permanent disability and 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 September 20, 2016, is hereby affirmed and adopted.

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

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

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: FEB 7 - 2020
o01/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0094

HOUSE, VERNON
Employee/Petitioner

Case# **12WC006283**

12WC031860

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 9/20/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

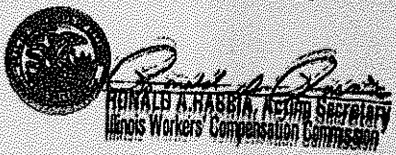
5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOULUS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

SEP 20 2016



20IWCC0094

20IWCC0094

STATE OF ILLINOIS)
)SS.
COUNTY OF **LaSalle**)

- [ ] 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

Vernon House
Employee/Petitioner

v.

Illinois Dept. of Transportation
Employer/Respondent

Case # **12** WC **6283**

Consolidated cases: **12WC31860**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa**, on **August 29, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0094

FINDINGS

On **1/20/12 and 8/5/12**, 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 these dates 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 injuries, Petitioner earned $**70,037.68**; the average weekly wage was $**1,346.88**.

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 $**142,927.48** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**142,927.48**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits at the rate of $897.92/week for 92 weeks, commencing 1/23/12 through 6/25/12 and 9/25/12 through 2/5/14, temporary partial disability at a rate of $691.67 for a further period of 19 weeks, commencing 2/6/14 through 6/19/14, and at a rate of $537.92 for a further period of 6-4/7 weeks commencing on 6/20/14 through 8/4/14as provided in Section 8(b) of the Act. Respondent to receive credit for all sum previously paid hereunder.

Respondent shall pay all outstanding reasonable and necessary medical services related to Petitioner's injuries pursuant to the medical fee schedule, including $36,254.04 to Orland Park Orthopedics/Dr. Rhode and $29,366.00 to City Center Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also reimburse Petitioner $561.00 in out-of-pocket costs for reasonable and necessary medical treatment. Respondent shall also hold petitioner harmless from any claims by any providers of the services for which Respondent received a credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent disability benefits, commencing 8/5/14, of $881.16/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, 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.

[signature]
Signature of Arbitrator

September 16, 2016
Date

SEP 20 2016

20 I W C C 0 0 9 4

[12 WC 6283, 12 WC 31860]

FINDINGS OF FACT

Petitioner, Vernon House, was employed by the Respondent, Illinois Department of Transportation, as a highway maintainer. Mr. House testified his responsibilities include mowing interstate highways, plowing snow, cleaning up and clearing roadways after accidents, performing emergency highway repair, and repairing heavy equipment, among other tasks delineated in Px. 11. While performing these duties, Mr. House is often required to lift objects weighing 100 lbs. or more. Id.

On January 20, 2012, Mr. House was tasked with plowing approximately four inches of snow and ice from the highway between the City of Mendota and the Village of Ohio, Illinois. While doing so, ice began to accumulate on the windshield of the snowplow. As a result, Mr. House pulled off the roadway and in to an empty lot. He then attempted to scrape the windshield free of ice while standing on an icy step. Mr. House explained his foot slipped off the step, causing him to fall approximately two and a half feet to the ground where he came down on his right side. He immediately felt pain over his right side, especially his shoulder. He could only raise his right arm to waist level and believed the shoulder was dislocated. Mr. House managed to get up and notify his supervisor, Bob Hubber, of the accident over the snowplow's radio.

Due to his injuries, he was unable to finish his shift and, with difficulty, drove the plow back to Respondent's yard facility in Ladd, Illinois. Mr. Hubber completed an injury report and instructed Mr. House to call the Respondent's injury hotline. Due to his injuries, Mr. House stated he was unable to work his next scheduled day, the following Monday, and sought medical attention.

The medical records indicate Mr. House was first examined by Dr. Mary Chinn at Mendota Community Hospital ("MCH") on January 23, 2012. Px.2. Mr. House reported right

shoulder pain after slipping and falling 2 ½ feet to the ground on an outstretched right arm while cleaning his snowplow windshield on January 20, 2012. Id. Dr. Chinn noted right posterior shoulder tenderness upon palpation, a burning sensation to pressure over the anterior shoulder, and a loss of push/pull strength. Id. X-rays of the right shoulder were obtained and were unremarkable except for postoperative changes from a partial resection of the lateral clavicle dating back to a prior shoulder surgery in 2010. Px. 6. An ultrasound of the abdomen was also obtained January 24, 2012, following complaints of right upper quadrant pain but were negative with the exception of an exophytic right renal cyst. Id. Dr. Chinn prescribed anti-inflammatory medication, took Petitioner off work, and ordered an MRI. Px. 2.

On January 25, 2012, Mr. House received treatment from Dr. Roger Miller at Family Chiropractic Health Center for neck and upper back pain resulting from the fall. Px. 5. Petitioner subsequently followed with Dr. Miller for four additional treatments over the next three months. Id.

The Petitioner returned to Dr. Chinn on January 26, 2012 with continued complaints of right-sided pain. Px.2. Dr. Chinn wrote Mr. House could not raise his extended right arm above 90 degrees without pain and was experiencing paresthesia in his right thumb and 2nd finger. Id. The pain was persistent, but worse with movement, and kept Mr. House awake at night. Id. Dr. Chinn continued to keep the Petitioner off work. Id.

Mr. House underwent a right shoulder MRI on January 30, 2012. Px 6. This demonstrated tendinosis of the supraspinatus and infraspinatus tendons along with a tear of the distal supraspinatus tendon near its insertion. Id. The records of February 7, 2012 note Dr. Chinn indicated Mr. House needed a rotator cuff repair surgery and also returned him to work with restrictions of no use of the right upper extremity, except for doing paperwork. Px. 2. The

Petitioner subsequently underwent an arthroscopic right rotator cuff repair and subacromial decompression surgery that was performed by Dr. Keith Minihane at MCH on February 20, 2012. Px.6. He was ordered to begin a course of physical therapy at MCH shortly thereafter and to remain off work until his follow-up with Dr. Minihane six weeks later. Px.2.

Mr. House returned for his follow-up evaluation with Dr. Minihane on April 10, 2012. Id. At that visit, Dr. Minihane noted Petitioner continued to experience occasional right shoulder aching and "pops and clicks" but had been progressing well in physical therapy. Id. Petitioner was also released for limited work, desk duty only, with restrictions of limited use of the right upper extremity and no lifting greater than 2 lbs. Id. However, Respondent had no work available within those restrictions and Petitioner remained off work.

Mr. House continued to receive physical therapy at Mendota Community Hospital ("MCH") and followed with Dr. Minihane. Px. 2 & 6. On May 22, 2012, Dr. Minihane noted continued shoulder soreness with overhead motion, trapezial and medial parascapular tightness, and parascapular muscle spasms. Px. 2. At this visit, Dr. Minihane modified Mr. House's work restrictions to limited use of the right upper extremity, no lifting greater than 10 lbs., no repetitive pushing, pulling, grasping, or twisting; no climbing, kneeling, or squatting; and no lifting at/or above head level. Id. MCH physical therapy records indicate Mr. House's symptoms remained about the same near the time Dr. Minihane released Petitioner to full duty work starting June 25, 2012. Px. 2 & 6. Mr. House testified he returned to his prior position with Respondent on that date but continued to experience limited pain in the back and front of his right shoulder. He worked without issue or incident until August 5, 2012.

On the above date, Mr. House and two co-workers were called into work by Respondent to cut and clear a tree limb that had fallen onto Route 6. While using both hands to pick up and

move cut log segments, weighing between 30-40 lbs. in an overhead fashion, Mr. House felt a sharp pain and stinging sensation in his right shoulder. Px. 2. He testified the pain was different than he felt as the result of the January 20, 2012 incident and affected a larger area of his shoulder. The Petitioner immediately reported the incident to his co-workers, as well as to Mr. Hubber when he returned to Respondent's facility the following morning. Mr. House testified to right shoulder pain and discomfort in the days that followed his injury and made performance of his regular duties intolerable. As a result, he scheduled an appointment with Dr. Minihane, but was unable to get in to see him until August 28, 2012.

On August 28, 2012, Dr. Minihane noted Mr. House's complaints of sharp pain radiating from the right shoulder to the right arm following an incident lifting logs at work on August 5, 2012. Px. 2. X-rays of the right shoulder were negative for acute findings. Id. Dr. Minihane initially diagnosed the Petitioner with a right rotator cuff strain and possible biceps strain and ordered physical therapy. Id. Dr. Minihane also provided Mr. House with work restrictions of limited use of the right upper extremity, no lifting greater than 25 lbs., and no lifting at/or above head level. Id. The Respondent did not have work available within these restrictions and Mr. House remained off work while he underwent physical therapy at MCH and following up with Dr. Minihane. Px. 2; 6.

After several weeks with no improvement in his symptomology, Petitioner, on the order of Dr. Minihane, returned to MCH for an MRI arthrogram of his right shoulder on September 28, 2012. Px. 4. The arthrogram revealed a long intra-substance, longitudinally oriented tear of the supraspinatus tendon involving most of the anterior to posterior portion of the supra spinatus. Id. Partial thickness tears of the distal mid suprasinatus tendon and superior labrum were also noted. Id. On October 9, 2012, Dr. Minihane, after reviewing the test results, recommended surgery

and continued work restrictions while awaiting approval from the workers' compensation carrier. Px.2.

On October 24, 2012, Mr. House underwent right shoulder arthroscopy where superior labral tear, rotator cuff debridement with subacrominal decompression, and biceps tenotomy was performed by Dr. Minihane at MCH. Px. 4. Petitioner was subsequently ordered off work while he completed a course of physical therapy at City Center Rehabilitation. Px. 7.

On January 7, 2013, Mr. House was evaluated by Dr. Blair Rhode at Orland Park Orthopedics. Px. 4. He explains he sought a second opinion because of poor relief from the surgery. At that visit, Mr. House reported continued significant lateral arm pain with weakness to forward and overhead reach. Id. Dr. Rhode reviewed Petitioner's medical history, noting Petitioner returned to full unrestricted work following a right shoulder distal clavicle resection in 2009 until suffering a work-related right shoulder injury in January of 2012. Id. He underwent surgical repair of that injury on February 20, 2012 and, again, returned to full and unrestricted duty until the work-related injury of August 5, 2012. Id. Dr. Rhode wrote Mr. House last underwent a SLAP tear repair with biceps tenotomy for this recent injury, but no formal repair of the rotator cuff was performed. Id. After a physical examination and ultrasound, Dr. Rhode suspected the Petitioner's supraspinatus repair failed and ordered an MRI. Id. However, the MRI revealed no gross evidence of re-tear to the labrum or rotator cuff, as a consequence Mr. House was provided a steroid injection on January 16, 2013. Id.

Mr. House reported only 3 days relief from the injection when he returned to Dr. Rhode on February 1, 2013. Id. After personally reviewing the MRI, Dr. Rhode wrote: "I believe that Vernon has a high grade injury to his supraspinatus due to his work injury. He is unwilling to live with his current symptoms and wishes to proceed with an arthroscopic rotator cuff repair."

Id. Mr. House next underwent an arthroscopic subacrominal decompression and rotator cuff repair that was performed by Dr. Rhode on February 26, 2013. Id.

Mr. House remained off work, entered into physical therapy, and continued treatment with Dr. Rhode post-surgery. Id. On July 11, 2013, Dr. Rhode authorized Mr. House to return to light-duty work (max. 20 lbs. or less left/carry; frequent at 10 lbs.) with maximum lifting above the shoulder of 10 lbs. and no frequent lifting above the shoulder of more than 5 lbs. Id. However, no work was made available by the Respondent. At his August 8, 2013 visit, Dr. Rhode noted Mr. House continues to experience significant pain and swelling after activity six months status post rotator cuff repair and opined his progress had plateaued and recommended a functional capacity evaluation ("FCE"). Id. In the interim, Dr. Rhode modified Petitioner's work restrictions to medium work (max. 50 lbs. or less lift/carry; frequent at 25 lbs.). Id. Mr. House remained off work due to unavailability of work. Id.

Petitioner underwent the recommended FCE on September 27, 2013. Id. The FCE report indicates Petitioner fully cooperated with all aspects of the exam. Id. The FCE identified limitations of decreased right upper extremity strength and active range of motion into forward elevation and abduction at or above shoulder height, and decreased upper extremity strength with lifts. Id. The FCE recommended light duty for overhead and exclusive right upper extremity use, and medium duty for all other activities. Id.

At Petitioner's follow-up visit of October 7, 2013, Dr. Rhode declared him at maximum medical improvement and provided permanent work restrictions of medium duty (max. 50 lbs. or less lift/carry; frequent at 25 lbs.), with modified above shoulder lift restrictions of 20 lbs. maximum, 10 lbs. frequent. Id. He further wrote Mr. House may require future oral medications for treatment of his shoulder symptoms. Id.

Mr. House testified the Respondent called him shortly after the FCE and informed him that, based on the FCE results, he could no longer work for Respondent. Thereafter, Petitioner began vocational rehabilitation as well as looking for work within his restrictions on his own and was able to obtain employment in February of 2014 working approximately 20-25 hours per week as a service agent for Enterprise Rent a Car, earning $8.75/hr. Px.8. His job duties included washing, cleaning, vacuuming, and otherwise preparing cars for rental. He admitted difficulty performing these tasks, explaining his shoulder pain and swelling would get progressively worse throughout the day to the point of being intolerable.

Petitioner continued to follow with Dr. Rhode for ongoing right shoulder pain and weakness. Id. On February 20, 2014, Dr. Rhode modified Petitioner's permanent restrictions to modified-medium with above shoulder lift restrictions of 10 lbs. maximum, 5 lbs. frequent. Id. After Mr. House's pain symptoms did not improve, Dr. Rhode referred Petitioner to Rockford Pain Center. Id.

There, he was evaluated by Dr. Freeman for pain on April 4, 2014. Px. 3. Dr. Freeman noted Mr. House has right shoulder pain both anteriorly and posteriorly with radiation into the trapezius musculature and proximal right upper arm. Id. He describes the pain as aching and occasional burning-type pain and rates the pain between 4/10 and 9/10. Id. The pain tends to worsen as the day progresses and causes him difficulty sleeping. Id. His current pain medications include, among others, Meloxicam during the day and Norco at night, which provide some relief. Id.

Upon physical examination, Dr. Freeman noted pain at the apex of the Neer's exam, a positive Hawkin's Kennedy test and anterior shoulder pain with Scarf test. Id. Dr. Freeman diagnosed Petitioner with chronic persistent right shoulder pain status post-surgery. Id. Dr.

Freeman modified Mr. House's pain medications and recommended future consideration of either a subacromial bursa or acromioclavicular joint injection. Id. The Petitioner returned to Rockford Pain Center several times over the next 1 ½ years for management of his medications. Id.

Mr. House returned to Dr. Rhode on May 23, 2014, with continued complaints of right shoulder pain and tingling to the right ring and little finger and was provided a steroid injection. Px. 4. In June of that year, Petitioner testified, he began working full time for Enterprise, and he stated that this led to an increase in symptoms in his left shoulder. He reported this when he returned to Dr. Rhode on August 4, 2014 and Dr. Rhode modified his work restrictions to add a limit of 25 work hours per week. Id. Showing no improvement on October 2, 2014, Dr. Rhode further limited Mr. House to a maximum 8 hour work day. Id. Vernon House continued care with Dr. Rhode and Dr. Freeman before presenting to Dr. Gregory Primus for an Independent Medical Evaluation ("IME") at Respondent's request on April 8, 2015. Px. 3; 4; Rx. 2.

Dr. Primus reviewed Mr. House's medical history and noted a work-related right shoulder injury on 1/20/12; right rotator cuff repair on 2/20/12, work-related right shoulder re-injury on 8/5/12; SLAP repair with biceps tenotomy on 10/24/12; and subacrominal decompression with a rotator cuff repair revision on 2/26/13. Rx. 2. He explained that following a FCE on 9/20/13, Petitioner was provided permanent modified medium work restrictions of 50 lb. max, frequent 25 lb. lift, which was modified by Dr. Rhode to 10 lb. max, 5 lb. frequent with the right upper extremity. Id. He began working 20-25 hours a week at Enterprise, but began to experience re-occurring shoulder pain and swelling over the course of his 11-12 hour shift. Id. Accordingly, Dr. Rhode limited Mr. House to a maximum 8 hour workday and a 25 hour work

week. Id. On the date of the IME, Mr. House reported ongoing pain and weakness with overhead activities, increased with prolonged activity. Id.

Upon physical examination, Dr. Primus noted pain on palpation of the right AC joint, coracoid tip, and long head biceps. Id. Mr. House's right arm also demonstrated a positive Hawkin's, cross arm, and Speed's maneuver. Id. Dr. Primus also reviewed Petitioner's medical records and imaging, though noted he did not have the repeat MRI scan taken before the second surgery or the operative photographs. Id. The exam further revealed slow forward elevation and abduction associated with pain. Id. Dr. Primus diagnosed Mr. House with residual right shoulder pain, and specifically AC joint pain and anterior shoulder pain, status post three shoulder surgeries addressing a torn rotator cuff, the AC joint and SLAP lesion with biceps tenotomy. Id. In his opinion, the medical treatment Mr. House received appeared to be reasonable and necessary for the work-related injuries he sustained. Id. Dr. Primus opined that Mr. House was at MMI and no additional treatment was required at that time. Id. Dr. Primus agreed with Mr. House's permanent lifting restrictions, noting he should not lift more than 20 lbs. overhead, but did not believe the 25-hours per week limitation was reasonable. Id. Dr. Primus also agreed Mr. House "should avoid working 10 to 12 hour shifts that require a lot of use of his shoulder, as these prolonged hours may contribute to fatigue and lead to increased risk of injury." Id. Finally, using the AMA Guidelines, he claimed Mr. House has an upper extremity impairment rating of 4% and a whole person impairment rating of 2%. Id.

On May 16, 2015, Mr. House underwent an IME permed by Dr. Robert Eilers. Px. 13. Dr. Eilers summarized Mr. House's course of treatment and noted he has been off work following an aggravation of shoulder pain when he attempted to return to full-time work with Enterprise. Id. Prolonged driving, lifting, repetitive movement, and any overhead reaching or

lifting increases his right shoulder pain. Id. He gets relief with rest, ice, and pain medications. Id. His shoulder limitations prevent him putting a belt on, lifting objects overhead, or other tasks like yardwork or cleaning that requires pushing, pulling or lifting overhead. It also causes him difficulty performing other activities of daily living such as reaching to his back pocket for his wallet or wiping after using the restroom. Id.

Following a physical examination, Dr. Eilers attributed all of Mr. House's medical treatment to the work injuries on 1/20/12 and 8/5/12, indicating the Petitioner has chronic pain in the right shoulder as a result of his injury, as well as limitation with forward flexion/abduction and limitation in his internal rotation limiting his activities of daily living. Functional capacity evaluation shows limits to 5 or 10 pounds occasional lifting with his right upper extremity from this injury. He continued and reported his work-related injuries had resulted in a loss of function of his right upper extremity, which is his dominant extremity for work activities. Id.

Dr. Eilers opined Mr. House's time off work had been reasonable and appropriate, noting Petitioner had not embellished his symptoms, is motivated to be employed and had made every effort to return to work. Id. Dr. Eilers also wrote the medical treatment Mr. House received for his shoulder and the cost of that treatment had been reasonable, appropriate, and necessary to manage his condition of ill-being. Id. Dr. Eilers indicated Mr. House is only capable of returning to sedentary work. Id. He reports the Petitioner will not be able to ever return to his work in the highway department. Id. He was not going to be able to climb into rigs, operate a truck, or drive a heavy rig. He would probably have difficulty with maintaining his CDL license due to his limitations. Id. He might be able to continue doing some tasks at Enterprise if they are light and sedentary. Id. However, as he works more hours, he has more dysfunction with his right upper extremity. Id. He does need to continue with pain medication. Id.

Dr. Eilers stated the Petitioner has deficits that are permanent. Id. His shoulder dysfunction is likely progressive as a result of these injuries and will develop further degenerative pain as he uses these extremities. Id.

Petitioner continues to follow-up with Dr. Rhode for treatment of his right shoulder. Px.4. Most recently on August 5, 2016, Dr. Rhode noted Mr. House continues to be symptomatic and require permanent restrictions. Id. He had been working within his restrictions but reported worsening symptomology. Id. Dr. Rhode also noted Mr. House's pain medications were being denied by workers' compensation insurer reportedly because his pain was not due to his injury. Id.

Following an examination of Mr. House and a thorough review his medical records, Dr. Rhode completed a Nature and Extent of Disability Report. Px. 4; 17. This report evaluated Petitioner's final impairment ratings, based upon the AMA Guidelines, at 6% for his right upper extremity and 4% impairment for his person as a whole. Id.

According to Mr. House's trial testimony and the vocational rehabilitation interview report completed by Steven Blumenthal, a certified rehabilitation counselor, on March 9, 2015, Petitioner was a "C" student in high school and placed in remedial reading classed due to having a tested reading level of 3rd or 4th grade. Px. 10. During the last two years of High School, he enrolled in and took classes at occupational center where he learned welding before graduating in 1976. Id. Thereafter, Mr. House attended El Camino Community College for two weeks before dropping out due to difficulty understanding the school material and enrolled in the U.S. Army. Id. Over 20 years ago, Mr. House attended two semesters at Illinois Valley Community College,

where he took a remedial grammar class, an English literature class, and states that he attempted to take an Algebra class but became so upset with the class he 'ripped the book up'. Id.

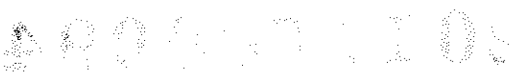
Petitioner served in the maintenance battalion of the U.S. Army maintaining track and wheeled vehicles from 9/27/76 to 9/27/79. Id. From 1979 to 1989, Mr. House performed landscaping and parking lot maintenance for commercial buildings as owner operator of a landscaping company in California. Id. After that, he worked as a farmhand and truck driver hauling produce for Gleim Farms in Mendota, IL from 1989 until 2003. Id. Also during that time, he cleaned bank offices part time as part of a janitorial co-op from 1991 to 2001. Id. From 2000 to 2003, Mr. House was employed by Wal-Mart Distribution as a truck spotter. Id. From 2003 to 2007, he earned approximately $18/hour working in loss prevention at Walmart, checking trucks and patrolling the warehouse. Id. Mr. House became employed as a highway maintainer/crew leader with Respondent in 2007 and joined Teamsters Local #722. Id. He was earning $31/hourr at the time of injury, operating and maintaining heavy equipment, setting out barricades and barrels, mowing, plowing, and removing trees. Id. Performing these duties often required Petitioner to lift in excess of 100 lbs., but most lifting was between 50-100 lbs. Id.

After Mr. House's injuries prevented him from returning to work with Respondent, CMS assigned Gary Willhelm, CRC, to assist him in finding work within his restrictions. Px.10; 8.Petitioner worked with Mr. Wilhelm through August of 2014. In February of 2014, Petitioner obtained part-time employment as a service agent/driver at Enterprise Rent a Car through his own unassisted efforts. Px. 10. Petitioner's starting pay for this position was $8.25/hour, but was increased to $9.00/hour on 1/1/15. Px. 9-10 & 16. At that time, this was the highest paying job available identified by Mr. Wilhelm. Px. 10. His job duties include cleaning vehicles, filling washer fluid, cleaning windows, checking tire pressure, using a pressure washer and scrub brush

to wash vehicles, and picking up and dropping off customers an average of one or two times a day. Id. In June he was offered, and accepted, full time work at this position. He testified that working full time aggravated the symptoms of pain and swelling in his left shoulder. After this attempt to work full-time at Enterprise, he returned to see Dr. Rhode, at which time Dr. Rhode ordered him to return to part-time 25 hours per week maximum. Px. 10; 4. He currently works two 8-10 hour shifts during the week and 4 hours on three Saturdays a month, averaging 15-25 hours of work per week. Px. 10; 16.

Mr. Blumenthal completed a Transferable Skills and Aptitude analysis and concluded "Mr. House is capable of performing work as a security guard (given completion of a background check, completion of a 20 hour unarmed security guard class, and acquisition of a State of Illinois PERC card at a projected cost of $250.00) or as a retail salesperson. Px. 10. However, "Mr. House would need to be accommodated to a 25 hour part time work schedule". Id. The entry level to median wage range for these positions is $8.75 to $12.64 an hour. Id. Accordingly, Mr. Bluenthal opined "Mr. House's current employment and earnings is representative of his current earning capacity in a stable labor market." Id. In comparison, Mr. House's labor union agreement shows he would be earning $6,187/month, $74,244/year, or $38/hour, at his previous position with the Respondent effective 7/1/14. Px. 10; 11.

Through the date of hearing on August 29, 2016, Mr. House incurred gross medical bills of $228,052.03 (MCH: $68,291.57; Physician Services of MCH/Chinn, Minihane: $30,570.00; Hospital Radiology: $1,552.00; Orland Park Orthopedics/Dr. Rhode: $57,279.42; South Chicago Surgical Solutions/ Dr. Rhode: $26,500.21; Bob Rady: $4,620.00; Pulmonary & Critical Care Consultants/ Dr. Ambrose: $1,247.83; Center for Primary Healthcare/Dr. Ambrose: $391.00; City Center Physical Therapy: $36,948.00; Rockford Pain Center/Dr. Freeman: $652.00). Px. 1.



Of this amount, Respondent paid $101,659.08, Petitioner's personal insurance paid $10,862.18, insurance discounts were received in the amount of $49,349.73, Petitioner paid $561.00 out-of-pocket, and $65,620.04 remains outstanding (Orland Park Orthopedics/Dr. Rhode: $36,254.04; City Center Physical Therapy: $29,366.00). Id.

ISSUES & CONCLUSIONS OF LAW

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

The Arbitrator incorporates by reference the above Findings of Fact herein.

It is undisputed that Mr. House sustained two work-related injuries to his right shoulder, one on January 20, 2012 and another on August 5, 2012. After each of these injuries, the medical records show Mr. House was consistent in his complaints and his treaters were consistent in their diagnoses and treatment. Although it appears Mr. House did have a prior right shoulder surgery in 2009/2010, it is clear those problems had resolved and he was able to work for Respondent unrestricted for approximately two years before suffering his first work-related injury on January 20, 2012. Further, Mr. House's treating physicians, as well as both IME doctors, attributed Petitioner's current condition of ill-being to his work-related injuries. Following consideration of the undisputed testimony and evidence presented, this Arbitrator finds Petitioner's current condition of ill-being causally related to the work injuries he sustained on January 20, 2012 and August 25, 2012.

J. Were 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 by reference the above Findings of Fact and Conclusions herein. The medical records presented demonstrate Mr. House sustained serious work-related

right shoulder injuries requiring multiple surgeries and several years of medical treatment. The Petitioner submitted treatment records supporting the severity of the injuries and the reasonableness and necessity of the medical care and services provided. Px 3-8 & 10-11. Respondent has offered no evidence to refute the severity of these injuries or the reasonableness or necessity of the medical services provided. Both IME physicians, Dr. Eilers and Dr. Primus, opined Petitioner's medical treatment was reasonable and necessary and causally related to the work injuries as alleged herein. Px. 13 & Rx. 2. Accordingly, following consideration of the evidence and testimony presented, this Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary.

This Arbitrator further finds Respondent has not paid all appropriate charges for reasonable and necessary medical services. As reflected in Petitioner's Exhibit 1, there are gross medical bills of $228,052.03. Px. 1. Of this amount, Respondent paid $101,659.08, Petitioner's personal insurance paid $10,862.18, insurance discounts were received in the amount of $49,349.73, Petitioner paid $561.00 out-of-pocket, and $65,620.04 remains outstanding (Orland Park Orthopedics/Dr. Rhode: $36,254.04; City Center Physical Therapy: $29,366.00). Id. Respondent shall reimburse Petitioner for his out-of-pocket expenses, pay all outstanding medical expenses as set forth above to the extent of the Medical Fee Schedule, and hold Petitioner harmless from any repayment obligations of group insurance for bills paid relative to this matter.

K. What temporary benefits are in dispute? (TTD)

Petitioner and Respondent agree Petitioner's average weekly wage, calculated pursuant to Section 10 of the Act, was $1,346.88. Arb. 1. Accordingly, Petitioner's TTD rate is $897.92/week. Petitioner claims to be entitled to 227 weeks of TTD from 1/23/12 to 6/25/12 (22

weeks) and 9/25/12 to 8/29/16 (205 weeks). Id. Thus, the total TTD claimed by Petitioner is $203,827.84. Respondent claims it paid $119,391.04 in TTD and no TTD is owed. Arb. 1; Rx. 6. Respondent further claims it paid Petitioner $23,586.91 in maintenance and $10,310.89 in other benefits. Id. The total credit claimed by Respondent is $153,288.84.

According the records submitted by Respondent, it paid 20 5/7 weeks of TTD following the 1/20/12 work injury from 1/31/12 through 6/24/12. Rx. 6. The total TTD paid during this period was $17,519.52, or approximately $845.77/week. Id. This Arbitrator finds Respondent should have paid Petitioner TTD for the entire 22 week period claimed at the proper rate of $897.92/week, or $19,754.24. This Arbitrator finds Respondent owes Petitioner $2,234.72 for this initial injury period.

Following the second work injury on 8/5/12, Respondent's records also show it paid Petitioner total TTD in the amount of $101,871.52 for the periods of 9/7/12 to 1/31/14 (73 weeks) and 1/11/15 to 9/30/16 (89 5/7 weeks). Id. This Arbitrator notes that Respondents payment schedule extends past the 8/29/16 hearing date, and the last TTD entry associated with a check date and number was for the pay period of 4/16/16-4/30/16. Id. Respondent's records also show it paid Petitioner $23,586.91 in maintenance benefits for the period from 2/1/14 to 9/30/14 (34 3/7 weeks), and $10,310.89 in "wage loss temporary" benefits from 10/1/14 through 1/10/15 (14 3/7 weeks). Id. Therefore, Respondent claims to have paid Petitioner a total of $135,769.32 in benefits. However, Respondent shall only receive a credit for benefits actually paid. Because it does not appear Respondent actually paid Petitioner the $10,361.36 in TTD benefits from 5/1/16 to 9/30/16, the amount of Respondent's total credit following the 8/5/12 injury is reduced to $125,407.96. This Arbitrator finds Respondent should have paid Petitioner TTD benefits for the period claimed by Petitioner, from 9/25/12 to 2/5/14, the date he began employment at

Enterprise, at the proper rate of $897.92/week. The Arbitrator notes that Petitioner was involved in vocational rehabilitation for a portion of this period as well as conducting a self directed job search, but also noting that although Dr. Rhode found him to be at MMI on 10/7/13, he continued to be symptomatic, continued to treat for his shoulder, and that his condition continued to change, as reflected in the varying restrictions he was given over the next year and three quarters, and finds that Petitioner's condition had not yet stabilized, and that he was not in fact at MMI, and awards this period as TTD rather than maintenance. The Arbitrator notes that Petitioner worked 25 hours per week at $8.25 per hour from February 5, 2014 through June 19, 2014, for a weekly wage of $206.25, and is entitled to TPD for this period in the amount of $691.67 per week. On June 20, 2014, Petitioner began working full time 40 hours per week for Enterprise at $9.00 per hour, resulting in a weekly wage of $360.00 per week, through August 4, 2014, when he was placed on a 25 hour per week restriction by his treating physician Dr. Rhode, who at that point found him to be at MMI and imposed permanent light duty restrictions. He is therefore entitled to TPD in the amount of $537.92 for that period of time. At that point, Petitioner having been found to be at MMI by his treating physician and his condition apparently stabilized and his restrictions remaining the same to the present time, the Arbitrator finds that he was in fact at MMI as of that date, and TTD should be and is terminated as of that date. Respondent shall pay the above TTD amounts to Petitioner and shall be entitled to a credit for all sums previously paid hereunder.

What is the nature and extent of the injury?

O. Wage Differential.

The Arbitrator incorporates by reference the above Findings of Fact and Conclusions herein. Petitioner sustained a serious work-related right shoulder injury on 1/20/12, underwent a

rotator cuff repair on 2/20/12, sustained a work-related right shoulder re-injury on 8/5/12, underwent a SLAP repair with biceps tenotomy on 10/24/12, and underwent a subacrominal decompression and rotator cuff repair revision on 2/26/13. Rx. 2. Mr. House testified that his right shoulder never returned to its pre-injury condition and continues to cause him significant pain and weakness. An FCE performed on 9/27/13 identified limitations of decreased right upper extremity strength and active range of motion into forward elevation and abduction at or above shoulder height, and decreased upper extremity strength with lifts. Px. 4. This FCE recommended light duty for overhead and exclusive right upper extremity use, and medium duty for all other activities. Id. On 10/7/13, Dr. Rhode declared Mr. House at maximum medical improvement and provided permanent work restrictions of medium duty (max. 50 lbs or less lift/carry; frequent at 25 lbs), with modified above shoulder lift restrictions of 20 lbs. maximum, 10 lbs. frequent. Id. On 2/20/14, after Mr. House experienced aggravation of his shoulder symptoms while performing his part-time job duties, Dr. Rhode further limited Petitioner's permanent above shoulder lift restrictions to 10 lbs. maximum, 5 lbs. frequent. Id. After Mr. House's problems continued, Dr. Rhode further limited Petitioner to a 25 hour work week on 8/5/14, an 8 hour work day on 10/2/14, and 2 hours per day of washing vehicles on 7/30/15. Id. These permanent restrictions remain in place as of the date of hearing.

Respondent's IME physician, Dr. Primus, agreed with all of Petitioner's permanent work restrictions but for the 25-hours per week limitation. Rx. 2. In his 5/16/15 IME report, Dr. Eilers also agreed with Petitioner's permanent restrictions, writing and indicated Mr. House continues to have chronic pain in the right shoulder as a result of his injury, as well as limitation in forward flexion/abduction and limitation in his internal rotation. His FCE shows limits of 5 or 10 pounds occasional lifting with his right upper extremity. Px. 13.

Dr. Eilers further reports Mr. House is limited to sedentary work and his shoulder deficits will likely deteriorate with time and use. Id. Unfortunately, these deficits will be permanent. Id. His shoulder dysfunction is likely to be progressive in nature as a result of these injuries and as he develops further degenerative pain as he uses these extremities. Id.

The Arbitrator incorporates by reference the above Findings of Fact and Conclusions herein. Section 8(d)1 of the Workers' Compensation Act deals with the employee who sustains an accidental injury and as a result becomes partially incapacitated from pursuing his or her usual and customary line of employment. It provides:

> 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. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

820 ILCS 305/8(d)1. In the instant matter, Mr. House's physician has provided him with permanent work restrictions of medium duty (max. 50 lbs or less lift/carry; frequent at 25 lbs), with modified above shoulder lift restrictions of 10 lbs. maximum, 5 lbs. frequent; 25 hour maximum work week, 8 hour maximum work day, and no more than 2 hours of washing vehicles per day. Px. 4. Respondent's IME physician, Dr. Primus, agreed with all of these permanent work restrictions but the 25-hours per week limitation. Rx. 2. Dr. Eilers also agreed these permanent restrictions were appropriate. Px. 13.

With respect to Mr. House's cognitive abilities, the undisputed testimony and evidence presented demonstrates he was a "C" student in high school, was placed in a remedial grammar class, and took two years of classes at the occupational center but earned his diploma. Px. 10. His attempts at obtaining further education were unsuccessful. Id. Instead, Mr. House began a career of physically-demanding labor jobs, starting as a mechanic in the U.S. Army, a landscaper, farm hand, janitor, and truck driver before becoming employed as a highway maintainer/crew leader for Respondent. Id.

It is undisputed that Mr. House's right shoulder deficits and resulting work restrictions are permanent in nature. and Respondent informed Petitioner he could not return to his position. Moreover, Dr. Eilers stated Mr. House will not be able to ever return to his work in the highway department. He felt that Petitioner was not going to be able to climb into rigs, operate a truck, or drive a heavy rig. He would probably have difficulty with maintaining his CDL license in light of his limitations and the need for physical ability in operating and managing a truck. Px 13. Accordingly, following consideration of the evidence and testimony presented, this Arbitrator finds Mr. House is incapacitated from pursuing his usual and customary line of employment due to his work related injuries of 1/20/12 and 8/5/12, and as stated above, he reached MMI as of 8/4/14.

Pursuant to Section 8(d)1, the amount of a wage differential award is "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. Therefore, calculating the wage differential involves a determination of the petitioner's earnings in the full performance of the occupation at

the time of accident but calculated based on the rate he would have earned at the time of hearing as compared to earnings or what he was able to earn upon return to work following the injury.

If Mr. House were still in full performance of his employment with Respondent, he would be earning $6,187/month, or $38/hr., according to the labor union agreement submitted by Petitioner. Px. 11. However, due to his right shoulder deficits and associated work restrictions, Mr. House is only capable of working 25 hours a week, and he earns $9.00/hour at his position with Enterprise Car Rental. Moreover, the unrebutted opinions of certified vocational rehabilitation counselor Steven Blumenthal establishes that "Mr. House's current employment and earnings is representative of his current earning capacity in a stable labor market". Px.10. Further, it is noted that Respondent terminated all vocational rehabilitation as soon as Petitioner began working full duty at Enterprise, indicating that this was in fact suitable employment for Petitioner. As a result, Mr. House the Arbitrator finds that Petitioner iscurrently capable of earning $225.00/week as opposed to the $1,546.76/week he would now be making in full performance of his duties with Respondent, a difference of $1,321.75. Taking two-thirds of that difference results in a wage differential of $881.16/week. The Arbitrator finds that this wage differential shall have begun on August 5, 2014.

Accordingly, following consideration of the evidence and testimony presented, this Arbitrator awards Petitioner wage differential benefits in the amount of $881.16/week from August 5, 2014 until Petitioner turns age 67, pursuant to Section 8(d)1 of the Act.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator incorporates by reference the above Findings of Fact and Conclusions herein. Petitioner filed a petition for penalties pursuant to Section 19(k), 19(l) and Section 16. Based on the record as a whole, the Arbitrator finds that the Respondent did not act unreasonably

or vexatiously in this matter in such a way as to warrant the imposition of penalties herein, and therefore denies Petitioner's Petition for Penalties and Attorney 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

KATHLEEN MELSER,

Petitioner,

vs. NO: 14 WC 6589

AMERICAN AIRLINES,

Respondent.

20IWCC0095

DECISION AND OPINION ON REVIEW

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

The arbitration decision delineates the facts of the case in detail and specifically addressed Petitioner's credibility. As relevant to the issues on appeal, the Commission notes that the Arbitrator weighed the facts in evidence to assess Petitioner's credibility including over 37 years of work for Respondent and a detailed description of her duties, which would typically weigh in her favor. However, the Arbitrator also found evidence weighing against a finding that Petitioner was credible overall; specifically, Petitioner's notice-related testimony and the lack of medical records from Dr. DangVu prior to the alleged accident. With regard to notice, the Arbitrator noted Petitioner's testimony that she informed Ms. McGavin of the injury the day after it occurred, but if her accident had occurred as claimed, then "why did she call Dr. DangVu's office on January 13, 2014 to inquire as to whether her back pain 'could be work-related?'"

Further, Petitioner initially sought medical treatment a few days after the alleged accident on January 8, 2014 with Dr. DangVu. The treatment record notes Petitioner's ongoing low back

pain since October of 2013. While Petitioner acknowledged treating with Dr. DangVu in the fall of 2013 for an ear infection, she denied the presence of low back symptomatology at that time characterizing Dr. DangVu's notation of back pain as a misunderstanding due to "being flippant" with the doctor. Petitioner's treatment records prior to January 8, 2014 were not submitted into evidence.

In her credibility assessment, the Arbitrator noted Petitioner's election to exclude these prior medical records, stating that their presence would have offered context to her testimony. The Arbitrator then applied the presumption that the records would be adverse to Petitioner's case citing *REO Movers, Inc. v. Industrial Commission* stating, "where a party fails to produce evidence in his control, the presumption arises that the evidence would be adverse to that party." 226 Ill.App.3d 216, 223 (1992). The appellate court in *REO Movers* went on to note its decision in *Singh v. Air Illinois*, addressing Illinois Pattern Jury Instructions, Civ. 2d No. 5.01 (IPI No. 5.01) holding "that a jury should not be instructed on such a presumption where the evidence showed that there was a reasonable excuse for the failure to produce the evidence and that the evidence was equally available to the other side." *Singh v. Air Illinois, Inc.*, 165 Ill. App. 3d 923 (1988). IPI No. 5.01 provides that if a party has failed to offer evidence within his power to produce, it may be inferred that the evidence would be adverse to that party if : 1) the evidence was under the control of the party and could have been produced by the existence of reasonable diligence; 2) the evidence was not equally available to an adverse party; 3) a reasonably prudent person under the same or similar circumstances would have offered the evidence if he believed it to be favorable to him; and 4) no reasonable excuse for the failure has been shown.

The Commission finds that the Arbitrator's credibility assessment was correct, and it was unnecessary to make an adverse inference against Petitioner with regard to the lack of Dr. DangVu's pre-accident medical records. The prior records were equally available to both Petitioner and Respondent and, thus, the second element required to make an adverse inference under either *REO Movers* or IPI No. 5.01 was not satisfied. Regardless, the Arbitrator correctly questioned Petitioner's credibility based on the medical records in evidence and Petitioner's testimony that she provided notice to Ms. McGavin. If Petitioner's accident had occurred as claimed—as the result of work on a particular flight in which she struggled with a 300-pound cart which she recalled twisted before she was able to get it right—it is curious that Dr. DangVu's record of January 8, 2014 would reflect an onset of pain "[f]or the last several months since October 2013" as well as a January 13, 2014 phone call from Petitioner inquiring whether her back pain could be work-related.

Based on the foregoing, the Commission finds that the weight of the evidence supports the Arbitrator's conclusion that Petitioner's testimony was not credible without the need to make an adverse inference.

All else is affirmed.

IT IS THEREFORE FOUND BY THE COMMISSION that the weight of the evidence supports the Arbitrator's conclusion that Petitioner's testimony was not credible, and that Petitioner failed to establish that she sustained a compensable accident as claimed.

20 IWCC0095

IT IS THEREFORE 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: FEB 7 - 2020
O: 12/19/19
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

MEISER, KATHLEEN
Employee/Petitioner

Case# **14WC006589**

AMERICAN AIRLINES INC
Employer/Respondent

20IWCC0095

On 6/28/2017, 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 1.11% 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
EILEEN LIAO
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER STORM
DEREK A STORM
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KATHLEEN MELSER,
Employee/Petitioner
v.
AMERICAN AIRLINES, INC.,
Employer/Respondent

Case # **14** WC **6589**

20 IWCC0095

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **January 3, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment. For the reasons set forth in the attached decision, the Arbitrator finds it unnecessary to address the remaining disputed issues.

Timely notice of the claimed accident ***was*** given to Respondent. Arb Exh 1.

In the year preceding the injury, Petitioner earned $**53,820.00**; the average weekly wage was $**1,035.00**.

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

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

At the hearing, the parties stipulated that Respondent is entitled to Section 8(j) credit for medical expenses and sick pay.

ORDER

FOR THE REASONS SET FORTH IN THE ATTACHED DECISION, THE ARBITRATOR FINDS PETITIONER FAILED TO ESTABLISH A COMPENSABLE WORK ACCIDENT OF JANUARY 3, 2014. THE ARBITRATOR FINDS IT UNNECESSARY TO ADDRESS THE REMAINING DISPUTED ISSUES. COMPENSATION IS DENIED.

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

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

Molly C. Mason

Signature of Arbitrator Molly Mason

6/28/17
Date

JUN 28 2017

Kathleen Melser v. American Airlines
14 WC 6589

Summary of Disputed Issues **20 IWCC0095**

Petitioner, an international flight attendant, claims she injured her back aboard a flight on January 3, 2014, when she was trying to maneuver a cart during a period of turbulence. At issue are accident, notice, causal connection, medical expenses, temporary total disability and nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she has worked for Respondent since February 1, 1980. Before the accident, she was classified as an international flight purser. She testified that a purser has supervisory authority and is a liaison with the pilot. In general, her job involved providing customer service and rendering medical treatment as necessary. As a purser, she took orders from customers and delivered meals to them by hand, restaurant-style. When she worked the main cabin, however, she pushed carts. She testified that a first class cart could weigh 300 pounds since was stocked with heavier items such as bottles of champagne. Certain factors, including turbulence, can make it more difficult to push the carts.

Petitioner testified her lower back felt fine when she began her workday on January 3, 2014. She denied seeking low back care prior to that date.

Petitioner testified she was working aboard a 14-hour flight to Shanghai at the time of the accident. She did not work as a purser on that flight. Instead, Carol McGavin worked as the pursuer and assigned her to work in the first class galley. She described the first class meal and beverage service as elaborate. The cart used in first class is three-tiered and stocked with desserts, wine bottles, etc.

Petitioner testified she began serving the first meal about 2 or 2 ½ hours into the flight. As she was finishing this service, turbulence hit and the flight attendants were instructed to stow carts and strap into their jump seats. Petitioner testified she "struggled" to keep the cart upright and get it back into its housing. At one point, the cart "twisted" but she was able to right it. After she stowed the cart, she took a jump seat and strapped in. She remained seated for the next couple of hours. When she got up from the jump seat, she felt what she described as "almost pain." Her back was "sore and not normal."

Petitioner acknowledged finishing the flight to Shanghai and subsequently working the return flight to Chicago. When she was showering and getting dressed in the hotel, prior to the return flight, she experienced back pain and dizziness. It was difficult for her to put on her required pantyhose.

Petitioner testified she informed Carol McGavin of her injury either when she got on the airplane or in the hotel lobby. She was worried she might have to fly back as a passenger because of her symptoms but she was able to work the return flight, with the assistance of other first class attendants. The flight landed in Chicago at approximately 5 PM on January 5, 2014. She was living in Milwaukee at that time and traveled there via bus.

Petitioner acknowledged she first sought treatment on January 8, 2014. On that date, she saw her internist, Dr. Dang Vu. The doctor noted complaints of non-radiating lower back pain and feeling "winded" due to this pain. She indicated Petitioner was addressing this pain with "heat application and rare doses of Advil." She also indicated Petitioner "has not been exercising as getting on the treadmill exacerbates the pain."

The following history appears in the doctor's January 8, 2014 note:

> "For the last several months since October 2013 the patient has had low back pain. However, over the weekend the pain has worsened. It is worse with lying flat on her back, getting up from lying down or sitting position. She is an airline attendant and stated that her symptoms were exacerbated with pushing luggages [sic] at work."

On direct examination, Petitioner disagreed with the doctor's statement that her back pain began in October 2013. She also took issue with the doctor's statement that she exacerbated her back "pushing luggages." She ascribed this to "bad English." She does have to pull luggage while getting on a plane but her duties aboard an aircraft do not involve handling luggage. She acknowledged seeing the doctor at some point in the fall of 2013, due to an ear infection. She also acknowledged being "slow to get up" from the examination table during that visit. She attributed the doctor's misunderstanding as to the duration of her pain to her "being flippant" with the doctor at the fall 2013 visit. [The doctor's records concerning treatment rendered prior to January 8, 2014 are not in evidence.]

On examination on January 8, 2014, Dr. Dang Vu noted tenderness over the low lumbar region in the midline and also over the SI joints bilaterally, aggravated with flexion. She described straight leg raising as negative bilaterally.

Dr. Dang Vu recorded the following "impression and plan":

> "Low back pain at least 3 months duration without neurologic signs and symptoms. Pain worse over the last couple of days."

The doctor prescribed X-rays "because of the longer duration of the pain." She indicated she would recommend physical therapy if the X-rays were negative. The X-rays demonstrated moderate joint space narrowing at L5-S1 and mild facet joint osteoarthritis in the lower lumbar spine, more pronounced at L4-L5. A note dated January 8, 2014 reflects that the doctor "reviewed X-ray report" with Petitioner and prescribed physical therapy. PX 1.

Records in PX 1 reflect Petitioner spoke with a member of Dr. Dang Vu's staff via telephone on January 13, 2014, complaining of back pain of six days' duration and associated difficulty bending. The staff member indicated Petitioner "would like to know if this could be work-related" and "also will need a work excuse starting 1/13/14 until?" The staff member indicated Petitioner would pick up the excuse on January 15th assuming the doctor approved. A subsequent note reflects the doctor called Petitioner the same day: "Called patient. She will try to return to work on January 23. In the meantime, she will start PT. I will hold off on return to work slip pending her progress in PT at this point." PX 1.

Petitioner underwent a physical therapy evaluation on January 15, 2014. The evaluating therapist noted a complaint of low back pain. She described the mechanism of injury as follows: "airline flight pushing the heavy carts on the plane – did try a massage." Petitioner characterized this description as accurate.

Following the evaluation, Petitioner participated in therapy on January 17, 20, 22 and 29, 2014. PX 1.

A note in PX 1 reflects Petitioner spoke with a member of Dr. Dang Vu's staff on January 22, 2014, indicating she was scheduled to see the doctor on January 29th "for workman comp clearance" and needed an "excuse for her job that she cannot go back to work until after her appt on 1/29/14 if cleared." The doctor approved this request.

The final therapy note of January 29, 2014 reflects that Petitioner reported feeling "very good" and complained of intermittent back stiffness. The therapist noted that Petitioner "feels she may return to work, she feels she doesn't have lifting requirements and she can operate the doors and windows." PX 1.

Petitioner also saw Dr. Dang Vu on January 29, 2014. The doctor noted that Petitioner was being seen "for follow-up of low back pain sustained on the job as airline attendant." She described Petitioner's back pain as "much improved." She indicated Petitioner denied any leg symptoms and felt "ready to return to work, full duty, as an airline attendant." She released Petitioner to full duty, with occasional Advil usage as needed, noting Petitioner "plans to fly to Shanghai in 2 days." PX 1.

Petitioner testified she was off work from January 13 through January 29, 2014 due to the claimed accident. She missed two work flights during this period. She received sick pay while she was off.

Petitioner returned to Dr. Dang Vu on December 10, 2014, for treatment of a rash. The doctor's note of that date reflects that Petitioner "still has low back pain associated with work injury but it is better." The doctor indicated that Petitioner denied any leg symptoms. PX 1.

Petitioner saw Dr. Dang Vu again on April 13, 2015, complaining of urinary symptoms and low back pain. The doctor noted Petitioner planned to travel to Machu Picchu in one week. She prescribed medication to prevent altitude sickness. PX 1.

Petitioner testified she continues to experience intermittent low back pain. She takes three or four Advils when the pain gets very bad. She no longer works the galley when she flies on Boeing 777 or 787 aircraft due to the number of carts involved.

Petitioner described herself as very active before the accident. She engaged in yoga and regularly played tennis and golf. She no longer plays tennis and golfs irregularly. She is "very cautious" and avoids overstressing her back. She no longer wears a backpack when hiking.

Under cross-examination, Petitioner testified she continues to work in the galley on planes other than 777s and 787s. She acknowledged that Carol McGavin was not at the Commission to testify on her behalf. The co-workers who she described as helping her on the return flight were also not

present. She was unable to identify any of those co-workers. The only person she can recall from the flights is Carol McGavin.

Petitioner testified she landed in Shanghai on January 4, 2014. After a de-briefing, she went to a hotel, taking her own luggage along. She did not seek any medical treatment or notify any supervisor of the accident while she was in Shanghai. She has undergone medical training and understands the importance of an accurate patient history. She had to stow the cart when the turbulence occurred. To her knowledge, the pilots have to document any major turbulence. She has not requested any such documents relative to her claim. She worked the return flight to Chicago because no one was available to fill in for her. If she had flown as a passenger, the flight would have been short-staffed.

Petitioner testified she attended a de-briefing at O'Hare, after the flight landed on January 5, 2014. She is not aware of Respondent having any on-site medical clinic at O'Hare. She took her luggage to a bus and took the bus to a lot in Milwaukee where her car was parked. The trip would have taken about 1 hour and 40 minutes. After she arrived at the lot, she drove home. The drive took about 15 minutes. She did not stop for treatment at any point that night. She first underwent treatment on January 8, 2014.

Petitioner testified she was not aware of any Respondent rule requiring an employee to immediately report any on-the-job injury to a supervisor. She never underwent any training concerning the reporting of such injuries. She did have a work injury prior to the accident at issue. She reported this injury to her supervisor.

Petitioner described Carol McGavin as her supervisor at the time of the accident. She informed McGavin of her accident on either January 3 or 4, 2014. [The Request for Hearing form reflects she reported the accident to McGavin on January 6, 2014. Arb Exh 1.]

Petitioner testified she has seen Dr. Dang Vu for years. After the accident, she sought care with Dr. Dang Vu on her own. When asked whether she told the doctor the truth, she replied, "I think I did." Dr. Dang Vu did not tell her that the X-ray results were normal. She cannot recall whether the doctor gave her an "off work" slip at the first visit. She recalls telephoning the doctor later, to request such a note, but she cannot recall the date she did this. She told Carol McGavin of her injury on January 5 rather than January 6, 2014. She cannot recall telephoning Dr. Dang Vu again on January 22, 2014. She does not believe the doctor examined her on that date. The doctor wrote a one-line report, taking her off work from January 22 through 29, 2014. The doctor examined her on January 29, 2014 and released her to full duty. She resumed full duty thereafter and still works for Respondent. She went to Machu Picchu for pleasure in April 2015. The flight from Miami to Lima, Peru took four or five hours. She was not able to climb any of the ruins at Machu Picchu.

Petitioner denied re-injuring her back after the claimed accident.

On redirect, Petitioner testified she did not appreciate the severity of her injury when it occurred. In the past, she has "shaken off" other work injuries. This injury "was different." When she has any injury, she waits to see whether it will get better. Her pain became much worse the day after the January 14, 2014 accident. She did not seek treatment on the night she arrived at O'Hare because she did not get home until about 8:30 PM and thought she would improve. She got help with her luggage when she took the bus home that night. If another employee had been available to take her place on the return flight, she would have flown back to Chicago as a passenger. There can be various

degrees of turbulence. Low impact turbulence can affect a cart more. Moderate turbulence affects the plane "in a big way." Immediately before the accident, there was a "quick bump" and "low to moderate impact" turbulence.

Respondent objected to the admission of PX 1, Dr. Dang Vu's records, arguing that the standard for admission, i.e., inherent reliability, was not met since Petitioner took issue with the doctor's history of January 8, 2014. The Arbitrator overruled this objection and admitted the records. Petitioner also offered the doctor's bills into evidence. PX 2.

No witnesses testified on behalf of Respondent. Respondent offered into evidence Dr. Dang Vu's typed note of January 29, 2014. This note is addressed to Respondent's medical department. It reflects that Petitioner "will be able to return to full duty as a flight attendant as of January 29, 2014." RX 1.

Arbitrator's Credibility Assessment

Petitioner has worked for Respondent for over 37 years, a factor that would typically weigh in her favor, credibility-wise. Petitioner's description of her galley duties was detailed and believable. The Arbitrator does not, however, believe that Petitioner injured her back as she described. Petitioner testified to a specific incident involving a cart yet Dr. Dang Vu's initial note of January 8, 2014 contains no mention of such an incident and instead describes Petitioner's low back pain as starting in October 2013. Petitioner took issue with this history but admitted seeing Dr. Dang Vu in the fall of 2013. She attributed the timeline discrepancy to a "flippant" comment she made to the doctor at that time, as she was getting up from the examination table. The doctor's pre-accident records would have afforded the Arbitrator an opportunity to place that testimony in context but Petitioner elected not to offer those records. "Where a party fails to produce evidence in his 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 (1st Dist. 1992).

Petitioner's notice-related testimony also undermined her credibility. She testified she informed Carol McGavin of her injury the day after it occurred. If so, why did she call Dr. Dang Vu's office on January 13, 2014 to inquire as to whether her back pain "could be work related?" PX 1.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on January 3, 2014 arising out of and in the course of her employment?

Based on the foregoing credibility assessment, the Arbitrator finds that Petitioner failed to prove a compensable work accident of January 3, 2014. The Arbitrator finds it unnecessary to address the remaining disputed issues. 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 PEORIA	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deann Freesmeyer,
Petitioner,

vs. No: 11 WC 03088

State of Illinois,
DCFS.
Respondent.

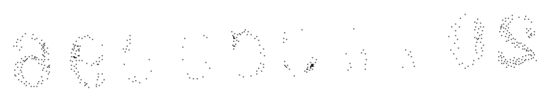
20IWCC0096

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 2018 is hereby affirmed and adopted.

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



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: FEB 10 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

mp-wj
o-02/06/20
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FREESMEYER, DEANN
Employee/Petitioner

Case# **11WC003088**

13WC037744

STATE OF ILLINOIS - DCFS
Employer/Respondent

20IWCC0096

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

If the Commission reviews this award, interest of 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

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

0498 STATE OF ILLINOIS
ATTORNEY GENERALL
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

OCT 4 - 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF **Peoria**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Deann Freesmeyer
Employee/Petitioner

Case # **11** WC **3088**

v.

Consolidated cases: **13** WC **37744**

State of Illinois - DCFS
Employer/Respondent

20IWCC0096

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **August 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 **December 30, 2010,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$57,072.08**; the average weekly wage was **$1,097.54**.

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

Respondent shall be given a credit of **$65,019.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$65,019.00.**

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

ORDER

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

Respondent shall be given a credit of **$65,019.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** in non-occupational indemnity disability benefits, for a total credit of **$65,019.00.**

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

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

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

Melinda M. Rowe Sullivan
Signature of Arbitrator

10/2/18
Date

OCT 4 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Deann Freesmeyer
Employee/Petitioner

Case # **11** WC **3088**

v.

Consolidated cases: **13** WC **37744**

State of Illinois - DCFS
Employer/Respondent

20 I W C C 0 0 9 6

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she works for the Department of Children and Family Services. She testified that on December 30, 2010, she worked in the office building located in Pekin and that she held the job title of Child Protective Service Worker. She testified that she would take her case files and laptop computer home with her, and that she would take her case materials and laptop computer home with her in a rolling cart.

Petitioner testified that on December 30, 2010, she drove to the parking lot behind the building she worked in. She testified that on that date, the parking lot was covered in ice. She testified that the sidewalk next to the parking lot had been plowed. She testified that she walked from her parked car to the plowed sidewalk. She testified that she was pulling her cart as she walked to the plowed sidewalk. She testified that she was walking on the plowed sidewalk and noticed chunks of ice from the middle of the sidewalk that had been pushed to the sides of the sidewalk, and that her cart got stuck on some of the ice and that as she pulled on her cart, she fell onto her right knee and right arm. She testified that after she fell, her prior knee issues and the hard fall knocked the wind out of her. She testified that she noticed her files in the cart were starting to shift.

Petitioner testified that two co-workers, Shellie Himes and Erica Frantz, were outside the door on a smoke break. She testified that her two co-workers saw her fall. She testified that her two co-workers came over to her to help her after her fall. She testified that Erica carried her cart inside the office building and that Shellie helped her into the building. She testified that she noticed her cart inside her office by the time she got up to her office. She testified that she sought medical treatment at Pekin Memorial Hospital's emergency room the day of the incident. She testified that she left her car in the parking lot. She further testified as to the course of medical treatment that was rendered for her right tibial plateau fracture, including the pulmonary embolism that developed in early 2011. She testified that she was released to full duty by Dr. Mitzelfelt on August 26, 2011.

Petitioner testified that on October 2, 2013, she fell at work while walking to her supervisor's office. She described that she got off the elevator and was pulling her cart with her left hand, that her foot caught on carpet and that she let go of the cart, and that as she was stumbling forward, she caught herself on a table outside an office. She testified that the "drag" from the cart and the fact that her right leg was not functioning caused her fall. She testified that she went to Pekin Hospital's emergency room for treatment the same day. She further testified as to the course of medical treatment that was rendered for her back after the October 2, 2013 incident, including a consultation with Dr. Williams, a vascular surgeon.

Petitioner testified that she still has pain from the complications from the IVF filter. She testified that she still has tightness and weakness in her knee, that she has difficulty walking up and down stairs, and that she also has difficulty walking long distances.

On cross examination, Petitioner admitted that she was familiar with the parking lot and sidewalks involved with the December 30, 2010 incident. Petitioner agreed that she was able to do her current job, which is different from the position that she held previously. Petitioner testified that she earns more money now than when either incident occurred. Petitioner further testified that she has had no supervisor state that she is unable to do her job.

On cross examination, Petitioner testified that it was her understanding that the State of Illinois was responsible for having the parking lot scooped and maintained and that they would then, in turn, call the City of Pekin to perform the work. She testified that she walked on the sidewalk because the parking lot had not been cleared of snow and ice. She testified that her employer did not instruct her to use a cart.

On cross examination when asked about the October 2, 2013, fall and if she tripped on anything, Petitioner responded, "[t]here was nothing in front of me other than the floor. Um, I don't know if I tripped on the carpet or if my foot wasn't working or – I don't know." Petitioner further testified that as to the October 2, 2013 accident, she was starting to fall and caught herself at the edge of the table.

Shellie Himes was called as a witness by Respondent at the time of arbitration. Ms. Himes testified that she worked with Petitioner at DCFS on December 30, 2010. Ms. Himes described Petitioner's fall as Petitioner parking her car, getting out of her car, going to step up on the sidewalk, slipping on the ice and falling on her knee, and then falling down on her backside. Ms. Himes testified that she and Erica Bourscheidt (now Frantz) helped Petitioner up and that she took her to the hospital after reporting the incident to the supervisor. She testified that Petitioner parked her car along the curb on the street next to the sidewalk before her fall. Ms. Himes reiterated that she saw Petitioner park along the street and not in the parking lot behind the building in which they worked. She testified that she did not see Petitioner with a cart. She further testified that she did not see Petitioner with any case files, work materials, or anything that she dropped when she fell.

Erica Frantz (formerly Bourscheidt) was called as a witness by Respondent at the time of arbitration. Ms. Frantz testified that she worked with Petitioner on December 30, 2010. She testified that she saw Petitioner park along the street and not in the parking lot next to the office. She testified that she did not see what caused Petitioner to fall. She testified that she helped Petitioner into the building after the fall. Ms. Frantz did not remember seeing a cart or work-related things that Petitioner had dropped when she fell.

Alyssa Graham was called as a witness by Respondent at the time of arbitration. Ms. Graham testified that she worked with Petitioner on October 2, 2013. She testified that she observed Petitioner get off the elevator in the office building, then hearing Petitioner's feet shuffle and then seeing Petitioner put her hands out on a nearby table. She testified that she did not see anything on the ground that would have caused a trip. She testified that Petitioner did not fall on the ground at all. She testified that she did not fill out a witness form because she did not believe it was a "big deal." She testified that everyone simply went about their day as normal after the incident. She testified that she did not see Petitioner receive any medical attention. She testified that she saw Petitioner pulling a cart prior to tripping.

Petitioner called Cindy Malin as a rebuttal witness at the time of arbitration. Ms. Malin testified that she is Petitioner's sister and that after the December 30, 2010 incident, she drove to Petitioner's office

and picked up her car that was parked there. She testified that on December 31, 2010, she picked up Petitioner's car in the parking lot located behind the building.

The Applications for Adjustment of Claim were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. (PX1).

The Unusual Incident Reporting Form dated December 30, 2010 and the Employee's Notice of Injury dated October 2, 2013 were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The Unusual Incident Reporting Form noted a date and time of incident of December 30, 2010 at 8:40 and the Summary of Incident section of the Form noted that at approximately 8:40 a.m. on Thursday, December 30, 2010, Petitioner, a Child Protection Specialist, had exited her car, had parked in the lot immediately behind the Pekin Field Office, that this was the parking lot where Pekin Field Office employees parked their vehicles while at work and that the parking lot had been snow-covered but that, with rain and overnight low temperatures, the snow had begun to melt and ice was present. It was noted that Petitioner slipped on the ice and fell, landing on her right knee, that she phoned the Regional Administrative Office to notify Edie Woods of her fall and injury, that she spoke to Danis Klatt (as Ms. Woods was off work) and that she was taken to Pekin Hospital emergency room for examination and treatment. It was noted that Ms. Klatt contacted CMS via e-mail as procedure required. The Reporter of Incident section noted that the employee reporting the incident was that of Sharon Stewart. (PX2).

The Workers' Compensation Employee's Notice of Injury form was prepared by Petitioner on January 4, 2011 and noted a date of injury or illness of December 30, 2010 at 8:35 a.m. When asked what duty she was performing at the time of the injury, Petitioner indicated that she was going into the office from the employee parking lot, that the place where the injury occurred was that of the backyard of the building leading to the employee door and that she fell on ice while trying to get to the employee door. The witnesses to the injury were identified as Shellee Frederking and Erica Bourcheidt. The Supervisor's Report of Injury was completed on January 19, 2011 and noted a date and time of incident of December 30, 2010 at 8:40 a.m. It was noted that Petitioner's activity at the time of the incident was that of coming to work, that the location was that of the parking lot and sidewalk in the back of the office and that notice was received on January 3, 2011. When asked to provide the contact information for the negligent party, Ms. Kedzior indicated "Not unless you count that our parking lot is never plowed or salted". It was noted that the unsafe acts or conditions that contributed to the accident included the unplowed/unsalted parking lot. (PX2).

The Worker's Compensation Witness Report prepared by Shellie Frederking dated January 14, 2011 noted that she saw the incident on December 30, 2010 at 8:40 a.m. It was noted that Ms. Frederking walked out the back door of the office building and saw Petitioner "go down" after slipping on ice, that she fell very hard on her knee and then onto her buttocks and that Erica and she assisted Petitioner in getting up off the ground. It was noted that Petitioner was very slow in getting up and walking away and that they then reported to Sharon Stewart about Petitioner's fall and that she probably needed to go to the hospital. It was noted that Ms. Stewart then asked Ms. Frederking to transport Petitioner to Pekin Hospital emergency room, which she did. It was noted that the exact location was that of 1 S. Capitol in Pekin on the sidewalk next to the building. The Worker's Compensation Witness Report prepared by Erica Bourscheidt dated January 18, 2011 noted that she saw the incident on December 30, 2010 at 8:40 a.m. It was noted that she walked out the back door of the office building and saw Petitioner walking on the sidewalk, that she then saw Petitioner slip on the ice and fall, that she fell hard on her knee and arm and that she was visibly shaken and had a very hard time getting up. It was noted that she and Ms. Frederking assisted Petitioner in getting up, that an unknown man came from across the street and asked Petitioner if she wanted an ambulance called and that Petitioner stated that she did not. It was noted that Petitioner slowly walked to the front of the building, that they then reported to the supervisor Sharon Stewart what happened and that she said that

Petitioner probably needed to go to the hospital. It was noted that the exact location was that of 1 S. Capitol in Pekin and that the incident occurred on the sidewalk next to the parking lot/building. (PX2).

The Workers' Compensation Employee's Notice of Injury dated October 19, 2013 noted that the incident occurred on October 2, 2013, that Petitioner was reporting to work to her supervisor, that the incident occurred outside the supervisor's office and that she was walking up to the supervisor's office pulling the cart on her left side as the right leg was tight at the knee and that her right let did not "get picked up" for her foot to clear the floor, causing her to trip and start falling forward. It was noted that Petitioner tried to right herself but could not get her foot under her until she grabbed the table outside of her supervisor's office to keep from hitting the floor face forward and that when she tried to stand up straight, it hurt to put pressure on her right leg. It was noted that a colleague got Petitioner's cane from her car and with that and her cart, she limped to her office. It was noted that Petitioner had muscle spasms and pain which caused her to leave at 9:30 a.m. and that she drove to Pekin emergency room where she was seen, x-rays were done, an immobilizer was placed and medications were given. (PX2).

The Pekin Hospital medical records dated December 30, 2010 were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 30, 2010, at which time it was noted that she was a 47-year-old white female that went to work that morning, slipped and fell on the ice and had intractable pain of her right knee. It was noted that Petitioner apparently went to work and while walking across the sidewalk hit a patch of ice and fell, that she initially hit her right knee followed by her left knee and left elbow and that she then turned over and sat up and could not get up by herself. It was noted that a co-worker assisted Petitioner up but that she was unable to bear weight on her right lower extremity and that she said she was having bad muscle spasms associated with this. It was noted that Petitioner went into work and sat at her desk but that the longer she sat there, the pain got worse with increased stiffness to the point she came to the emergency room for evaluation. It was noted that Petitioner had had an x-ray that suggested that she had a lateral tibial plateau fracture but that she had intractable pain and muscle spasm, and that she was admitted for pain control and evaluation of the possible fracture. The records reflect that Petitioner underwent x-rays of the left elbow on that date, which were interpreted as revealing no acute left elbow fractures. Petitioner also underwent x-rays of the right knee on that date, which were interpreted as revealing questionable subtle fracture of the lateral tibial plateau in the right knee; CT would be helpful. The records reflect that Petitioner underwent a CT of the right knee on that date as well, which was interpreted as revealing lateral tibial plateau fracture with mild depression; tricompartmental arthritis; large effusion; osteopenia. Petitioner also underwent x-rays of the left wrist on that date, which were interpreted as revealing no left wrist fractures, as well as x-rays of the left shoulder which were also interpreted as revealing no acute fracture in the left shoulder. The impression was noted to be that of (1) possible knee fracture; (2) left arm, wrist, elbow and shoulder pain; (3) gastroesophageal reflux; (4) morbid obesity; (5) reactive airways; (6) osteoarthritis; (7) history of pulmonary embolus, remote. It was noted that the plan was for pain medication, an orthopedics evaluation, physical therapy/occupational therapy evaluation and supportive care as needed. The Discharge Summary dated January 1, 2011 noted that Petitioner was to be non-weightbearing of the right lower extremity, that she was to use a walker and wheelchair at home as indicated, that she was going to need some time off work and that it would be handled through Orthopedics. The Discharge Summary and Course noted that Petitioner had had several knee surgeries and had had several orthopedic problems, that the pain was controlled with Percocet and Flexeril and that once physical therapy worked with her, Petitioner agreed to use a walker instead of crutches to get around. It was noted that according to Orthopedics, Petitioner was going to be off at least three months because she was non-weightbearing and that it was believed to pose a financial hardship on the patient, that all medical issues were stable and that she was deemed stable for discharge to home with her mother with good prognosis. (PX3).

The medical records of Pekin Family Practice/Dr. C. William Fisher were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on March 12,

2014 for follow-up on asthma. At the time of the February 26, 2014 visit, Petitioner was seen for a cough and shortness of breath. At the time of the December 12, 2013 visit, Petitioner was seen for a rash and welt on the back of her head. At the time of the October 9, 2013 visit, it was noted that Petitioner was there for a note for work. It was noted that the prior Wednesday Petitioner was walking towards the elevator near her supervisor's office, that she caught her toe on the carpet and that she fell but caught herself on a table. It was noted that Petitioner had an appointment with Orthopedics. (PX4).

The records of Pekin Family Practice reflect that Petitioner was seen on September 16, 2013, at which time it was noted that she had had right leg pain for three weeks. It was noted that Petitioner had right knee pain in cold temperatures and that she had had surgery on both knees previously. The clinical impression was noted to be that of bilateral knee pain, right greater than left. Petitioner was recommended to undergo x-rays of her bilateral knees. At the time of the August 16, 2013 visit, Petitioner was seen to discuss her labs. It was noted that Petitioner forgot to take Lipitor. The clinical impression was noted to be that of hyperlipidemia. At the time of the January 12, 2012 visit, Petitioner was seen for multiple issues including abdominal pain. The records reflect that Petitioner walked out. At the time of the October 24, 2012 visit, it was noted that the Lyrica was doing well for paresthesias and that she used a CPAP and was very tired at the end of the day. The clinical impression was noted to be that of peripheral neuropathy and OSA. At the time of the October 3, 2012 visit, Petitioner was seen for pain and burning in her legs. The assessment was noted to be that of peripheral neuropathy, among other issues. (PX4).

The records of Pekin Family Practice reflect that Petitioner was seen on July 24, 2012 so as to discuss the echo. It was noted that Petitioner was getting a venous study and seeing Dr. Ash and that she refused compression hose as she stated they hurt her leg. The clinical impression was noted to be that of obesity and decreased venous insufficiency. At the time of the June 22, 2012 visit, it was noted that Petitioner had a rash on the back of her left leg. It was also noted that Petitioner had recent lightheadedness and dizziness and that she had stubbed her left fifth toe and that it hurt and was swollen. It was noted that Petitioner had venous stasis of the left posterior leg with tenderness to the touch to the left lower extremity. The clinical impression was noted to be that of left foot pain, left lower extremity pain, chest pain and dynamic venous stasis of the left lower extremity. Petitioner was recommended to undergo an echocardiogram, a chest x-ray, x-rays of the left foot and a venous study. At the time of the May 3, 2012 visit, it was noted that Petitioner's skin was red, hot and tight on the left leg. The clinical impression was noted to be that of pedal edema and asthma, among other issues. At the time of the December 13, 2011 visit, Petitioner was seen for left knee pain. It was noted that Petitioner was complaining of left posterior medial knee pain. It was noted that a discussion was had regarding the risk of injecting the knee. The clinical impression was noted to be that of left posterior aspect medial knee pain. Petitioner was given a prescription for Voltaren gel. (PX4).

The records of Pekin Family Practice reflect that Petitioner was seen on November 28, 2011, at which time it was noted that she was seen for a two-month follow-up on chest pain. It was noted that Petitioner had gone to the emergency room for chest pain, where it was determined that low calcium was the reason for the chest pain. It was noted that Petitioner had left knee pain for 1½ weeks and that she had been using crutches and a cane. The clinical impression was noted to be that of left knee pain and high lipids. Petitioner was recommended to undergo left knee x-rays. At the time of the September 28, 2011 visit, it was noted that Petitioner had had chest pain and shortness of breath and she was being seen in follow-up after the emergency room. It was noted that Petitioner had decided not to proceed with surgical intervention for weight loss and that she needed a script for Coumadin. The clinical impression was noted to be that of asthma and abdominal pain. At the time of the August 16, 2011 visit, it was noted that Petitioner wanted to lose weight and to discuss her labs. The clinical impression was noted to be that of hyperlipidemia. It was noted that Petitioner was to check on a bariatric surgeon in her plan. (PX4).

The records of Pekin Family Practice reflect that Petitioner was seen on May 24, 2011, at which time it was noted that she was there to discuss labs. The clinical impression was noted to be that of hyperlipidemia. At the time of the May 16, 2011 visit, it was noted that Petitioner was seen in follow-up for chest pain. It was noted that Petitioner had a history of hyperlipidemia. The clinical impression was noted to be that of chest pain and muscle spasm. At the time of the April 5, 2011 visit, it was noted that Petitioner was there to discuss her appointment with cardiology/stress test. It was noted that sitting at rest Petitioner had chest pain, but that when she exerted it was not as bad. The clinical impression was noted to be that of anterior lateral chest wall pain. It was noted that they had ruled out cardiac and muscular and that Petitioner could be sent to physiatry or pain management. At the time of the March 2, 2011 visit, it was noted that Petitioner was seen in follow-up from the emergency room. It was noted that Petitioner had had substernal and right anterior lateral and lateral chest pain. The clinical impression was noted to be that of chest pain of possible MS etiology. Petitioner was recommended to undergo an adenosine stress test. It was noted that Petitioner was already on a PPI and anti-coagulant. (PX4).

The records of Pekin Family Practice reflect that Petitioner was seen on February 25, 2011, at which time it was noted that she had left lateral chest wall pain with deep breaths and when she moved. It was also noted that Petitioner had a blister on her index finger of the left hand from a hot oatmeal spill. The clinical impression was noted to be that of musculoskeletal chest wall pain, left anterior lateral. At the time of the January 24, 2011 visit, Petitioner was seen for hospital follow-up with blood clots. It was noted that Petitioner also had vision changes and a headache. Petitioner was advised to change her Coumadin dosage. The clinical impression was noted to be that of pulmonary embolus and right lower extremity DVT. The records reflect that Petitioner underwent regular Protime testing during the timeframe of February 25, 2011 through May 3, 2013. The records reflect that Petitioner underwent chest x-rays on June 6, 2013, which were interpreted as revealing mild pulmonary vascular congestion with no dense consolidative infiltrates. The Clinical Indication was noted to be that of shortness of breath; chest pain; pressure. Petitioner underwent chest x-rays on June 22, 2012, which were interpreted as revealing cardiomegaly; mild pulmonary vascular prominence. The history was noted to be that of left-sided chest pain. Included within the records of Pekin Family Practice was an interpretive report dated May 3, 2012 pertaining to a scoliosis study which noted a history of upper and lower back pain; pain worse the last month; no known injury. The records reflect that Petitioner underwent left knee x-rays on November 28, 2011, which were interpreted as revealing degenerative changes in the left femoral patellar compartment; no acute fracture. The history was noted to be that of left knee pain. (PX4).

The medical records of Pekin Orthopedics/Dr. Mitzelfelt were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner called on April 8, 2014, at which time she reported numbness to the right leg along with a "cold feeling and burning sensation" to the right leg. It was noted that Petitioner felt that she needed to see Dr. Williams for issues with circulation. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on December 20, 2013, at which time it was noted that she had a chief complaint of right knee pain and back and bilateral leg pain. It was noted that Petitioner injured the knee at work and tripped and fell, and that during the fall the knee was twisted in an uncertain manner. It was noted that the pain had been waxing and waning in severity but overall was progressively worsening, that the weakness in the right leg developed months ago, was moderate to severe and involved the leg diffusely, and that the left-sided leg weakness started months ago, was moderate to severe and involved the leg diffusely. It was noted that Petitioner had a history of a fall at work several years ago in which she fell in an icy parking lot and sustained a non-displaced lateral tibial plateau fracture, that she reportedly re-injured her right knee at work, that she reportedly was pushing a cart down the hall when both of her legs "gave out" causing her to catch her right foot on a rug or carpet and fall on her right knee and that she went to the emergency room later that day for evaluation. It was noted that an MRI of the right knee demonstrated a degenerative tear of the medial meniscus with extrusion and that there was also high grade chondromalacia in the weightbearing portion of the medial joint. The

assessment was noted to be that of degenerative joint disease of the knee and spinal stenosis, lumbar region. It was noted that treatment options for the knee included cortisone injections, viscosupplement injections and oral NSAIDs. It was noted that Petitioner also reported pain in the low back and posterior hip regions that radiated into the buttocks and lower extremities that got worse with ambulation and better with rest, and that she reported that her legs "gave out" while at work causing her to fall and land on both knees. It was noted that Petitioner had symptoms consistent with spinal stenosis and that they would await the results of the MRI of the lumbar spine. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on October 10, 2013, at which time it was noted that she presented for a chief complaint of low back pain, right knee pain, right hip pain and right leg pain and weakness with giving way. It was noted that Petitioner had a six-month history of right knee pain, right leg pain and left leg pain. The assessment was noted to be that of derangement of posterior horn of medial meniscus; joint pain; right knee pain with chronic venous insufficiency; medial joint pain with degenerative joint disease, possible meniscal tear; sciatica; and right leg pain and weakness, with giving way and now beginning to have left leg symptoms. It was noted that Petitioner was recommended to undergo MRIs of the right knee and lumbar spine. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on February 2, 2012, at which time it was noted that the chief complaint was that of right knee pain. It was noted that Petitioner had a year's history of right knee pain, that the pain was currently mild and that it had an aching and dull quality. It was noted that Petitioner sustained a tibial plateau fracture over a year ago to the right leg and that she admitted to achy pain in both the left and right knees, that the pain was worse first thing in the morning and in the evening and that it got better as she ambulated. It was noted that Petitioner's pain was typical of arthritic knee pain and that she had a referral to a rheumatologist from Dr. Fisher. It was noted that Petitioner was a maximum medical improvement and that she was to follow-up as needed for any other orthopedic issues that needed to be addressed. At the time of the November 9, 2011 visit, it was noted that Petitioner returned for a follow-up visit for a fracture of the right tibia and that the injury occurred 11 months ago. It was noted that Petitioner was at work and fell, that during the fall the ankle was twisted in an uncertain manner, that she reported experiencing immediate pain and noticed a deformity of the lower leg and that she denied any additional injury. It was noted that Petitioner stated that her symptoms had gotten a little better and that she continued to experience intermittent spasms in the right leg as well as giving way. Petitioner was given prescriptions for Vicodin for pain and Skelaxin for spasms. She was instructed to follow-up in three months. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on August 26, 2011, at which time it was noted that she was 8½ months status post a right tibial plateau fracture. It was noted that in regard to her right knee, Petitioner continued to make steady improvements every time that she was seen and that during her last appointment she was working on being to go from a seated to a standing position without any aides. It was noted that Petitioner had been doing physical therapy for strengthening over the course of the last six weeks and that overall, she felt that her strength was improving and that she felt that she would be able to perform all necessary duties at her job. It was noted that Petitioner also admitted that the buckling of her right knee only occurred occasionally as opposed to on a regular basis. The assessment was noted to be that of right tibial plateau fracture. Petitioner was allowed to return to work full duty with no restrictions. It was noted that Petitioner was to continue physical therapy for strengthening and was also going to acquire a membership at the local YMCA to start doing some water therapy and aquatic therapy as well. At the time of the July 15, 2011 visit, it was noted that Petitioner had been doing physical therapy over the course of the last three months and had noticed gradual improvement in her strength and endurance in the right leg but that she did note some weakness and imbalance in the leg at times. It was noted that Petitioner also noted that at times the knee would give out on her. It was noted that Petitioner noted that she was still unable to ascend and descend stairs one foot over the other, but overall she was making improvements and was making gains in physical therapy. The assessment was noted to be that of right

tibial plateau fracture. It was noted that Petitioner's fracture had healed but that she was in the rehab phase of her recovery where she was building up the muscular strength and endurance in the right leg. It was noted that before she was released to go back to work full duty, Petitioner needed to be able to do key things such as ascending and descending stairs and going from a seated to a standing position without the use of a walking aid. Petitioner was recommended to continue physical therapy and strengthening for the next six weeks. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on June 17, 2011, at which time it was noted that she sustained a fracture of her right tibial plateau about six months ago, that she had initially been treated non-operatively and conservatively with non-weightbearing activity and a brace and that over the course of the past 2½-3 months she had been doing physical therapy to regain range of motion, strength and mobility in the right knee. It was noted that Petitioner stated that she was now able to ambulate with a cane, that she was starting to increase her activities and that over the past week she had been doing a lot of walking. It was noted that Petitioner had two instances where her knee buckled and gave out on her when she was walking, but that she was making progress and felt that she was getting stronger and building up endurance in the right knee. The assessment was noted to be that of right tibial plateau fracture. It was noted that Petitioner continued to do physical therapy and strengthening for her right knee and that she continued to make gains and improve every time she was seen. Petitioner was to continue physical therapy and strengthening of the right knee for the next four weeks and was also allowed to return to work light duty only. At the time of the May 20, 2011 visit, it was noted that Petitioner had steadily continued to improve in terms of strength and function in the right leg and that she had been doing intensive physical therapy over the past four weeks. It was noted that Petitioner noted that she was now able to do leg extensions on her own as well as leg raises on her own, and that she was still ambulating with one crutch but at times noted that she needed to use both crutches. The assessment was noted to be that of status post right tibial plateau fracture. It was noted that Petitioner worked as a case investigator for DCFS and that before she would be released to return to work, physician's assistant Jones wanted her to be 100% fully rehabbed as in her job she was going to need to conduct interviews in which she may be standing for a prolonged period of time. Petitioner was instructed to continue physical therapy for the next four weeks. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on April 22, 2011, at which time it was noted that she continued to steadily improve, that she was now ambulating with crutches, that she was recently discharged from home physical therapy, that she also recently got cardiac clearance, that she had a failed cardiac stress test and subsequently underwent a coronary angiogram which came back negative for any evidence of coronary artery ischemia and that she also recently underwent a procedure where her vena cava filter was adjusted. The assessment was noted to be that of status post right tibial plateau fracture. Petitioner was encouraged to wean from crutches to cane when she could. It was noted that she recently finished home physical therapy and was given a prescription for outpatient physical therapy for range of motion, stretching, and modalities with gradual strengthening. Petitioner was also given a prescription for compression stockings as she had been experiencing some swelling in both lower extremities. At the time of the March 25, 2011 visit, it was noted that Petitioner had been non-weightbearing in a Bledsoe brace for the past three months, that she presented for an x-ray evaluation and follow-up and that she recently had an adenosine stress test which came back abnormal. It was noted that immediately after her appointment, Petitioner was getting ready to go to St. Francis for an angiogram and possible stent placement in her coronary arteries. The assessment was noted to be that of right tibial plateau fracture. It was noted that in comparison to x-rays that were done in January, Petitioner's fracture showed obvious signs of healing. Petitioner was allowed to be weightbearing as tolerated with no assistive devices, but that as she had been wheelchair-bound for the past three months she wanted to start off weightbearing with crutches. It was noted that Petitioner could weightbear as tolerated and start doing physical therapy for range of motion and strengthening. (PX5).

The records of Pekin Orthopedics reflect that Petitioner was seen on February 11, 2011, at which time it was noted that she had had a rather complicated course over the past 3-4 weeks. It was noted that over the past 3-4 weeks Petitioner had developed a blood clot in her right leg, that initially when she was sitting at home she started to have some chest pain and labored breathing, that she ended up going to the Pekin Hospital emergency room where she was diagnosed with a pulmonary embolus and that she was then transferred to St. Francis Hospital where Interventional Radiology apparently dissolved the clot, removed it and inserted a Greenfield vena cava filter. It was noted that Petitioner was now on Coumadin and had a vena cava filter, that she continued to complain of pain in the right knee and that she was in a Bledsoe brace locked in full extension. The assessment was noted to be that of right lateral tibial plateau fracture. Petitioner was instructed to have home health initiate therapy for her right knee and start range of motion exercises for the right knee. It was noted that Petitioner was to continue non-weightbearing on the leg for the next six weeks. At the time of the January 14, 2011 visit, it was noted that Petitioner was seen in follow-up for a complaint of right knee pain. It was noted that Petitioner sustained a fall about two weeks ago when she was walking from her car through the parking lot into work and that she slipped and fell on the ice. It was noted that when she fell Petitioner immediately began to have pain in the right knee, that she was taken to Pekin Hospital emergency room for an x-ray evaluation and that the x-rays were found to show a lateral tibial plateau fracture with a minimal joint line depression. It was noted that Petitioner was admitted to the hospital for pain control, that she was placed in a knee immobilizer with the instructions to follow-up with Dr. Mitzelfelt's office and that she still noted pain in the lateral aspect of the right knee. It was noted that Petitioner had been non-weightbearing in a wheelchair and that she had been using her knee immobilizer. The assessment was noted to be that of minimally displaced fracture, right lateral tibial plateau. It was noted that Petitioner would have to be non-weightbearing for three months in order for the fracture to heal and that she was to use the Bledsoe brace for at least the next four weeks. (PX5).

The medical records of Pekin Hospital dated January 15, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that the chief complaint was that of chest pain and shortness of breath. Petitioner's Significant Past Medical History was noted to include asthma, pulmonary embolism and a right leg fracture. It was noted that Petitioner had been wearing a knee immobilizer for a few weeks for a knee fracture and that she was mostly inactive in bed or the wheelchair. The interpretive report for a CT of the chest dated January 15, 2011 noted that the study was interpreted as revealing (1) massive bilateral pulmonary embolism in the main pulmonary arteries supplying the left and the right lungs; (2) findings consistent with elevated pressure in the right ventricle. The clinical impression was noted to be that of extensive pulmonary embolism. It was noted that Petitioner was to be transferred to OSF emergency room for intervention. (PX6).

The medical records of OSF St. Francis Medical Center dated January 16, 2011 through January 20, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Discharge Summary reflects that Petitioner was admitted on June 16, 2011 and discharged on January 20, 2011 with an admitting diagnosis of shortness of breath and a discharge diagnosis of massive pulmonary embolism. It was noted that Petitioner had presented to Pekin Hospital with a chief complaint of shortness of breath, that she stated that she had been short of breath all day and that it had gotten worse when she got up to go to the bathroom and that upon presentation to Pekin Hospital, a CT scan was done which showed a large bilateral saddle pulmonary embolism. It was noted that Petitioner was transferred to OSF for further treatment, that she was admitted to SICU and that IR was consulted. The procedures performed were noted to include IVC gram, IVC filter, bilateral pulmonary arteriogram, Perc mechanical thrombectomy, TPA infusion arteries per Dr. Brady, January 18, 2011 IVC cavogram, US and fluor-guided IVC filter repositioning and PICC line placement to the right upper arm. (PX7).

The records of OSF St. Francis Medical Center reflect that the Trauma/Critical Care Admission History and Physical noted that Petitioner had a history of pulmonary embolism in the past and had

presented to Pekin Hospital with a chief complaint of shortness of breath. It was noted that Petitioner had a tibia plateau fracture on December 30th and had been in a brace since then and that she stated that it felt similar to her prior PE. The records reflect that on January 16, 2011 Petitioner underwent right and left pulmonary arteriography IVC gram post TPA for a post-operative diagnosis of massive PE. The records further reflect that on January 16, 2011 Petitioner underwent IVC gram, IVC filter, bilateral pulmonary angiogram, Perc mechanical thrombectomy and TPA fusion pulmonary arteries for a post-operative diagnosis of massive PE. (PX7).

The medical records of Pekin Hospital Laboratory dated January 21, 2011 through October 11, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Also included in the medical records was the interpretive report for a bilateral screening mammogram performed on April 22, 2011. (PX8).

The medical records of Pekin Hospital dated March 1, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that she had a history of a tibial plateau fracture on December 30th and that she had a history of saddle embolism in her lungs on January 15th. It was noted that Petitioner was there for left-sided chest pain and that she felt short of breath. The interpretive report for chest x-rays dated March 1, 2011 noted that the films were interpreted as revealing mild central pulmonary vascular congestion. The interpretive report for a CT of the chest also dated March 1, 2011 noted that the films were interpreted as revealing (1) near complete resolution of the previously seen pulmonary embolism; (2) no new embolism; (3) no consolidation. The clinical impression was noted to be that of acute chest pain. (PX9).

The medical records of Pekin Hospital dated March 10, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent a myocardial perfusion scan on March 10, 2011, which was interpreted as revealing (1) findings concerning for anteroapical ischemia over a moderate area of left ventriculomyocardium; (2) normal ejection fraction of 73%; (3) normal TID of 1.12; (4) normal wall motion study. The Clinical Indication was noted to be that of chest pain and shortness of breath. (PX10).

The medical records of OSF HeartCare Midwest were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen on July 18, 2013 in the Vein and Vascular Office Center, at which time it was noted that she was status post left great saphenous vein radiofrequency ablation. It was noted that since the ablation, Petitioner's symptoms in that limb had entirely resolved and that she had no more numbness, tingling, aching or burning. It was noted that Petitioner had bilateral lower extremity edema, but that Dr. Ash thought that it was likely related to her weight. Petitioner was given a repeat prescription for more compression stockings. It was noted that the plan was for Petitioner to return in one year for repeat follow-up with a venous reflux study. At the time of the September 20, 2012 visit, it was noted that Petitioner battled with morbid obesity, that she presented some time ago with left lower extremity pain and was at that time found to have positive venous reflux in the saphenous vein on that extremity. It was noted that Petitioner complained of her symptoms being somewhat burning in nature so the concern was that they were missing an underlying arterial pathology versus neuropathy. Petitioner was placed in compression stockings for three months. It was noted that Petitioner continued to have symptoms in her left lower extremity despite wearing compression stockings, that she did have some element of heaviness, aching and edema, and that there was also an underlying burning pain that she experienced. It was noted that the plan was to perform an endovenous laser on the left great saphenous vein. (PX11).

The records of OSF HeartCare Midwest reflect that Petitioner was seen on March 22, 2011, at which time it was noted that she was seen in consultation for chest pain and an abnormal stress test. It was

noted that Petitioner for some time had noticed a left-sided chest discomfort that radiated to her left upper extremity that felt like a dull ache and caused her shortness of breath with nausea. It was noted that Petitioner had tingling in the left arm with the discomfort and that she could also have sharp pain at the site. It was noted that when Petitioner did leg raises or pushed herself in the wheelchair the discomfort occurred and that when she stopped activity, the discomfort resolved. It was noted that since she broke her leg on December 30, 2010. Petitioner had not been eating out as much but that for some prolonged time, she had been eating out at fast food restaurants 2-3 times per week. It was noted that Petitioner was on Coumadin for multiple pulmonary emboli since her leg fracture. It was noted that Petitioner's stress test was read in Pekin as anteroapical ischemia and that with her classic symptoms, she was recommended to undergo a coronary angiogram. At the time of the July 25, 2012 visit, it was noted that Petitioner had a history of TIA, lower extremity DVT and PE x 2 and that she also had a history of IVC filter placement. It was noted that Petitioner presented secondary to varicose veins and discomfort on the lower extremities, that she had a large number of reticular and truncular veins on the right lower extremity and had significant heaviness and aching on the left lower extremity, and that both were consistent with chronic venous hypertension. It was noted that Petitioner had a venous duplex performed on that date which was negative for acute deep vein thrombosis or superficial vein thrombosis and that there was no reflux noted on the right lower extremity, but that positive reflux was noted on the left lower extremity within the great saphenous vein. It was noted that the plan was to place Petitioner in compression therapy in both lower extremities and that she was to return in three months. It was noted that if Petitioner continued to be symptomatic she could be offered endovenous laser ablation of the saphenous vein in the left lower extremity but that in light of her complex medical history along with the pulmonary edema and chronic shortness of breath which may be secondary to pulmonary hypertension, Dr. Ash thought it was reasonable to send her for a work-up regarding this. It was noted that Dr. Wattanakit had a special interest in hypercoagulable disorders and that he would likely be able to address her shortness of breath that may be secondary to longstanding pulmonary hypertension as a result of her saddle embolus. (PX11).

The records of OSF HeartCare Midwest reflect that Petitioner was seen on August 8, 2012, at which time it was noted that she was seen for evaluation of thrombophilia and CP. It was noted that Petitioner had a TIA in July 2004, that in December 2004 she had PE and was treated with Coumadin for six months and that she had been doing well until December 2010 when she had a tibial fracture and was admitted to the hospital in Pekin and that she was treated conservatively for the fracture. It was noted that about two weeks later, Petitioner had syncope and was found to have a massive saddle PE requiring mechanical thrombectomy, that an IVC filter was placed, that her father had DVT and was on Coumadin for many years before passing away from sudden death and that she had chest pain and was seen by Dr. Cheng in the past. It was noted that Petitioner continued to have sharp, left-sided chest pain with exertion, that there was no change in severity or frequency of the chest pain and that she had been on Coumadin since 2011. It was noted that Petitioner's primary care physician had had difficulty regulating her INR and that she was seen by Dr. Ash for venous insufficiency and was referred for hypercoagulable work-up. The assessment was noted to be that of (1) atypical chest pain with normal LHC; (2) history of thromboembolism, status post IVC filter; the first one is related to oral contraceptive and the second to orthopedic fracture in the setting of inadequate treatment of anticoagulation: suspect that she may have situational-related VTE in the setting of possible underlying thrombophilia; (3) obesity; (4) venous insufficiency. Petitioner was ordered to undergo blood work, to continue Coumadin and to use compression stockings. (PX11).

The medical records of OSF St. Francis Medical Center dated March 25, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 12.[1] The records reflect that on March 25, 2011, Petitioner underwent left and right coronary angiography, left heart cath and left ventriculogram for chest pain and an abnormal stress test. The testing was interpreted as revealing (1) known cardiac chest pain; (2)

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

no significant coronary artery disease; (3) normal left ventricular systolic function; (4) EF is 65%; (5) mildly elevated LVEDP. (PX12).

The Interpretive Report for Bilateral Lower Extremity Venous Doppler dated April 19, 2011 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that on that date Petitioner underwent bilateral lower extremity venous duplex examination, which was interpreted as revealing no evidence of deep vein thrombosis in either the left or right lower extremity. (PX13).

The medical records of OSF St. Francis Medical Center dated April 20, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that on that date Petitioner underwent IVC gram and bilateral pelvic venogram and IVCF repositioning for a post-operative diagnosis of massive PE. The Interventional Radiology History & Physical noted that Petitioner had a history of right tibial fracture on December 2010, DVT to the right leg and massive bilateral saddle pulmonary emboli causing right heart dysfunction and hypotension and that she underwent IVC filter placement and pulmonary arteriogram with mechanical thrombectomy of the pulmonary arteries and catheter-directed thrombolysis on January 16, 2011. It was noted that Petitioner presented for IVC filter reposition as she needed the filter for three more months, that she was currently on Coumadin and that she had had a bilateral lower extremity venous duplex the day prior at Pekin Hospital which showed no evidence of DVT in either the left or right lower extremity. (PX14).

The medical records of IMPR – Pekin/Dr. Snyder dated April 29, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records reflect that Petitioner was seen by Dr. Snyder in consultation for left-sided chest wall pain. It was noted that Petitioner had a complicated medical history, that she stated that she suffered a tibial plateau fracture of the right leg on December 20th, that she was placed in a cast and no surgery was done, that she developed saddle emboli on January 15th and that she was hospitalized for this for anti-coagulation and that an IVC filter was placed. It was noted that Petitioner stated that before she got to the crutches, she started developing severe stabbing-type pain in the left lateral and posterior chest wall, that it would sometimes feel like it was radiating more anteriorly, that it varied as to when it occurred and that sometimes it was with mobility but sometimes when she was completely resting. It was noted that Petitioner's right leg was weak since the fracture but that the left leg was fine, that her walking tolerance was limited because of shortness of breath and that she had some falls associated with the onset of the PE. The impression was noted to be that of left chest wall pain, likely thoracic strain. It was noted that as Petitioner was already in physical therapy, Dr. Snyder would arrange for them to also address her chest wall discomfort. Petitioner was also given some Lidoderm patches to try for pain relief as well and it was noted that she could also use Tylenol and Hydrocodone (which she had a sufficient supply of) for pain relief as necessary as well. (PX15).

The medical records of Pekin Hospital dated September 25, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The records reflect that Petitioner was seen in the emergency room on that date, at which time she complained of chest pain with an onset/duration of 10 days ago. It was noted that Petitioner was also complaining of cramping in the bilateral lower extremities and edema, as well as a sore throat and nasal congestion. The records reflect that Petitioner underwent chest x-rays, which were interpreted as revealing stable patchy interstitial opacities from March 2011; no acute chest abnormality. Petitioner also underwent a lung perfusion scan on that date, which was interpreted as a low probability for PE, as well as bilateral lower extremity venous duplex which was interpreted as revealing no deep vein thrombosis within the bilateral lower extremities. The clinical impression was noted to be that of chest wall pain and constipation. (PX16).

The medical records of OSF St. Francis Medical Center dated September 30, 2011 were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that she had chest pain. It was noted

that Petitioner went to the Pekin emergency room last week for the same thing, that she had an evaluation with V/Q scan and was sent home, that she saw her primary care physician two days ago and that the pain was sharp under the left breast. It was noted that Petitioner had had DVT, was on Warfarin and had an IVC filter. It was noted that Petitioner also complained of a two-day headache that was typical of previous migraines, that she had had cough and congestion over the past few days and that there was no recent injury. It was noted that Petitioner's history, physical findings and risk factors were reviewed for the possibility that a venous thromboembolism/pulmonary embolism was the cause of her symptoms and that overall, it was felt that she was at low clinical risk for PE. Petitioner underwent a CT of the chest, which was interpreted as revealing (1) no CT evidence of pulmonary emboli; (2) prior granulomatous disease; (3) scattered regions of pleural-based linear opacity in the mid to lower lungs consistent with mild atelectasis and/or parenchymal scarring. Petitioner underwent chest x-rays on that date, which were interpreted as revealing mild cardiomegaly and pulmonary vascular engorgement. The diagnoses were noted to be that of chest wall pain, long-term (current) use of anti-coagulants and INR goal 2.0-3.0. (PX17).

The medical records of OSFMG Glen Park were entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The records reflect that Petitioner underwent left lower extremity venous insufficiency reflux/mapping on July 17, 2013, which was interpreted as negative for acute DVT in the common femoral, femoral, popliteal, posterior tibial and deep calf veins; negative for SVT in the LSV; the GSV appeared ablated from just past its origin to mid-thigh; a varicosity originating from the GSV at mid-thigh appears thrombosed; suboptimal visualization. The records reflect that Petitioner was also seen by Dr. Ash on that date as well, at which time it was noted that she was status post left great saphenous vein radiofrequency ablation. It was noted that since the ablation, Petitioner's symptoms in that limb had entirely resolved and that she had no more numbness, tingling, aching or burning. It was noted that Petitioner had bilateral lower extremity edema, likely related to her weight. Petitioner was given a repeat prescription for more compression stockings. Petitioner was instructed to return in one year for repeat follow-up with a venous reflux study. (PX18).

The medical records of Pekin Hospital dated October 2, 2013 were entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The records reflect that Petitioner was seen for an injury to the right leg and ankle, that the context was a fall and twist and that the severity of pain was moderate. The Triage Report noted that Petitioner was complaining of right lower leg tightness, pain, spasm and "poor movement" and that she had had a fracture of her right lower extremity three years prior. It was noted that Petitioner claimed that she had x-rays at Pekin Hospital two weeks prior to arrival but that she had not heard back the results from her doctor. The records reflect that Petitioner underwent x-rays of the right knee on that date, which were interpreted as revealing no acute fracture of the right knee. The Clinical Indication was noted to be that of a fall with pain and the inability to bear weight. The records also reflect that Petitioner underwent right ankle x-rays on that date, which were interpreted as revealing no acute bony abnormality. The Clinical Indication was noted to be that of patient tripped, now cannot bear weight on ankle. The clinical impression was noted to be that of a right ankle sprain/strain and internal derangement of the right knee. (PX19).

The medical records of Peoria Imaging Center dated December 16, 2013 were entered into evidence at the time of arbitration as Petitioner's Exhibit 20. The records reflect that Petitioner underwent an MRI of the right knee on that date, which was interpreted as revealing (1) degenerative radial and horizontal tearing of the medial meniscus posterior horn, close to the root; high-grade chondromalacia medical compartment chondromalacia; (2) high-grade patellar chondromalacia; moderate chondromalacia of the lateral femoral trochlea; (3) mild chondromalacia of the lateral compartment; (4) mild patellar tendinosis; (5) moderate-sized joint effusion. The History was noted to be that of right knee pain, status post injury October 2, 2013; no prior surgery. (PX20).

The medical records of OSF St. Francis Medical Center Diagnostic Testing dated February 20, 2014 were entered into evidence at the time of arbitration as Petitioner's Exhibit 21. The records reflect that Petitioner underwent a CT of the lumbar spine on February 20, 2014, which was interpreted as revealing (1) accentuated lumbosacral lordosis; (2) no evidence of significant central spinal canal encroachment; (3) at least minimal/mild annular bulging at L2-36, L3-4 and L4-5, without evidence of significant resultant neural impingement; (4) asymmetric left L5-S1 foraminal encroachment of at least mild degree, related to asymmetric left facet arthropathy; (5) recommend clinical correlation regarding inferior vena cava filter, including struts extending beyond the confines of the inferior vena cava, with the left posterior strut extending to the anterior aspect of the L3-4 intervertebral disc/anulus. The Clinical History noted that Petitioner was a 50-year-old woman with low back and bilateral lower extremity pain and weakness, that her symptoms worsened with ambulation and that there was less than one half city block ambulation. Petitioner also underwent a lumbar myelogram on February 20, 2014, which was interpreted as revealing evidence of annular bulging at L2-3, L3-4 and L4-5, worsening upon extension; no significant resultant neural impingement, beyond mild anterior extradural impressions; correlation recommended with the post-myelogram CT examination of the lumbosacral spine. The Clinical History noted that Petitioner was a 50-year-old woman with low back and lower extremity pain and weakness, that her symptoms worsened with ambulation and that there was less than one city block ambulation. The records reflect that Petitioner also underwent x-rays of the lumbar spine on that date as well, which were interpreted as revealing (1) diffuse lumbar degenerative spondylosis; (2) thoracolumbar levoscoliotic curvature of 17 degrees with apex at L2-3. The Clinical History noted that Petitioner was a 50-year-old woman with low back and lower extremity pain and weakness and that symptoms were worse with ambulation. (PX21).

The medical records of Cardiac Thoracic & Endovascular Therapies/Dr. James Williams were entered into evidence at the time of arbitration as Petitioner's Exhibit 22. The records reflect that Petitioner was seen on May 8, 2014, at which time it was noted that she was seen in follow-up for status post IVC filter. It was noted that a discussion was had regarding removal. It was noted that the limb was perforated anterior artery from the spine and that Dr. Williams could not assure Petitioner that removal would be curative. The diagnosis was noted to be that of hypertension; varicose veins with edema, pain and swelling; and TIA. At the time of the March 13, 2014 visit, it was noted that Petitioner had undergone IVC filter placement by Dr. Brady in 2011 and that she now presented with abdominal pain and CT evidence of possible perforation of the IVC with one limb of the filter. It was noted that Petitioner had had many kinds of pain probably related to her back and to the filter. Petitioner was recommended to undergo a CT of the chest/abdomen/pelvis. The diagnosis was noted to be that of hypertension; varicose veins with edema, pain and swelling; and TIA. The Venous Health History Form signed by Petitioner on March 13, 2014 noted that at times she walked with her right leg lifted like a person with cerebral palsy would walk to ensure that the foot was picked up enough to clear the floor so that she did not trip herself and that if she started walking as soon as she stood up her knee was more likely to buckle, but that if she stood for a short time before walking she walked better then then it became stiff around the knee. (PX22).

The medical records of Pekin Orthopedics/Dr. Mitzelfelt were entered into evidence at the time of arbitration as Petitioner's Exhibit 23. The records reflect that Petitioner was seen on March 10, 2014, at which time it was noted that the chief complaints were that of back pain, back and bilateral leg pain, abnormal imaging studies, right knee pain and right hip pain. It was noted that Petitioner continued with low back pain bilateral, primarily right hip, knee and leg pain and that she was also complaining of bilateral carpal tunnel symptoms. It was noted that the diagnostic testing findings were discussed as was the possibility that the vena cava filter could require surgical intervention and may cause some of her symptomatology. Petitioner was referred to Dr. Williams for evaluation and appropriate treatment options. It was noted that Petitioner was also known to have chronic venous insufficiency in the lower extremities with chronic swelling and multi-joint disorder and that she was pursuing disability. The assessment was noted to be that of lumbar region disc disorder; lumbar spondylosis; lumbosacral radiculopathy; sciatica;

derangement of the posterior horn of the medial meniscus; and joint pain. Petitioner was instructed to return as needed. (PX23).

The records of Pekin Orthopedics reflect that Petitioner was seen on June 16, 2014, at which time it was noted that she returned after seeing Dr. Williams with regard to the IVC filter. It was noted that Dr. Williams felt that it would be too dangerous to attempt to remove the filter and that it was safest to leave it in place, being unsure as to how much of her pain may be coming from it. It was noted that Petitioner continued with burning pain over the anterior and lateral thigh which stopped at the knee with weakness and burning in the right leg. It was noted that Petitioner had difficulty sitting, standing or walking for any extended period, that she required change of position frequently to relieve symptoms and that with increased use she had increasing numbness and tingling. It was noted that Petitioner utilized a cane for ambulation assist at all times. It was noted that Petitioner had numerous issues which would in all likelihood need to be tolerated without definite resolution. It was noted that Dr. Mitzelfelt recommended a referral to Dr. Henry for evaluation and treatment options regarding her pain. The assessment was noted to be that of lumbar region disc disorder; lumbar spondylosis; lumbosacral radiculopathy; sciatica; derangement of the posterior horn of the medial meniscus; and joint pain. Petitioner was referred to pain management. (PX23).

The medical records of OSF Heartcare Midwest dated July 31, 2014 were entered into evidence at the time of arbitration as Petitioner's Exhibit 24. The records reflect that Petitioner was seen by Dr. Wattanakit on that date, at which time it was noted that she was seen in follow-up of venous hypertension. It was noted that Petitioner had left GSV ablation and that since then, the symptom of ache in the left leg had resolved. It was noted that Petitioner's main complaint was that of pain and increased sensitivity in the right thigh and that she was awaiting to see a neurologist. The records reflect that Petitioner underwent a vascular lower extremities venous insufficiency procedure on that date, which noted vascular monitoring recommendations suggest follow-up exam at physician's discretion. The assessment was noted to be that of venous hypertension, s/p successful left GSV ablation. Petitioner was recommended to wear the compression stock as needed and to return to the clinic as needed. (PX24).

The medical records of UnityPoint Methodist Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 25. The records reflect that Petitioner underwent outpatient testing on October 11, 2014 related to a liquid-based Pap smear. The records further reflect that Petitioner underwent a CT of the thorax and CT of the abdomen and pelvis on April 29, 2014, which were interpreted as revealing (1) IVC filter as described; retroaortic left renal vein; (2) fatty liver; (3) non-aneurysmal aorta; no dissection. The history was noted to be that of pre-op to clip IVC filter; back pain shooting down the legs. (PX25).

The medical records of Pekin Hospital Pain Management Center/Dr. Grochowski were entered into evidence at the time of arbitration as Petitioner's Exhibit 26. The records reflect that the current diagnoses were noted to be that of (1) lumbar muscle spasms; (2) thoracic spondylosis; (3) lumbar spondylosis; (4) left T12-L1 facet syndrome; (5) right L3-S1 facet syndrome; (6) right L5 radiculopathy; (7) right hand neuropathic pain; (8) labia majora pain. It was noted that trigger point injections were performed in the office on that date and that facet joint injections were to be scheduled after Petitioner discussed them with her primary care physician. It was noted that Petitioner could return to work immediately with days off for required treatment (1-2 days per month) and that she was to continue a home exercise program. (PX26).

Additional medical records of Pekin Family Practice/Dr. Fisher were entered into evidence at the time of arbitration as Petitioner's Exhibit 27. The records reflect that Petitioner was seen on February 20, 2015, at which time it was noted that she stated that she had been put back to work and was not very happy about it, and that she stated that she hoped she did not fall at a client's house. It was noted that Petitioner's mother had recently passed away and that she had been non-compliant with Coumadin. At the time of the December 9, 2014 visit, it was noted that Petitioner had had an IME and that she went to the pain clinic. It

was also noted that Dr. Williams confirmed that the filter anchor leg was causing regular thoracic pain. The records reflect that further reflect that Petitioner underwent regular Protime testing during the timeframe of May 16, 2013 through August 10, 2015 and that she underwent a CTA of the chest on June 13, 2015, which was interpreted as revealing (1) no evidence for a pulmonary embolus; (2) diffuse fatty infiltration of the liver. The indication was noted to be that of chest pain. Petitioner also on that date underwent chest x-rays, which were interpreted as revealing cardiomegaly and mild central pulmonary vascular congestion; no new pulmonary consolidation. (PX27).

The medical records of OSF INI Neurology were entered into evidence at the time of arbitration as Petitioner's Exhibit 28. The records reflect that Petitioner was seen on January 27, 2015 for a neurologic consultation. It was noted that Petitioner stated that she had been having right leg pain and "nerve pain" for several years, that it all started with the injury in December 2010 while at work and that it required prolonged use of a leg splint. It was noted that Petitioner's fracture eventually healed and that she started back to work eventually, and then a second accident happened in October 2013 while at the office. It was noted that Petitioner tripped over the carpet, that she felt her right leg give out due to spasm and that she was able to hold onto the table in front of her but that she continued to have severe pain in the right leg. It was noted that since then the pain was present on and off and triggered by different activities including prolonged sitting, standing and walking. It was noted that Petitioner stated that the first injury in 2010 was complicated by DVT/pulmonary embolism, that since then she needed to be on Coumadin, and that during that time she had inferior vena cava placement which, after some time, revealed that it was misplaced with the left posterior strut extending into the anterior aspect of L3-L4 intervertebral disc, right paracentral. It was noted that it was felt that Petitioner's right leg pain may be associated with that and that she was sent to a vascular surgeon, Dr. Williams, who felt that it would be too dangerous to attempt to remove the filter. It was noted that Petitioner stated that in addition to pain and cramps in her leg sometimes she tripped over her right leg, that it gave out, that her right foot gave out and that she complained of some numbness and sharp pains going down her leg mainly in the anterior aspect of her thigh. It was noted that Petitioner denied any similar problem in her left lower extremity. The diagnoses were noted to be that of low back pain; lumbosacral radiculopathy at L1; and lumbosacral radiculopathy at L2. Petitioner was recommended to undergo an EMG/nerve conduction studies of the right lower extremity. It was noted that there was a suspicion that a lot of Petitioner's pain was due to weightbearing on the lumbar spine resulting in paraspinal lumbar muscle chronic sprain and degenerative changes. (PX28).

The records of OSF INI Neurology reflect that Petitioner was seen on February 6, 2015, at which time it was noted that she needed a work comp letter saying that she could not work. The records reflect that on March 11, 2015 visit, Petitioner underwent an EMG/nerve conduction studies by Dr. Blume. At the time of the April 13, 2015 visit, Petitioner was seen for right leg numbness and pain and the EMG results. It was noted that the conclusion was that there was essentially normal electrodiagnostic study except Petitioner was found to have very minimal abnormalities suggestive of the right lateral femoral cutaneous nerve of the thigh region. It was noted that Petitioner stated that she had been back to work, that the prolonged driving made her pain worse and that she stated that when she walked in bare feet it was usually much better than when she wore shoes. The diagnosis was noted to be that of meralgia paraesthetica, right. Petitioner was advised to contact her primary care physician to be referred to a weight loss program. It was noted that it was discussed that the right thigh numbness and pain was most likely a result of pressure on the femoral nerve due to body habitus. (PX28).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 29.

The transcript of the deposition of Dr. Donald Mitzelfelt was entered into evidence at the time of arbitration as Petitioner's Exhibit 30. Dr. Mitzelfelt testified that he is a board-certified orthopedic surgeon that he specializes primarily in knees, hips and shoulders. (PX30).

Dr. Mitzelfelt testified that his physician's assistant. Robert Jones, first saw Petitioner on January 14, 2011. at which time she had complaints of right knee pain. He testified that Petitioner was noted to have reported that she had fallen about two weeks previous when she was walking from her car through the parking lot into work and slipped and fell on the ice, that on falling she had immediate pain to the right knee and that she was taken to Pekin emergency room. He testified that Petitioner was admitted to the hospital for pain control. was placed in a knee immobilizer and was seen in follow-up at that time, and that the x-rays had revealed a minimally displaced lateral tibial plateau fracture involving the lateral 1-1.5 cm of the tibial plateau. He testified that Petitioner was maintained in the knee immobilizer and placed into a Bledsoe brace. He testified that the fall on the ice in the parking lot on December 30. 2010 was the cause of the tibial plateau fracture. (PX30).

Dr. Mitzelfelt testified that Petitioner was next seen by his physician's assistant on February 11, 2011, at which time it was noted that since the last time she was seen she had had an episode of shortness of breath and labored breathing. He testified that Petitioner had gone to Pekin emergency room where she was found to have a pulmonary embolism and she was transferred to St. Francis, where a vena cava filter was placed. He testified that Petitioner was in the ICU for approximately four days, that she was put on a blood thinner and that the PE subsequently cleared. He testified that Petitioner most likely had a DVT in the right lower extremity, that it could have been on the left but that the right one was the one which was immobilized and that the DVT subsequently broke off and went to the lungs. He testified that this was a complication from being immobilized and/or the fracture, and that it was based on the immobilization and the swelling around the knee which also caused distal swelling and pooling. (PX30).

Dr. Mitzelfelt testified that the IVC filter was placed to catch the blood coming back to stop any further clots from going to the lungs and that it was preventive for additional pulmonary insult. He testified that Petitioner's filter could not be removed as it had grown into the vena cava and was growing out past the vena cava. He testified that he had Petitioner see Dr. Williams after the issue had come up. He testified that Petitioner was also placed on Coumadin, which was a medication used to keep any further clots from forming and to help break down any clots which were present. He testified that Petitioner may be on Coumadin for the rest of her lift. but necessarily because of the fracture. (PX30).

Dr. Mitzelfelt testified that Petitioner was next seen on April 22, 2011, at which time conservative care was started on her tibial plateau fracture. He testified that Petitioner underwent physical therapy, range of motion, stretching, gradual strengthening, stabilization and mobilization, as well as wearing compression stockings. He testified that as of June 2011 Petitioner was making slow progress and had complained of a dull, achy pain in the back of her right knee, but otherwise was doing fairly well. He testified that Petitioner had had a couple of incidents of her knee buckling when she was walking, but she primarily had just weakness and was gradually trying to strengthen her leg. He testified that the buckling was, in part, due to weakness from her injury. He testified that when he saw Petitioner at the July 15th appointment not much had changed, and that he noted that she continued to have some weakness. He testified that Petitioner was still under work restrictions at that time and was gradually slowly making improvement. (PX30).

Dr. Mitzelfelt testified that as of the August 26, 2011 visit, Petitioner was almost nine months status post fracture and the emboli and was continuing to make steady improvements. He testified that Petitioner had been doing therapy for strengthening and that she was continued on modified duty. He testified that he placed Petitioner at maximum medical improvement as of February 2, 2012. He testified that at that point, Petitioner's pain was currently mild, aching and dull quality and that she reported pivoting pain, giving way and crepitus. He testified that Petitioner was having achy pain in both the left and right knees, worse first thing in the morning and evening and better when she ambulated, and that her primary care physician had referred her to a rheumatologist. He testified that pain was typical of arthritic knees, that Petitioner had significant arthritis in both knees, that she was doing fairly well with regard to the fracture and that the arthritis in the right knee would get worse after a tibial fracture. He testified that Petitioner

was instructed to return as needed. He testified that Petitioner would have been given permanent restrictions for the tibial plateau fracture, but that he could not say what they were without seeing a copy of the script. (PX30).

Dr. Mitzelfelt testified that he next saw Petitioner on October 10, 2013, at which time she had a history of low back pain, right knee pain, right hip pain, and right leg pain and weakness with giving way. He testified that Petitioner reported a six-month history of right knee pain, right leg pain and left leg pain and that she stated that it had been waxing and waning in severity. He testified that there were multiple issues going on, but that she had a posterior horn medial meniscus tear on the right knee and right knee pain with chronic venous insufficiency in the right leg, and that he recommended she undergo an MRI of the right knee. He testified that Petitioner also had sciatica from her low back, secondary right leg pain and weakness and giving way, and also left leg symptoms. He testified that he also recommended that Petitioner also undergo an MRI of the lumbar spine as well. (PX30).

Dr. Mitzelfelt testified that an MRI of the right knee was performed on December 16, 2013 and that Petitioner was next seen on December 20, 2013. He testified that Petitioner gave a history of a work accident where she tripped and fell and that she had reinjured her right knee at work. He testified that Petitioner reportedly was pushing a cart down the hall when both of her legs gave out causing her to catch her right foot on a rug or carpeting, subsequently falling to her right knee, and that she went to the emergency room later that day. He testified that this history was not given on the prior visit and that he thought it was probably a medical records error. When asked to assume that on October 2, 2013 Petitioner was at work pushing a cart and tripped and fell, injuring her right knee, and whether that was consistent with the history that he had on December 20, 2013, Dr. Mitzelfelt responded affirmatively. He testified that on reviewing the diagnostic testing, the treatment options discussed included injections, viscosupplementation, oral NSAIDs and possibly bracing versus possible knee replacement. He testified that Petitioner also reported pain in the low back and posterior hip that radiated into the buttocks and lower extremities that got worse with ambulation and better with rest, and that her symptoms were consistent with a spinal stenosis or radiculopathy originating in the lower spine. He testified that the incident of Petitioner pushing a cart and falling would aggravate her right knee condition, and that he thought that the fall while pushing the cart aggravated her chondromalacia and arthritis in her knee. He testified that the incident also could have caused or aggravated the degenerative tear of the meniscus, and that the need for further treatment for the right knee was related to the fall while pushing a cart. He further testified that he believed that the fall with the cart aggravated her lumbar condition, and that the aggravation was the reason that he recommended an MRI. (PX30).

Dr. Mitzelfelt testified that the CT myelogram of the lumbar spine showed lordosis and no significant spinal stenosis, annular bulging of the discs at L2-3, L3-4 and L4-5 and no significant neural impingement. He testified that Petitioner had a left L5-S1 foraminal encroachment and that it was noted that the superior tip of the IVC filter was at the L2 vertebral level and that some element of the strut extension was demonstrated external to the inferior vena cava with the left posterior strut extending to the anterior aspect of the L3-4 intervertebral disc on the right paracentrally. He testified that the fall while pushing the cart would have not have caused the problem, but that it could have initiated increased pain because when Petitioner went down she jarred it and the legs could have caused the nerves to flare and start giving her more pain. He testified that the fall while pushing the cart caused the pain complaints in Petitioner's lumbar spine. He testified that when Petitioner "went down" she would have aggravated the bulging at L2-3, L3-4 and L4-5 degenerative condition, and that the L5-S1 foraminal encroachment could have been flared and caused increased pain from that area. He testified that he could not say, however, whether it increased the severity of the encroachment. He testified that most of the conditions that he saw on the CT were degenerative but that "going down" could definitely flare it up. (PX30).

Dr. Mitzelfelt testified that he next saw Petitioner on March 10, 2014, at which time she continued to note low back pain bilaterally, primarily right hip, knee and leg pain, and also bilateral carpal tunnel symptoms. He testified that recommendation was made for a referral to Dr. Williams, a vascular surgeon, for evaluation and treatment options regarding the filter. He testified that Petitioner was also known to have chronic venous insufficiency in the lower extremities with chronic swelling and multi-joint disorder, that she was pursuing disability and that with her numerous issues he tended to agree that she was unable to work at that time or in the foreseeable future. He testified that Petitioner was to see Dr. Williams. He testified that he did not have any treatment recommendations for the knee and low back at that point except having Petitioner see Dr. Williams regarding the filter. He testified that he last saw Petitioner on June 16, 2014, at which time she complained of back pain, back and bilateral leg pain, leg weakness, right knee and hip pain. He testified that he noted that Dr. Williams felt that it would be too dangerous to attempt to remove the filter and that it was felt to be safe to leave it in place being unsure as to how much of Petitioner's pain may be coming from it. He testified that Petitioner continued with burning pain over the anterior lateral thigh which stopped at the knee with weakness and burning in the right leg, and that the significance of that was primarily that referred pain which was usually felt to come from the discs was different from radicular pain in that it would advance down the leg to the knee but not go below, and that radicular pain secondary to nerve impingement would go below the knee down to the calf, foot and ankle. He testified that Petitioner had numerous issues which would in all likelihood need to be tolerated without definitive resolution, that he recommended a referral to Dr. Henry at the pain clinic for evaluation and treatment options for her pain and that he did not feel that there was anything definitive that he could offer Petitioner to aid in her treatment. (PX30).

When asked whether the October 2, 2013 tripping while pushing a cart incident caused the need for knee replacement, Dr. Mitzelfelt responded that Petitioner had arthritis which was "a good portion of it" and that the lateral tibial plateau fracture would definitely damage the joint and make it more likely that arthritis was going to get worse for which she would need treatment. He testified that with the fall, Petitioner probably primarily damaged the patellofemoral joint and maybe the meniscus tears. He testified that whether it made Petitioner more likely to get a knee replacement he did not know, but that it was possible that it at least accelerated the condition for the knee replacement "[w]hen you go down like that." He testified that Petitioner's lumbar condition got a lot worse after the tripping and falling with the cart. He further testified that the tibial plateau fracture that Petitioner suffered on December 30, 2010 aggravated or accelerated the need for the knee replacement. (PX30).

Dr. Mitzelfelt testified that the permanent restrictions that he recommended on a Physician's Statement on June 16, 2014 were that of limitations with standing, lifting, climbing, bending or stooping and that her physical impairment was noted as severe limitation of functional capacity, incapable of sedentary activity for a good portion of the day, and prolonged sedentary. He testified that he felt that these were permanent restrictions at that time unless they could find some way to alter her present symptoms and when asked what medical condition caused the need for them, Dr. Mitzelfelt responded that it was the clot, embolism, filter and extrusion of the IVC filter, as well as the pain and weakness in Petitioner's legs, some of which was secondary to chronic swelling and some of it may have been secondary to the filter. He testified that the tripping and falling of the cart on October 2, 2013 was also an aggravating factor in the need for the restrictions. He testified that all the treatment that he rendered was reasonable and necessary and when asked whether he would perform a knee replacement if Petitioner requested it, Dr. Mitzelfelt responded that it would depend on what was going on with her back and leg pain and weakness. (PX30).

On cross examination, Dr. Mitzelfelt agreed that his practice was not focused on back injuries and that if a patient came to him and indicated that they had back pain, he would refer them elsewhere. He agreed that his physician's assistant drafted the office notes independently. He agreed that larger individuals were more susceptible to blood clots. He agreed that he would categorize Petitioner as morbidly obese. He agreed that he did not install vena cava filters and that he was not a vascular surgeon. (PX30).

On cross examination, Dr. Mitzelfelt agreed that his physician's assistant in the April 22, 2011 did not indicate that Petitioner was unable to do her work and that at that time there was no review of what her work duties were at that time. He testified that he did not discuss with Petitioner how frequently she picked up kids in her practice at work, nor did he discuss with her how much she walked in her work duties. He agreed that it was his understanding that Petitioner worked in an office and that people came to her. (PX30).

On cross examination, Dr. Mitzelfelt agreed that he did not testify that the arthritis was caused by either one of her falls and that it pre-dated the fall in 2010. When asked if Petitioner's left knee had in any way been influenced by the falls that she had had, Dr. Mitzelfelt responded that he was sure that it made the arthritis worse and that it was worsening in degree only. He agreed that arthritis was a degenerative condition and that, by definition, a degenerative condition got worse over time. (PX30).

On cross examination, Dr. Mitzelfelt agreed that if a patient gave him information he would include all the relevant information in the medical records as he was creating them. He agreed that if a patient had suffered a fall, he would have the option to type that information into the EMR system and that if a patient came to him complaining of pain and that they had suffered a fall, it would be relevant information to him that he would want to include. (PX30).

On cross examination, Dr. Mitzelfelt testified that bilateral arthritis could cause a person's knee to give out. He agreed that as to the October 2013 incident, he understood that Petitioner's knees gave out and that that was how she fell. He agreed that in the December 20, 2013 note, he had the option to type out whether Petitioner fell on October 2, 2013. He agreed that he did not indicate that that was the day that she fell, but testified that he indicated that she had recently reinjured her knee at work and that she had fallen. When asked to confirm in that in the medical records from the previous visit there was no mention of a fall, Dr. Mitzelfelt responded that it was probably because he was in a hurry and clicked notes, but that Petitioner was gradually having symptoms that were gradually worsening and became much worse after the fall. He agreed that if a patient gave him notable information pertinent to their care, he would include that in the medical records. (PX30).

On cross examination, Dr. Mitzelfelt agreed that he could not identify when the meniscal tear in Petitioner's right knee occurred. When asked to clarify his testimony that the pain in Petitioner's legs was disc-related, Dr. Mitzelfelt responded that she had referred pain which was more from the joints and discs, and that the pain could follow a radicular-type pattern but that it did not usually go below the knee. When asked to refer to the February 20, 2014 CT of the lumbar spine, Dr. Mitzelfelt agreed that the bulging that was described was not caused by either one of Petitioner's falls and was a preexisting condition. (PX30).

On redirect, Dr. Mitzelfelt testified that his understanding of Petitioner's work duties in no way affected how or what he wrote in the permanent restrictions and he agreed that he based the restrictions on Petitioner's medical conditions. He agreed that as to the October 2, 2013 accident, it was his understanding that Petitioner not only fell but that her legs gave out, her knees gave out and that it occurred while she was pushing a cart. (PX30).

On redirect, Dr. Mitzelfelt agreed that there was a discrepancy in the records in which she had an accident in which she went to the emergency room on December 2, 2013 while pushing a cart but that his October 10, 2013 record made no mention of that. He testified that it was not included in the record because he took the "short course" rather than dictating out the history. He testified that it was his issue and not Petitioner's, and that that was why he came back in and did it the next time. He testified that the December 20, 2013 note which discussed a fall was the fall that occurred on October 2, 2013. (PX30).

On further cross examination, Dr. Mitzelfelt agreed that there was no mention of any injury in October 2013 anywhere in his medical records. (PX30).

On further redirect, Dr. Mitzelfelt agreed that the December 2013 note stated that it had happened within a couple of months and that it gave him a timeframe, but not the exact date. (PX30).

The Topical View Photo was entered into evidence at the time of arbitration as Petitioner's Exhibit 31. The Back Door Photo was entered into evidence at the time of arbitration as Petitioner's Exhibit 32.

The Notice of Injury Packet for the December 30, 2010 incident was entered into evidence at the time of arbitration as Respondent's Exhibit 1. While primarily duplicative of those documents as contained in Petitioner's Exhibit 2, also included in Respondent's Exhibit 1 was document entitled "Worker's Compensation Claim – An Occupationally-Connected Injury" which was completed by Petitioner on January 4, 2011. The form noted that the date and time of injury was that of 8:35 a.m. on Thursday, December 30, 2010, that the injury occurred in the back yard of the office/parking lot and that Petitioner fell in ice. It was noted that Petitioner fell down on the way to the employee door to enter the building from the parking lot for DCFS employees and that she was attempting to enter the building. It was noted that the injury occurred while Petitioner was coming to work/entering the building. (RX1; PX2).

The Notice of Injury Packet for the October 2, 2013 incident was entered into evidence at the time of arbitration as Respondent's Exhibit 2. While primarily duplicative of those documents as contained in Petitioner's Exhibit 2, also included in Respondent's Exhibit 2 was a Supervisor's Report of Injury or Illness dated October 30, 2013, which noted that Petitioner tripped, with nothing obstructing her, over her own feet and that she was walking towards Andrea Detra's office. (RX2; PX2).

The IME Reports dated October 2, 2014 and February 5, 2015 were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report dated October 2, 2014 was authored by Dr. Nemickas, who noted that Petitioner was frustrated by the process, that some of her answers to interrogatories were short and clipped, that differing portions of the exam were punctuated by tearful responses and that there was a significant sense of underlying passive resistive behaviors. (RX3).

The October 2, 2014 report noted that Petitioner noted no appreciable pain and/or discomfort in her right knee, either from the fracture or subsequent injury on October 2, 2013, that she felt that that issue had resolved fully and that she remained with severe mid-thoracic back pain and lower lumbar pain radiating into the right buttock and thigh, both anterolaterally and laterally to the level of the knee. It was noted that Petitioner found some relief while shopping with leaning over a shopping cart and had recently begun using two canes to help and facilitate leaning over to walk. It was noted that Petitioner had symptoms and pain in all positions, including standing, sitting and lying, that they changed to a degree with their extent and severity but were never fully resolved, and that she stated that she had not been pain-free in so long that she forgot what it was like to live without pain and discomfort. It was noted that Petitioner noted marked sleep disturbance and impedance in routine and customary activities, and that she was frustrated that her final orthopedic and vascular examinations resulted in a referral to a pain clinic with no further recommendations for treatment and/or care. It was also noted that Petitioner stated that her initial incident was well described and that her subsequent incident in which she stumbled, catching herself before landing face first on the 2nd of October 2013 caused severe right knee pain that took about six weeks to resolve and that since that time she had really only had the residual lumbar issues that had not appreciably improved. (RX3).

The October 2, 2014 report noted that the assessment of Dr. Nemickas was that of (1) status post fall with right knee lateral tibial plateau fracture, healed without sequelae; (2) status post right knee sprain, resolved; (3) symptoms consistent with presumed neurogenic claudication secondary to her presumed IVC filter malposition and associative epidural venous congestion. It was noted that Dr. Nemickas opined that as to Petitioner's right leg, the lateral tibial plateau was causally related to the direct trauma that resulted in the lateral tibial plateau fracture on December 30, 2010 and had healed without sequelae. It was noted that as key records were not available for review, Dr. Nemickas deferred conclusions around what occurred on the second date of loss until records prior to the October 10, 2013 visit were available. It was noted that

Dr. Nemickas opined that the objective findings of the CT myelogram of the lumbar spine and the associative weakness in the distributions in Petitioner's right lower extremity supported the subjective complaints of neurogenic claudication and stenosis secondary to presume IVC filter placement with the aberrant L3-4 limb, causing presumed congestion of the venous epidural plexus. (RX3).

The October 2, 2014 report noted that as to Petitioner's right knee and right leg fracture, Dr. Nemickas opined that Petitioner had reached maximum medical improvement and that he anticipated no further intervention, evaluation, treatment and/or care to be necessary and required and that, with regard to her lumbar spine, Petitioner had reached maximum medical improvement based upon the opinion of the cardiothoracic surgeon that any intervention and attempt to facilitate and improve her functionality by removal of the IVC filter was of too significant a risk to be undertaken. It was noted that conclusions regarding Petitioner's right knee as it related to the alleged 2013 fall were deferred pending further records being made available. It was noted that Dr. Nemickas opined that Petitioner was capable of working with regards to her right leg and right knee injuries and that he would anticipate no restrictions related to the same, and that as to the lumbar spine and the ongoing neurogenic claudication/spinal stenosis with the associative presume venous congestion due to the L3-4 extruded limb of the IVC filter, Petitioner would require a sedentary position with postural changes as needed with no greater than 10 pounds of lifting, carrying, pushing or pulling. (RX3).

The February 5, 2015 Addendum Report of Dr. Nemickas noted that based upon a review of his independent medical evaluation, the associated records and the interim records contained in the report, he would defer to the opinion of Dr. Grochowski regarding Petitioner's interval functional improvement, as after his last visit of December 5, 2014 he confirmed that he felt that medical management had made sufficient progress to allow her to return to work with a physical impairment class I, no limitation functional capacity, capable of heavy work. It was noted that Dr. Nemickas concurred that Petitioner was capable of returning to work full duty without restrictions. (RX3).

The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The Photographs marked by Shellie Hymes were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Photographs marked by Erica France were entered into evidence at the time of arbitration as Respondent's Exhibit 6.

CONCLUSIONS OF LAW

As it pertains to 11 WC 3088 for the alleged date of accident of December 30, 2010:

With respect to issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on December 30, 2010.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois*

Workers' Compensation Comm'n, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

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

As the Fourth District Appellate Court has explained, "[e]mployment 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." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799, 304 Ill. Dec. 722 (2006), as cited in *Decatur Memorial Hospital v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100733WC-U.

In the case at hand, the Arbitrator notes that the undisputed evidence reveals that Petitioner fell while walking into work on December 30, 2010. The undisputed evidence further reveals that Petitioner was on a sidewalk outside the entrance to the building when she fell on December 30, 2010. Petitioner's recollection of the incident, however, differs from that offered by the two witnesses called at the time of arbitration by Respondent. Petitioner testified that she parked in a parking lot reserved for DCFS workers and then walked to the sidewalk that had been cleared, and that it was on this cleared sidewalk where she encountered a chunk of ice that caught the wheel of her rolling cart in which she was hauling her case files and laptop computer. Both of Respondent's witnesses, however, testified that Petitioner did not park in the parking lot behind the building, but rather parked along the street and walked onto the cleared-off sidewalk where she fell.

As to the issue of whether Petitioner was performing some work-related task which contributed to her risk of falling, the Arbitrator notes that Petitioner testified that Ms. Frantz carried her cart inside the office building and that Ms. Himes helped her into the building after her fall. Petitioner further testified that she noticed her cart inside her office by the time she got up to her office. Ms. Frantz, however, testified at the time of arbitration that she did not remember seeing a cart or work-related things that Petitioner had dropped when she fell. Ms. Himes testified that she did not see Petitioner with a cart, and she further

testified that she did not see Petitioner with any case files, work materials, or anything that she dropped when she fell.

While the evidence reveals that Petitioner testified to -- and documented the presence and involvement of -- a cart in the October 2, 2013 incident, the Arbitrator notes that no such references were made in any of the written documentation as to the presence and involvement of the cart in the December 30, 2010 incident. (PX2; RX1; RX2). In fact, the Arbitrator was unable to find a single reference to the involvement of the cart in the post-accident witness or accident reports or post-accident medical records submitted by either party at the time of arbitration, despite Petitioner's extensive testimony surrounding the cart at the time of arbitration. (PX2; PX3; RX1). Furthermore, the Arbitrator notes that the evidence reveals that there exists a dispute even as to the presence of the cart at the time of the December 30, 2010 alleged accident based upon the testimony of Petitioner, Ms. Himes and Ms. Frantz. Placing greater weight upon the testimony of Respondent's witnesses on the issue of the cart, the Arbitrator finds that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on December 30, 2010.

Based upon the foregoing and the record as a whole, the Arbitrator finds that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on December 30, 2010. As a result thereof, all benefits are denied. The remaining issues of causation, medical bills, temporary total disability benefits and nature and extent of the injury are moot, and the Arbitrator makes no conclusions as to those issues.

As it pertains to 13 WC 37744 for the alleged date of accident of October 2, 2013:

With respect to issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on October 2, 2013.

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

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be

expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶21.

As the Fourth District Appellate Court has explained, "[e]mployment 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." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799, 304 Ill. Dec. 722 (2006), as cited in *Decatur Memorial Hospital v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100733WC-U.

In the case at hand, the Arbitrator finds that Petitioner's incident was not caused by any defect or hazard in the area where the incident occurred, and the Arbitrator further finds that no evidence was presented at arbitration that suggested that any hazard existed or that there was a defect of any kind. The Arbitrator notes that Petitioner testified on direct examination that the "drag" from the cart and the fact that her right leg was not functioning caused her fall, and yet on cross examination when asked about the October 2, 2013, fall and if she tripped on anything, Petitioner responded, "[t]here was nothing in front of me other than the floor. Um, I don't know if I tripped on the carpet or if my foot wasn't working or – I don't know." Petitioner further testified on cross examination that she was starting to fall and caught herself at the edge of the table, which the Arbitrator notes is significantly different than the description of the incident as posed to Dr. Mitzelfelt, upon which his causation opinion was based. (PX30).

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on October 2, 2013. As a result thereof, all benefits are denied. The remaining issues of causation, medical bills, temporary total disability benefits and nature and extent of the injury are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deann Freesmeyer,
Petitioner,

vs. No: 13 WC 37744

20IWCC0097

State of Illinois,
DCFS.
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 2018 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: FEB 10 2020

Marc Parker

Barbara N. Flores

mp-wj
o-02/06/20
68

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FREESMEYER, DEANN
Employee/Petitioner

Case# **13WC037744**

11WC003088

STATE OF ILLINOIS - DCFS
Employer/Respondent

20IWCC0097

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

If the Commission reviews this award, interest of 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

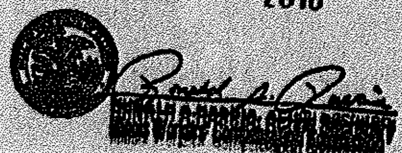
0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

OCT 4 - 2018



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

Deann Freesmeyer
Employee/Petitioner

v.

State of Illinois - DCFS
Employer/Respondent

Case # **13** WC **37744**

Consolidated cases: **11** WC **3088**

20IWCC0097

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **August 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$57,072.08**; the average weekly wage was **$1,097.54**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** dependent child.

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

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

ORDER

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

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

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

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

10/2/18
Date

OCT 4 - 2018

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF KANE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Heraclio Camargo,

Petitioner,

vs. NO. 13WC008756

IDHS/State of Illinois,

Respondent.

20IWCC0098

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 benefit rates, wage calculations, employment relationship, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 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, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: FEB 1 1 2020

Stephen J. Mathis

SJM/sj
o-12/18/2019
44

Douglas D. McCarthy

DISSENT

I find Petitioner is not an employee as contemplated by the Illinois Workers' Compensation Act but merely a volunteer. I would reverse the decision of the arbitrator and deny all benefits. Therefore, I respectfully dissent.

The Act provides coverage to "[e]very person in the service of another under any contract of hire, express or implied, oral or written…" *820 ILCS 305/1(b)2* (West 2013).

> [I]t is generally recognized that a true employer-employee relationship does not exist in the absence of the payment or expected payment of consideration in some form by employer to employee. As a consequence, the workmen's compensation statutes throughout this country have uniformly been construed to exclude from coverage purely gratuitous workers who neither receive, nor expect to receive, pay or other remuneration for their services. *Board of Education v. Industrial Commission*, 53 Ill. 2d 167, 171, 290 N.E.2d 247 (1972).

Moreover, mutual assent must be manifested by both parties not just reside in the mine of one party. See *Cowger v. Industrial Commission*, 313 Ill. App. 3d 364, 370, 728 N.E.2d 789 (2000) ("Here, although claimant may have believed that he was hired as of his conversation with John and therefore gave notice that he would be leaving the employ of TLC, the employer-employee

relationship is based on *mutual* assent [citation omitted], not the understanding of *one* party." (emphasis in the original)).

Petitioner failed to prove he received consideration for the "services" he provided to Respondent. Petitioner testified he is a recipient of benefits from Respondent in the form of money and food stamps. T. 6. Petitioner received the benefits under TANF- Temporary Assistance to Needy Families, a federal program administered by the State for families in need. T. 7, 48-52. To maintain access to the benefits, Petitioner was required to obtain work experience through volunteer opportunities at not-for-profit organizations. T. 49. Respondent offered such work experience in its offices to recipients who demonstrated transportation difficulties. *Id.* Petitioner was injured while performing his volunteer service activities in his home. T. 19.

Such facts do not establish Petitioner received consideration for the services he provided. In order to maintain eligibility for a federal program which provided benefits not only to him but his family, Petitioner was required to volunteer in order to gain work experience. Respondent in an effort to provide more volunteer opportunities for the recipients of this federal assistance allowed work experience in its offices. The benefits Petitioner and his family received simply were not consideration. Moreover, mutual assent as to an employment relationship is lacking. Certainly, Petitioner may have believed he was an employee, but Respondent did not.

Petitioner failed to prove he is an employee pursuant to the Act as no contract for hire exists. As such, I would reverse the decision of the arbitrator and deny benefits. I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARMANGO, HERACLIO Case# **13WC008756**
Employee/Petitioner

IDHS
Employer/Respondent

20IWCC0098

On 5/15/2017, 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 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AUORA, IL 60504

5462 ASSISTANT ATTORNEY GENERAL
MAGGIE TIMLIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAY 15 2017

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

20IWCC0098

____	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

HERACLIO CAMARGO
Employee/Petitioner

Case # **13 WC 08756**

v.

Consolidated Cases:

IDHS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica A. Hegarty, Arbitrator of the Commission, in the city of Geneva, Illinois, on January 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. What temporary benefits are in dispute?

______ TPD ______ Maintenance ______ TTD

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

M. Should penalties or fees be imposed upon Respondent?

N. Is Respondent due any credit?

O. Other ________________

FINDINGS

- On 01/18/12, 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 the Respondent.
- Petitioner's current condition of ill-being ***is*** causally related to the accident.
- In the year preceding the injury, Petitioner earned $15,600.00; the average weekly wage was $300.00.
- On the date of the accident, Petitioner was 51 years of age, ***married*** with 1 child under 18.
- Petitioner ***has*** received all reasonable and necessary medical services.
- Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of $ -0- for TTD, $ -0- for TPD, $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $ -0-.
- Respondent is entitled to a credit of $ -0- under Section 8(j) of the Act.

ORDER

- Respondent shall pay Petitioner $286.00 per week for a period of 27.95 weeks under Section 8(e)(2) because the injury caused a 65% loss of the left index finger. See the attached addendum for the Arbitrator's analysis pursuant to Section 8.1(b) of the Act.
- Respondent shall pay Petitioner $16,653.03, subject to the fee schedule, for the incurred reasonable and necessary medical expenses.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 5/12/17 Date

MAY 15 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

20IWCC0098

HERACLIO CAMARGO, Petitioner,	)	
	)	
vs.	)	**No. 13 WC 08756**
	)	
	)	
IDHS,	)	
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Petitioner testified that he was a recipient of Public Aid benefits on January 18, 2012. He received cash and other assistance in the amount of $300.00 per week. He testified that he was part of the Work Experience "WE" program and that in order to receive benefits, he was required to work. He worked 20 hours per week and was assigned to perform this work at the IDHS office across the street from his home in Aurora, Illinois. If he did not work, the State would suspend his benefits.

Petitioner testified that his supervisor at IDHS was a woman named Shirley who set his hours and assigned him various tasks. He did not recall her last name. Some of the tasks he performed were transporting boxes of papers and files, shredding papers, and other office type activities. IDHS provided him with an employee ID badge (Px 3) which identified him as a DHS clerical worker working in the WE program. This ID badge gave him access to the IDHS building.

Petitioner testified that he is a cabinet maker by trade. He testified that Shirley knew this and that she assigned him carpentry tasks around the DHS office, one of which, involved restructuring the slot mailboxes in the reception area of the DHS building. Petitioner testified that Shirley allowed him to use scraps of wood from the DHS building to construct the mailbox. He used his own tools, sometimes at his home. Petitioner testified that Shirley allowed him to work at home because that is where he kept some of his tools. The hours he worked at home counted toward his 20 hours.

Petitioner testified that on January 18, 2012, he was performing his assigned carpentry tasks at home. He was using a table saw to cut pieces of wood for the mailbox. As he was cutting, the saw blade caught his work glove and pulled his hand. The blade cut his left index finger. He testified that the finger immediately began to bleed and was extremely painful.

Petitioner received emergency medical care at Mercy Hospital whose records document Petitioner's report of cutting his left index finger while using a table saw at work. X-rays revealed a second mid-phalanx fracture and likely loss of bone. Physical evaluation of the finger revealed significant soft tissue lacerations. (Px 1). The emergency room physicians closed the wounds and splinted the fractured finger. The emergency room physician referred Petitioner for follow up to Castle Orthopaedics.

Petitioner testified he returned to work on January 19, 2012 and that he told Shirley about the injury. He testified everybody at work knew about his injury.

On January 19, 2012, Petitioner followed up with Dr. Velagapudi at Castle Orthopaedics who diagnosed a laceration of the flexor profundus tendon, loss of bone over the anterior surface of the middle phalanx, and macerated skin. Dr. Velagapudi indicated that Petitioner will need to adjust to using the middle finger and bypass the index finger because the index finger was now insensate. Dr. Velagapudi felt that Petitioner was not a good candidate for surgery. (Px 2). He recommended that Petitioner follow up in ten days.

Petitioner returned to the emergency room at Mercy Hospital on January 21, 2012, due to increased pain, swelling, and redness in his left index finger. He had developed an infection. His physician admitted him to the hospital for I.V. antibiotic treatment. He was discharged on January 23, 2012. (Px 1).

On February 3, 2012, Petitioner followed up with Dr. Velagapudi who removed Petitioner's left index finger stitches. The doctor noted that Petitioner had developed an eschar along the laceration site. Physical therapy was recommended. (Px 2).

On February 17, 2012, Petitioner followed up with Dr. Velagapudi. The doctor noted Petitioner might be a candidate for arthrodesis if the symptoms persisted. (Px 2).

On April 17, 2012, Petitioner followed up at Castle Orthopaedics with Dr. John Pinnello who noted ongoing loss of feeling in the injured finger. The doctor noted the severity of Petitioner's injury with the loss of tissue and bone was contributing to Petitioner's ongoing symptoms Dr. Pinnello noted Petitioner had persistent pain and numbness in the left index finger and no range of motion in the DIP joint. X-rays revealed osteopenia. Dr. Pinnello opined that Petitioner likely would be insensate distal to the laceration site permanently. In terms of the DIP joint, the doctor did not believe he would regain any motion. *Id.* However, for the PIP joint, the doctor recommended physical therapy to regain motion. *Id.*

Petitioner next followed up with Castle Orthopaedics on May 22, 2012. Dr. Pinnello noted that physical therapy was helping with scar management and range of motion, although Petitioner still could not pinch. Dr. Pinnello released Petitioner to follow up as needed. (Px 2).

Petitioner testified that he suffered a new injury to the left index finger on August 18, 2012. On that day, he was pushing an armoire at home when his hand slipped, striking his finger. Petitioner testified that he caught this finger while moving the armoire because it had been hanging out since the original injury. He received emergency room treatment at Mercy Hospital. X-rays revealed an acute extra articular fracture of the second middle phalanx. (Px 2).

Petitioner followed up at Castle Orthopaedics four days later. Dr. Pinnello noted Petitioner had minimal to no range of motion at the DIP joint, no active motion at the PIP joint, and that Petitioner remained insensate secondary to the original flexor tendon injury. Dr. Pinnello opined that Petitioner had suffered a new fracture at the malunion site of the original fracture. (Px 2). Dr. Pinnello recommended physical therapy and splinting.

Petitioner returned to Castle Orthopaedics on September 18, 2012. He was unhappy with his splint and the progress he was making. Dr. Pinnello fitted him with a new splint. Petitioner testified he last saw Dr. Pinnello on October 16, 2012. Dr. Pinnello noted Petitioner was not compliant with using the splint. Dr. Pinnello recommended no additional follow ups. Petitioner requested a release. (Px 2).

Petitioner testified that he was born on January 3, 1961. He testified that on the date of accident, he was married to Angelica Camargo. He testified he had one son under the age of 18, Alexis Brandon Camargo, who was born on February 27, 1999.

The Arbitrator observed Petitioner's left index finger which appeared to be discolored, red and displaying atrophy in the medial section as compared to his right index finger. His left index finger appeared to have decreased range of motion.

At the time of arbitration, Petitioner testified that his career as a cabinet maker was affected by his accident, because he cannot bend his left index finger to lessen his exposure to the blade when he cuts material. He experiences residual numbness in his finger tip. He further testified that the finger area remains painful and "cold." Petitioner does not take any medication for his pain.

Lorena Fellows testified for Respondent. She testified she was Petitioner's case worker on January 18, 2012. She testified that he was part of the WE program which was part of a larger TANF program. She testified that there was a work requirement for Petitioner's receipt of benefits. She confirmed that Petitioner performed his

work requirement at DHS in Aurora, Illinois. She identified his employee ID badge, (Px 3), and testified ID badges were required for WE workers at the DHS building.

CONCLUSIONS OF LAW

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

The Arbitrator concludes that Respondent was operating under the Illinois Workers' Compensation Act. Respondent is the State of Illinois. 820 ILCS 305 (1)(a)(1) defines the State of Illinois as an employer for purposes of the Act.

B. Was there an employee-employer relationship?

The Arbitrator concludes that an employment relationship did exist on January 18, 2012. Petitioner was receiving monetary and food TANF benefits. He was part of the WE (Work Experience) program. In order to receive benefits, he was required to work. Respondent's witness, Lorena Fellows, confirmed this work requirement. Petitioner testified his boss, Shirley, set his hours and assigned which tasks to perform. She also directed him where to perform these tasks. Respondent presented no contrary evidence. Based on the foregoing, the Arbitrator finds that an employment relationship did exist.

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

Petitioner testified that his supervisor, Shirley, assigned him to build mailboxes for the DHS Aurora office. She supplied the materials. She allowed him to make the necessary cuts at home because he had the equipment and tools there. On August 18, 2012, he was making mailboxes for DHS as directed by Shirley. He was making a cut with a saw at his home when the saw blade cut his left finger. The Arbitrator concludes that Petitioner was at a place Respondent reasonably could expect him to be performing a task he was assigned to do. His supervisor, Shirley, told him what to do and consented that he do it at his home. The use of a saw is an increased risk not faced by the general public. Therefore, the Arbitrator concludes that Petitioner suffered an accident which arose out of and in the course of his employment on January 18, 2012.

D. What was the date of the accident?

Petitioner testified that the accident took place on January 18, 2012. The medical records from Mercy Hospital from January 18, 2012 document that Petitioner cut his left index finger on a saw blade. (Px 1). The history contained in the medical records is the same history to which Petitioner testified at trial. Based on Petitioner's testimony and the corroborating hospital records, the Arbitrator concludes that the date of accident is January 18, 2012.

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

Petitioner testified he notified Shirley, his supervisor, about the injury on January 19, 2012. He further testified that everybody at DHS knew about his injury. Respondent presented no contrary evidence. Based on the foregoing, the Arbitrator concludes Petitioner gave timely notice.

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

Petitioner testified he had no prior injury to his left index finger. The medical records from Mercy Hospital and Castle Orthopaedics indicate that the injury caused bone loss, a fracture, a lacerated tendon, loss of motion, and loss of sensation in the left index finger.

The Arbitrator notes that Petitioner did suffer another fracture to the same index finger in August 2012. Petitioner testified that he hit that finger because of the loss of motion he had in that finger due to the work related injury at issue. The medical records document a fracture at the site of the malunion from the original

fracture. Based on the foregoing, the Arbitrator concludes that there is a causal relationship between Petitioner's current state of ill-being and the January 18, 2012 work related injury.

G. What were Petitioner's earnings?

Respondent's witness, Ms. Fellows, testified that Petitioner was entitled to benefits only if he worked. Petitioner received monetary and food assistance benefits for the work he performed. He testified his weekly benefits were $300.00. The benefits were placed on a card rather than paid by check. Respondent presented no contrary evidence to refute Petitioner's testimony regarding his weekly payments. Therefore, the Arbitrator concludes that Petitioner is average weekly wage is $300.00.

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

Petitioner testified he was born on January 3, 1961. The medical records from Mercy and Castle Orthopaedics, (Px 1, Px 2), corroborate this testimony. Therefore, the Arbitrator concludes that Petitioner's date of birth is January 3, 1961 and that he was 51 years old on the date of accident.

I. What was Petitioner's marital status and number of dependent children at the time of the accident?

Petitioner testified he married Angela Camargo in 1990. He testified he was married to her on January 18, 2012. The medical records indicate that Petitioner reported that he was married. Respondent presented no contrary evidence. Therefore, the Arbitrator concludes Petitioner was married on January 18, 2012. Additionally, the Arbitrator concludes that Petitioner had one child under the age of 18. Petitioner testified that his son, Alexis Brandon Camargo, was born on February 27, 1999. Respondent presented no contrary evidence.

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

The Arbitrator concludes that Petitioner's medical treatment was reasonable and necessary to cure the ill-effects of his injury. The records document that the treatment Petitioner received directly related to that injury. As such, the Arbitrator orders Respondent to pay Petitioner for the charges incurred at Castle Orthopaedics ($1,699.00) and Mercy Hospital ($14,954.03), subject to the fee schedule. The Arbitrator denies the emergency room charges from August 2012 as that injury was intervening.

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

Pursuant to Section 8.1(b) 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. 820 ILCS 305/8.1(b) states the criteria to be considered are as follows: (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. Applying this standard to this claim,

With regard to paragraph (i) of Section 8.1(b) of the Act: Petitioner did not undergo an impairment rating. Therefore, the Arbitrator places no weight on this factor.

With regard to paragraph (ii) of Section 8.1(b) of the Act: Petitioner testified he is a cabinet maker. This is the same type of job in which he was trained at the time of his accident. Petitioner testified he has ongoing problems performing his work as a cabinet maker due to the condition of his finger following the work related injury. Dr. Velagapudi indicated that Petitioner will need to adjust to using the middle finger and bypass the index finger because the index finger is now insensate. The Arbitrator is cognizant of the fact that cabinet

making and carpentry requires hand dexterity which has been compromised due to this accident, therefore, the Arbitrator places considerable weight on this factor.

With regard to paragraph (iii) of Section 8.1(b) of the Act: The Arbitrator notes that Petitioner is 57 years old and has many years of life and work expectancy to deal with his ongoing pain, loss of motion, and loss of sensation in his left index finger. The Arbitrator places significant weight on this factor.

With regard to paragraph (iv) of Section 8.1(b) of the Act: There is no evidence that Petitioner's future earning capacity has diminished as a result of this injury. The Arbitrator places little weight on this factor.

With regard to paragraph (v) of Section 8.1(b) of the Act: Petitioner testified that at the present time, his left index finger is numb and painful. It is discolored. He has decreased range of motion. He must use additional care when he uses it, especially when grabbing, lifting, and opening doors. He frequently hits the finger because he cannot bend it. It is cold weather sensitive. The medical records document Petitioner suffered bone loss (amputation), a lacerated tendon, and documented loss of sensation and range of motion. The Arbitrator places significant weight on this factor.

Therefore, after applying Section 8.1(b) of the Act in considering the relevance and weight of all factors for which evidence was presented, the Arbitrator concludes that Petitioner has suffered a statutory amputation. This entitles him to a minimum of 50% loss of the finger. Based on the other documented limitations to the finger, the Arbitrator concludes that Petitioner has sustained a 65% loss of use of his left index finger.

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

Judy Becker,
Petitioner,

20IWCC0099

vs.

NO: 13 WC 9007

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2018, is hereby affirmed and adopted.

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

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

There is no bond 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 Circuit Court.

DATED: FEB 11 2020
o1/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 IWCC0099

BECKER, JUDY
Employee/Petitioner

Case# **13WC009007**

13WC009009
13WC009010
13WC009011

UNITED THERAPIES
Employer/Respondent

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5122 PORRO NIERMANN LAW GROUP
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

20IWCC0099

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

JUDY BECKER
Employee/Petitioner

v.

UNITED THERAPIES
Employer/Respondent

Case # **13** WC **9007**

Consolidated cases:
13 WC 9009, 13 9010, and 13 WC 9011

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 29, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **JANUARY 14, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**57,949.32**; the average weekly wage was $**1,114.41**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

ORDER

The Arbitrator refers all orders relating to temporary total disability benefits, medical expenses and permanent partial disability benefits to the Arbitration Decision for Application 13 WC 9007.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 18, 2018
Date

OCT 1 9 2018

20IWCC0099

JUDY BECKER v. UNITED THERAPIES

13 WC 9007, 13 WC 9009, 13 WC 9010, & 13 WC 9011

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on November 29, 2017.[1] The issues in dispute were accident and the date of accident, notice, causal connection, medical bills, TTD benefits, and the nature and extent of the injury. (Arbitrator's Exhibits 1-4). The parties requested a written decision, including findings of fact and conclusions of law, and agreed to receipt of the same via e-mail. (Arbitrator's Exhibits (*hereinafter*, AX) 1-4).

FINDINGS OF FACT

Petitioner testified that she was employed by the Respondent on *August 19, 2010* as an office coordinator and credentialing coordinator up until May 2013 (Transcript 24), when she was terminated because her FMLA period ran out. (Transcript (*hereinafter*, Trans.) 25). She testified she had worked for the Respondent for 18 years. (Trans.104). She testified that starting August 2010, she primarily did credentialing work which she described as involving heavy lifting and pulling and grasping hard copy files. (Trans.25). She testified that all of the credentialing files were for physicians. (Trans.28). She testified that she had approximately 180 to 200 of those [credentialing] physician files in her office back in 2010. (Trans.29). She testified that there were a lot of documents that needed to be filed into credentialing folders on a daily basis. (Trans.26). She explained that credentialing files were legal size, made of cardboard, with cardboard inserts. (Trans.27). She testified that some of them were quite thick – five to six inches thick and containing all types of information. (Trans.27). She testified they were kept in a filing cabinet that was probably up to her nose or the top of her head. (Trans.30). She testified she is 5'5" in height. (Trans.30). She testified she had three sets of cabinets, each with three drawers, and each of the drawers had a top that pulled open. (Trans.30). She testified that she had to pull the drawers toward her to access the files. (Trans.31).

Petitioner testified that from 2008 to 2011, she would take files out of the cabinets when she needed to file a document on a daily basis. (Trans.27, 36). She testified she would

[1] During the hearing of these matters, with all parties present and represented by counsel, the Petitioner's fifth claim, 13 WC 9008, was dismissed for want of prosecution.

open the file cabinet, reach in, pull and grasp, and sometimes struggle to pull the files out because they were tightly packed in. (Trans.33, 34). She testified she could only grasp with her fingers because it was impossible to get her fingers down in between a whole file. (Trans.34). She testified she would have to raise her arms at least shoulder height, or two, four or six inches higher than her shoulders. (Trans.35). She testified there was no other file cabinet space available. (Trans.33). She testified she did not have a step stool. (Trans.35).

Petitioner testified that she worked eight-hour days. (Trans.36). She testified that on average she would spend three to five hours a day pulling/replacing files. (Trans.37). She testified that for the remaining times, she probably ran reports from a program on the computer. (Trans.37, 38). She testified she would then have to file the reports into the physicians' folders. (Trans.38). She testified she could run dozens of reports a day but would not work on all 200 reports in a day. (Trans.38). She testified she would hole-punch the documents and place them in a physician's file by attaching them to prongs on the inside of the file. (Trans.39). She testified that she would then put the file back into an already tightly-fitted drawer. (Trans.40, 41). She testified the files were not sticking out and she could close the cabinet door. (Trans.41). She testified that no one else had credentialing responsibilities between 2008 and 2010. (Trans.42). She testified she continued to do this type of work with the files until she left. (Trans.42).

Petitioner testified that she also worked with close to 100+ patient files per week, or month. (Trans.42, 43). She testified that patient filing cabinets were also three-drawer filing cabinets and would get very crammed and full. (Trans.44). She testified that when she took over the credentialing coordinator position, she still had to work with the patient files. (Trans.44). She testified that before she got the credentialing duties added onto her job duties, she was managing the front office and helping to schedule and "put out fires." (Trans.44). She testified she made sure the office was running smoothly and that they were fully staffed. (Trans.45). She testified that she occasionally had someone assist in the patient file work. (Trans.45). She testified that her job activities were interspersed during the course of a day. (Trans.53).

Petitioner saw Dr. Roman Dreyer at Dreyer Medical Clinic on *August 4, 2010*. (Petitioner's Exhibit 4, p.1111). Dr. Dreyer noted that Petitioner's pain started three weeks prior, gradually, with no trauma or injury. He noted she had a problem lifting light weights. His assessment was severe elbow pain with a concern for severe tendonitis. He prescribed 600 mg of ibuprofen and recommended an elbow strap and no lifting of weights or repetitive motion. He opined that if there was no improvement, then he would order an MRI of the right elbow. (Petitioner's Exhibit (*hereinafter*, PX) 4, p.1112).

Petitioner testified that on *August 19, 2010*, while performing credentialing file work she noticed her [right] elbow was beginning to hurt and continued to get worse. (Trans.46). She testified that she realized when she was pulling on files is when she had the most pain that was constant, chronic, and would never go away. (Trans.47).

Petitioner testified she sought treatment with Dr. James Anderson on *August 19, 2010*. (Trans.47). She testified she had reported to Dr. Anderson that she worked as a clerk in an office and that pulling files at work was bothering her. (Trans.47, 48). She testified that she did not tell Dr. Anderson anything specific about her work duties that caused her to see him because he did not ask. (Trans.123). Dr. Anderson's note of August 19, 2010 provides that Petitioner did some weight training which may have aggravated her right elbow. (PX4; p.1127). He noted that Petitioner had treated with a tennis elbow strap but had no other specific treatment. His assessment was right lateral epicondylitis. (PX4; p.1127). He gave Petitioner a corticosteroid injection into the *right elbow* on the same date. Petitioner testified she had about two to three weeks of temporary relief from the injection. (Trans.49).

Petitioner testified that while speaking with her supervisor, Patti Murphy, in person at Respondent's LaGrange office just before her August 19, 2010 appointment, she reported that her [right] elbow was hurting, and she associated it with pulling files. (Trans.60-62). She testified she told Patti that she thought it would be a good idea if the files were scanned. (Trans.63). She testified that Patti told her to just go to the doctor and she would be fine. (Trans.63).

Petitioner saw Dr. Roy Henderson on *September 29, 2010*, also at Dreyer Medical Clinic. Dr. Henderson noted that Petitioner told him her pain started in July 2010, that she sat at a desk most of the day, and did Jazzercise and weight lifting three to five times per week. There was no mention of any other specific work activities. Dr. Henderson had the same impression as Dr. Anderson. (PX4, p.1144).

Petitioner testified she did physical therapy and reported to the therapists what she was doing at work that was causing her symptoms. (Trans.48). Petitioner did her therapy at Dreyer Medical Clinic. A progress note for a therapy visit on *October 4, 2010* provides that Petitioner was an office manager and her duties were keyboarding, filing and writing, and Jazzercise is listed as a recreational activity. (PX4, p.1152).

Petitioner next saw Dr. Roy Henderson on *November 18, 2010*. He noted that Petitioner's right elbow pain was worsened by using her hand, picking up a coffee cup, and pulling files at work/gripping. That was the extent of work activities mentioned. He had the same impression as at the last visit. Dr. Henderson provided Petitioner with a cortisone injection into the right elbow. (PX4, p.1213).

Petitioner next saw Dr. Dreyer on *January 10, 2011* for routine lab work and follow up. Dr. Dreyer noted persistent pain and swelling in the right elbow and diagnosed elbow tendonitis. He recommended an MRI. (PX4, p.1246).

Petitioner had an MRI of her right elbow done on *January 14, 2011* at Dreyer Medical Clinic upon Dr. Dreyer's order. The MRI revealed a full-thickness tear of the common extensor tendon at the origin of the extensor carpi radialis brevis tendon [lateral epicondyle] and a small elbow joint effusion. (PX4, p.1250). Petitioner testified that she believed she told Patti a few days after this MRI of the elbow was done, that the MRI showed a torn tendon. (Trans.63, 64). She testified that she told Patti because she felt it was work-related, she was in pain, and struggling to do her job. (Trans.65).

Petitioner saw Dr. Neena Szuch, also at Dreyer Medical Clinic, on *January 21, 2011* for right lateral epicondylitis. The visit note contained no specific history, other than Petitioner had some physical therapy and used a forearm brace without adequate relief of symptoms. The visit note made no mention of any of Petitioner's work activities. (PX, p.1275). An x-ray of the left elbow revealed some spurring at the distal humerus. (PX4, p.1279). Dr. Szuch diagnosed right lateral epicondylitis and offered Petitioner a wrist brace. (PX4, p.1275).

Petitioner described the brace as going through the thumb and over the hand and up to right below the elbow, which fastened on the bottom. (Trans.56). She testified the brace did not interfere with flexion of the elbow joint. (Trans.56). She testified she did not hide the brace from co-workers. (Trans.55).

Petitioner saw Dr. Brian Hubbard, also at Dreyer Medical Clinic, on *February 19, 2011* for a complaint of bilateral upper and lower back pain which had been present for one day and started when she was at rest. (PX4, p.1304). There was no mention of any of Petitioner's work activities. The diagnosis was lumbar and thoracic strain. (PX4, p.1305).

Petitioner's next right elbow related treatment was on *June 24, 2011* with Dr. Roy Henderson. He noted that there was no mechanism of injury and that, again, Petitioner sat at a desk most of the day, and did Jazzercise and weight lifting. He reviewed the right elbow MRI done on January 14, 2011 and noted the full-thickness tear at the origin of the extensor carpi radialis brevis. He noted that Petitioner had seen Dr. Szuch who recommended non-operative treatment. Dr. Henderson's impression was right lateral epicondylitis with a full thickness tear at the wrist extensor insertion. He referred Petitioner to Dr. White. (PX4, p.1380).

Petitioner testified that she did Jazzercise two to four times a week. (Trans.66, 67). She testified it involved movements with feet and it was a dance class (Trans.66). She testified that some exercises can be done with two-pound weights, which she would hold and do whatever with them. (Trans.66, 67). She testified she did not notice any problems with her elbows or

shoulders while doing Jazzercise. (Trans.67). She testified she would lift the weights up to her shoulder and put them back down. (Trans.68).

Petitioner testified that in 2011 the records for credentialing started being scanned. (Trans.58). She testified that she had been asking for files to be scanned ever since she took over the credentialing position because of the difficulty in their physical presence and her ability to access those files. (Trans.58). She testified that at that time there were still physical patient files and physician files for physicians coming up for reappointment. (Trans.59).

Petitioner first saw Dr. Thomas White, also at Dreyer Medical Clinic, on *July 14, 2011*. He noted that she was a right-handed office manager who came in with a year's worth of pain in the lateral side of her right elbow. He noted her treatment history, but no specific work activities were mentioned. He reviewed the MRI of the right elbow. His assessment was chronic lateral epicondylitis in the right elbow and provided a Depo-Medrol and Marcaine injection. (PX4, p.1386).

Petitioner's next orthopedic-related visit was on *October 17, 2011* with Dr. Sunil Malkani, also at Dreyer Medical Clinic. She testified she complained about her *left shoulder and neck*. (Trans.69, 70; PX4, p.1502). Dr. Malkani noted the visit was for acute neck pain located in the back of the neck and radiating into the left shoulder. He noted the pain was dull. He noted there was no associated trauma, but that Petitioner sat in front of a computer all day. He diagnosed musculoskeletal neck pain and trigeminal neuralgia syndrome. (PX4, p.1504). Petitioner testified that Dr. Malkani recommended some physical therapy and prescribed a muscle relaxant. (Trans.70; PX4, p.1504). An x-ray of the neck was done on the same date and revealed mild degenerative changes, moderate left-sided facet hypertrophy, moderate left neural foraminal stenosis at C4-C5, and mild left neural foraminal stenosis at C5-C6 and C6-C7. (PX4, p.1507).

A physical therapy progress note dated *November 4, 2011* provides that Petitioner complained of pain over her cervical spine and into her left upper trapezius. The onset date was October 27, 2011 with no known incident. The subjective report was that symptoms were aggravated by sitting at a desk keyboarding and driving ("at times rests elbow on window"). It is noted that Petitioner did not have therapy before for these symptoms because she never had them before. (PX4, p.1527).

Petitioner called or emailed Dreyer Medical Clinic on *November 14, 2011* and Ernestina Sanchez, a nurse, documented the message. Petitioner asked whether it was "ok" for her to continue Jazzercise and other home exercise. The message was relayed to Dr. Farah K. Hussain, and Dr. Hussain responded to Petitioner to "go ahead and resume your exercise." (PX4, p.1550).

Petitioner saw Dr. Barry Abrams at Dreyer Medical Clinic on *March 23, 2012* due to an injury to her right foot after tripping and falling the night before. She was diagnosed with a sprain of the foot. (PX4, p.1614).

Petitioner's next orthopedic-related visit was on *August 23, 2012* with Dr. Thomas White. She testified she complained about her *right shoulder and arm*. (Trans.73; PX4, p.1697). Dr. White noted that a complaint of pain in the superior aspect of the right shoulder, which bothered Petitioner claimed bothered her particularly at night, and sometimes radiated down into her right arm. He noted that Petitioner did not recall any "recent or remote injury or change in activity." Dr. White assessed impingement syndrome. He wanted to rule out a rotator cuff tear. He provided an injection of Depo-Medrol and Marcaine into the subacromial space. (PX4, p.1697). There were no work-related activities mentioned at this visit. Petitioner testified that after she made this appointment, she told Patti Murphy over the phone that she was seeking treatment for her right shoulder. (Trans.82, 83). Petitioner testified that she also told Patti the same thing she had been telling her for months – that the pulling and grasping of the files were hurting her shoulder and elbows. (Trans.84). She testified that "they" never wanted to scan the files or alleviate that or accommodate her in any way, even knowing Petitioner was having pain from it. (Trans.84).

Petitioner had an MRI of the right shoulder done at Dreyer Medical Clinic on *November 13, 2012*. The reason for the MRI listed on the report was that Petitioner had right shoulder pain for six months without antecedent injury. The MRI revealed marked supraspinatus and lesser infraspinatus tendinopathy and a partial-thickness articular surface supraspinatus tear without a full-thickness rotator cuff tear demonstrated. There were also degenerative findings. (PX4, p.1744).

Petitioner followed up with Dr. White on *November 15, 2012*. Dr. White had reviewed the MRI and noted it revealed supraspinatus and infraspinatus tendinopathy with probable partial-thickness rotator cuff tear. He discussed with Petitioner a shoulder arthroscopy, as Petitioner had decided ahead of time that she did not want therapy. Petitioner asked that the surgery be done after the holidays. (PX4, p.1763).

Petitioner had a preoperative visit with Dr. Sharon Ollee at Dreyer Medical Clinic on *December 11, 2012*. Dr. Ollee noted a history of pain located in the superior aspect of the [right] shoulder which was worse at night and sometimes radiated down into the right arm. It is noted that Petitioner denied any preceding injury or change in activity. It is noted that Petitioner worked as an office manager at a surgery center. There was no mention about any specific work activities. (PX4, p.1797).

Petitioner next saw Dr. White on *December 19, 2012*. She testified she had told Dr. White that she did not recall an injury to her *left elbow*, but that she had been using her left arm a lot trying to protect the right. (Trans.87). Dr. White noted that Petitioner did not recall any injury, but that about a month before, she began getting pain in the lateral aspect of the left elbow. Dr. White further noted that Petitioner reported she had been using her left arm a lot trying to protect the right. Dr. White diagnosed left elbow pain and lateral epicondylitis. He provided an injection of Depo-Medrol and Marcaine to Petitioner's left elbow. (PX4, p.1805).

Petitioner testified that she probably told Patti the next day after her December 19, 2012 doctor's visit, or another day after that, that she developed pain in her left side. (Trans.88). She testified that she did not have a lot of conversations with Patti about treatment on her different body parts. (Trans.88). Petitioner testified that she got a left elbow cortisone injection on December 19, 2012 by Dr. White. (Trans.89).

Petitioner had surgery on her right shoulder by Dr. White on *December 28, 2012*. (PX4, p.1814). She testified that she went off work at that time and was off until she attempted to go back to work for two weeks and a couple of days starting *March 23, 2013*. (Trans.77, 78). The surgery was a right shoulder arthroscopy with rotator cuff repair and subacromial decompression. The preoperative and postoperative findings were right shoulder impingement with rotator cuff tear. (PX4, p.1814). Petitioner testified that she thought there was some improvement from the surgery, but it took an unusually long time. (Trans.77). Petitioner testified that while recuperating from her right shoulder surgery, she was having chronic pain in her left elbow. (Trans.86).

Petitioner testified she obtained a brace for her left arm in December 2012. (Trans.57). She testified she would not cover up her braces on either the right or left when Patti came to visit the office. (Trans.85). Petitioner testified she saw Patti roughly once a week. (Trans.85). She testified that Patti never suggested filing a workers' compensation case. (Trans.85).

A Dreyer Medical Clinic physical therapy note dated *January 18, 2013* provides that Petitioner reported falling down two stairs the previous night as she was going into her garage. She had been on a cell phone while wearing her sling but did not land on her right shoulder. She went to a walk-in care facility in the morning. The note provides that Petitioner reported no increased pain to her right shoulder due to the fall. (PX4, p.1864).

Another physical therapy note dated *January 22, 2013* provides that Petitioner reported pain in the anterior lateral portion of her right shoulder, which was different than what she had experienced, and it had started between 24-48 hours earlier. She reported that she did not know if she slept wrong or did something she was not supposed to do. (PX4, p.1878).

Petitioner saw Dr. White on *January 28, 2013*. Dr. White recommended continuing physical therapy and provided a note for Petitioner to be off work for another month. Here original work status was due to run out on February 8, 2013. (PX4, p.1908).

Petitioner returned to see Dr. White on *March 18, 2013*. It is noted that Petitioner advised she needed to get back to work by the end of the week because her FMLA would run out. However, Dr. White offered to continue Petitioner's disability. The note provides that Dr. White told Petitioner that any restrictions were acceptable to him and it really depended on what was acceptable to her employer. After having Petitioner go over her job with him, Dr. White suggested a five-pound lifting limit and no overhead use. (PX4, p.2035). Petitioner testified that she did not believe Dr. White placed any restrictions on her for the time she returned to work. (Trans.80).

Petitioner testified that during the work trial period *[March 23, 2013 through April 8, 2013]*, it was very difficult to get through a whole eight-hour day, especially sitting at the desk or doing any kind of grasping or pulling or lifting. (Trans.80). She testified that keyboarding was also difficult. (Trans.80). She testified that her right shoulder and both elbows were affected by these activities. (Trans.81, 82). She testified she tried not to do any lifting with her right arm. (Trans.129).

Petitioner testified she filed her cases at the Commission in the first quarter of 2013, before she was terminated by Respondent. (Trans.102, 103). The record reflects that Petitioner's Applications were all filed on *March 19, 2013*. She testified that nobody from the Respondent contacted her before she was terminated to discuss any of the claims. (Trans.103).

Petitioner did not return to see Dr. White, but instead saw Dr. Kenneth Schiffman at Hinsdale Orthopaedics for the first time on *April 9, 2013*. Dr. Schiffman noted that Petitioner sought a second opinion on her right shoulder and bilateral elbow pain. It is noted that she complained of pain with typing and pulling. That was the extent of work activities mentioned. Dr. Schiffman diagnosed status post right rotator cuff repair and bilateral lateral epicondylitis. He suggested continued physical therapy and placed Petitioner off work. (Respondent's Exhibit 20, p.012-014).

Petitioner saw Dr. Schiffman again on *May 10, 2013* and reported that her right shoulder pain woke her up at night, but that therapy was progressing well, and she had limited range of motion due to elbow pain. Dr. Schiffman recommended continued physical therapy on the right shoulder as well as on the left elbow. He provided a referral to Dr. Kirincic for pain management program to help with sleep and manage the pain in the elbow. He kept Petitioner off work for the next five weeks. (Respondent's Exhibit (*hereinafter*, RX) 20, p.008-009).

Petitioner testified that her last visit with Dr. Schiffman was on *June 20, 2013*, when he released her from care with permanent restrictions. (Trans.78). He noted that Petitioner's right shoulder was doing well but she had persistent [left] elbow pain secondary to lateral epicondylitis. He placed restrictions of no lifting more than five pounds, no overhead reaching, no repetitive motion for the elbow or wrist, and minimal keyboard use. He advised Petitioner to return as needed. (PX2). Petitioner testified that Respondent did not offer her a position to accommodate Dr. Schiffman's permanent restrictions. (Trans.94). Petitioner testified she would not be able to return to her previous job because she does not have the stamina for it, she would be in pain, and she would not last more than an hour at most probably. (Trans.94). She testified she has been unable to do her job between December 2012 and today. (Trans.95).

Petitioner testified that she was in a supervisory position with Respondent. (Trans.105). She testified that she understood the policy was for people under her supervision to report accidents or injuries to her. (Trans.105). She testified it was not something she/they were specifically trained on. (Trans.105). She testified she was responsible for a portion of the policy manual. (Trans.105, 106). Then she testified that she would not have contributed to the policy concerning reporting accidents and injuries. (Trans.106). She testified that the policy would have been drafted by a supervisor with more authority than herself. (Trans.106).

Petitioner testified she filled out an accident report in 2000. (Trans.106, 107; RX3). She identified her handwriting on Respondent's Exhibit 3 and identified it as an Employee Report of Occupational Injury or Illness. (Trans.107; RX3). She confirmed that her manager's name, Patti Murphy, is also listed on the report, which is dated February 23, 2000. (Trans.108). Petitioner testified that she was aware that the "company" [Respondent] had procedures in place for reporting accidents and injuries, and that she followed that. (Trans.108). Petitioner testified that she did not file or complete any accident reports for the current claimed accidents/injuries, but instead requested FMLA leave for the surgery on her right shoulder. (Trans.108).

Petitioner testified that she signed a form called a Certification of Health Care Provider and dated 2007. (Trans.110; RX 5). She testified she had requested Family Medical Leave on a prior occasion due to shingles. (Trans.111). Petitioner testified that Dr. White did complete a form for her to be off work in 2012 for her right shoulder surgery. (Trans.112). She testified that Dr. Malkani completed a form for her to be off work in 2011 for injuries she claims occurred at work. (Trans.112, 113).

When asked why she requested Family Medical Leave instead of filing for workers' compensation, Petitioner testified that she did file for workers' compensation and did notify her supervisor that she was hurt at work. (Trans.113). She testified that her supervisor told her to go to the doctor. (Trans.113). Petitioner testified that she did not tell anyone else [at work] other than Patti Murphy of her injuries from work activities. (Trans.131). Petitioner testified

that she had access to accident reports that could be completed for a work-related injury. (Trans.115). When asked if it was up to her as an employee of the company to complete an accident report if there was an accident or injury that occurred at work, Petitioner testified "yes" and that the circumstances of "that particular accident report" [the 2000 accident report], were that the nurse at the center pulled that report and filled it out and she signed it, because the nurse treated her foot that hit the door. (Trans.116).

Petitioner testified that she had her own office at United Therapies up to 2011, but after that she was at a desk with other employees in the front area. (Trans.116). Petitioner testified she did not have an assistant during the time she was with Respondent. (Trans.117). Petitioner testified that Joanna Guerra was not her assistant, but her subordinate and she was Joanna's supervisor. (Trans.117). Petitioner testified she did not ask Joanna to do her filing, or to pull files and bring them to her. (Trans.118). Petitioner testified that she would not ask Joanna to pull credentialing files because no one handled the credentialing files but Petitioner. (Trans.119). Petitioner testified that she would ask Joanna to pull and bring her a patient file. (Trans.119). Petitioner testified that she had control over how many files she could put in a cabinet. (Trans.119). Petitioner testified that when she was in her own office with the file cabinets, it was only possible to pull one file at a time, but she might have pulled several files to work on so as not to have to keep pulling and cramming. (Trans.117). She testified the files may have come out of different drawers. (Trans.117). Petitioner testified she was private about her health issues and treatment at work. (Trans.120). She testified that one of the files that she worked with weighed as much as a two-pound weight. (Trans.122). She testified that it was not an eight-hour, nonstop activity of pulling out files and putting back files, and that she did not type on a keyboard eight hours a day nonstop. (Trans.122). She testified that some of her activities [at work] involved being on the phone. (Trans.123).

She testified that the activity of running reports involved entering something into a computer and the reports would be printed out on a printer. (Trans.123).

Petitioner testified that she had to move files to a temporary location while the LaGrange facility was being remodeled in 2011. (Trans.126, 127). She testified she had to pack the files into boxes herself. (Trans.25). She testified that the Respondent did not hire a moving company to move files. (Trans.127). Then she testified that some of the files that were put in boxes during the remodel were moved by a hired company. (Trans.127). Petitioner testified that boxes of files she was working on went to the new location with her. (Trans.127).

Petitioner identified at trial a letter from Star Insurance addressed to her and dated *April 3, 2013* acknowledging a report of injury. (Trans.138, 139; RX16). She identified the date of injury in the letter as December 19, 2012. (Trans.139; RX16). Petitioner testified she had not

received any letters concerning any of her claims from any other insurance company prior to the April 3, 2013 letter from Star Insurance. (Trans.139).

Petitioner identified at trial a Memo dated *April 18, 2013* from Jackie Ladewig to her concerning a grant of unpaid personal leave of absence through *May 14, 2014*. (Trans.135, 136; RX12). She testified that it concerned recovery for her right shoulder surgery and bilateral elbows, although that specific information was not in the memo. (Trans.136; RX12). Petitioner agreed that the Memo requested that Petitioner advise Respondent of her status and ability to return to work on or before *May 14, 2013*. (Trans.136; RX12). Petitioner testified she told Respondent that she did not have a doctor's appointment until June and that is when she would know. (Trans.137; RX12). She testified that Respondent had a work status from Dr. Schiffman stating she would be off. (Trans.137; RX12).

Petitioner identified at trial a letter dated *May 17, 2013* from Patti Murphy to her which was a letter of termination. (Trans.137; RX14). Petitioner confirmed that the letter notified her that she had exhausted all 12 weeks of Family Medical Leave. (Trans.137, 138; RX14). Petitioner testified she had been unable to return to work by May 17, 2013. (Trans.138). Petitioner testified that she notified Respondent in *March 2013* of her work-related injuries and was terminated two months later. (Trans.149).

Petitioner testified there is an outstanding bill from ATI Physical Therapy for therapy concerning her right shoulder and both elbows, but primarily the left elbow and right shoulder. (Trans.96, 97; PX3). Petitioner testified she wasn't aware of an outstanding charge by Dr. Schiffman at Hinsdale Orthopaedic Associates. (Trans.97; PX2). Petitioner testified she is not aware of any outstanding balance for any treatment at Dreyer Medical Clinic. (Trans.98; PX4). Petitioner testified that her personal insurance through Respondent paid for treatment. (Trans.98). She testified that the insurance stopped when she was terminated on May 17, 2013. (Trans.98, 99). Petitioner testified she received short-term disability payments from the date of her surgery [December 28, 2012] up to March 22, 2013, and then from April 9, 2013, when Dr. Schiffman released her from care, through June 20, 2013. (Trans.100, 101; RX22). She testified she thought she received the short-term disability payments as part of the FMLA process. (Trans.101).

Petitioner testified at the time of the trial that her left shoulder is better than her right shoulder. (Trans.71). She testified that sometimes she cannot unload wet clothes out of a washing machine and put them into the dryer, and she cannot load groceries into the back of her car. (Trans.71, 90). She testified her husband must go shopping with her. (Trans.71). She testified her husband carries the laundry baskets of folded clothes upstairs and he helps to load and unload groceries. (Trans.91).

She testified she cannot do any kind of scrubbing or cleaning motion or lift anything too heavy because she feels weakness and has muscle spasms in both elbows from time to time. (Trans.90). She testified she notices the pain when she keyboards for about 15 to 20 minutes. (Trans.51). She testified she still has issues with her right elbow being tremendously weak and has pain located on the outside of her elbow. (Trans.51). She testified she notices pain and swelling in her left elbow that never completely goes away. (Trans.89). She testified she is not planning to get anymore treatment for her left shoulder. (Trans.72). She testified she has no plan to go out and look for work. (Trans.103, 104).

Petitioner testified that the most she can do at a gym is the treadmill. (Trans.92). She testified she cannot participate in any kind of sports-like activities and must be careful with even what she wears sometimes if it is difficult to put on or take off because it requires over-extension of her arms. (Trans.92). When asked what sports she is unable to do that she used to do, Petitioner testified she is unable to ride a bike like she did before. (Trans.130). She testified that gripping the handlebars, squeezing the brakes, and leaning forward while bike riding is difficult on her elbows. (Trans.170). She testified that her husband had not helped her put her boots on the day of trial because they zip [up], but he had helped her with her coat. (Trans.130). Petitioner testified she is not "whole anymore." (Trans.92, 93). Petitioner testified she has good and bad days and tries not to take any pain medication stronger than Aleve or Advil. (Trans.93). Petitioner testified she has not worked in an employment setting since terminated by Respondent, and not since released by Dr. Schiffman. (Trans.93).

Joanna Guerra-Barr testified that she works for the Respondent, United Therapies and started on June 23, 2010. She testified that Petitioner was her former manager. She testified that her job duties were/are to disassemble/assemble charts, get labs, file paperwork whenever needed, and pass out faxes. She further testified that sometimes she helps patients change whenever they need it and helps with translations from Spanish to English. (Trans.178). She testified that she did filing and would file for patients and doctors. (Trans.179). She testified that prior to switching to scanning, she would pull patient charts and file any paperwork in them. (Trans.180). She testified that doctors' file cabinets were in a "mobile room" and some were in Petitioner's office, but patient files were in the front office. (Trans.181). She testified there was a time when Petitioner had an office and then she no longer had an office. (Trans.181). She testified that the reason for the change was because the building [in LaGrange] went into construction in the middle of 2011 for the purpose of becoming am ambulatory surgery center. (Trans.182).

Joanna testified that while working at United Therapies when Petitioner was her manager, Petitioner would ask her to file for her. (Trans.184). She testified that Petitioner would ask her to file some of the doctors' credentialing paperwork for her. (Trans.184, 185).

She testified that Petitioner showed her where everything went so Joanna could help her out. (Trans.185). She testified that she did all the filing. (Trans.219). Joanna testified that Petitioner would show her how to look on the computer to check whether a doctor's license was current. (Trans.185). She testified that she filed for Petitioner on a daily basis and did the majority of filing for Petitioner. (Trans.186). She testified that when Petitioner wanted files boxed, she would show Joanna where the paperwork went and tell Joanna to box them up. (Trans.231).

Joanna testified that she is 5'2" and the filing cabinets were no higher than 5'3" or 5'4". (Trans.187). She testified that there were on average 40 sheets of paper in a patient file, and around 60-70 sheets of paper in each physician file. (Trans.188). She testified that if she did not have to schedule or check in a patient, she would file. (Trans.189). She testified she never had difficulty removing a file out of or placing a file into a cabinet, whether it was a patient or physician file. (Trans.190).

Joanna testified that after moving back into a remodeled LaGrange office, her seat was at the front desk, along with Zulema, a co-worker, and Petitioner. (Trans.196). She testified that she knew that Petitioner's job duties were to supervise her and Zulema, and also to do credentialing for the doctors and anesthesiologists. (Trans.199). She testified that she had opportunities to observe Petitioner during the time she was in the front desk area. (Trans.200, 201). She testified she had observed her on the internet, using the computer keyboard, and using the phone. (Trans.201, 202). She testified that she never observed Petitioner lifting boxes full of files during the time she worked with her. Joanna testified that she did observe Petitioner putting files into and taking files out of a cabinet, but she never observed Petitioner having difficulty doing that. (Trans.202, 203).

Joanna testified that Petitioner was very quiet about whatever she felt but complained about her shoulder or whatever was hurting her at the time. (Trans.203, 219). She testified that Petitioner would not be specific as to why. (Trans.203). She testified that Petitioner never told her she injured herself by doing something at work, during the time she worked with her. (Trans.203). She testified about the procedure she was aware of in the event of an accident or injury. (Trans.204). She testified that one would have to go to their manager and let them know, and that there was an incident report to fill out. (Trans.204, 205). She testified she was made aware of the procedure because "[w]e get trained on it, and also it's in our policy." (Trans.205). She testified that if she had become injured or had an accident at work, she would tell Petitioner. (Trans.205). She testified that Patti Murphy showed up at the office once or couple of times weekly. (Trans.235).

Kathleen Duprey-Tagge testified that she knows Petitioner from working with her at United Shockwave Therapies (United Therapies/Respondent). (Trans.256). She testified she started with Respondent in January 2003 and left in September 2010. She testified she became

the fixed site manager for LaGrange, Park Ridge and the Hinsdale facility, but primarily worked in Park Ridge. (Trans.257). She testified she did not have an office in LaGrange but would go and visit and meet with employees there. (Trans.257, 258). She testified that Petitioner reported to her from about 2005 or 2006 until she left in 2010. (Trans.258). She testified she was familiar with Petitioner's duties and had an opportunity to see Petitioner working while she was there. (Trans.259). She testified that when Petitioner was in the front desk space, Petitioner would sign in patients, answer phones, schedule patients, and prepare and assemble patient charts. (Trans.259). She testified that Respondent kept physician files for credentialing. (Trans.262). She testified that patient files were kept for a little while and purged every quarter.

Kathleen testified that when Petitioner had her own office, to the right of her desk there were three tall file cabinets, each containing four drawers. (Trans.263). Kathleen testified she had occasion to open the file cabinets and take physician files out when she was looking for physician information. (Trans.263, 264). She testified that some of the files could be full at times, but she does not believe she had difficulty taking a file out. (Trans.264).

Kathleen testified that employees under her supervision were informed through regular staff meetings of what to do if they became hurt at work. (Trans.265). She testified that the meetings occurred every one to two months and she was in attendance, along with supervisors and Patti Murphy. (Trans.266). She testified that Petitioner attended those meetings. (Trans.266). Kathleen testified that she was someone who prepared an accident/incident report and she had prepared accident/incident reports during the time she worked for Respondent. (Trans.267). She testified that based on her recollection, Petitioner never told her she injured herself from something she did while working. (Trans.267, 268).

Kathleen testified she would have prepared an accident/incident report if Petitioner had told her she was injured at work, as that was her practice. (Trans.268). She testified that based on her recollection, Petitioner never asked her to prepare an accident/incident report and did not do anything at work and then complain about being injured. (Trans.268). She further testified that to her recollection, no employee with Respondent told her that Petitioner had been injured while working. (Trans.268).

Kathleen testified that Petitioner's job for part of the time was organizing and keeping the credentialing files. (Trans.272, 273). She testified that based on her recollection, she didn't recall ever seeing Petitioner's forearm brace covering the thumb and coming around the side and coming up the forearm. (Trans.282). Kathleen testified that there were accident reporting procedures for employees and managers online and a hard copy. (Trans.284). Kathleen testified that she had met with Patti Murphy once or twice after she left the company and they did not talk about Petitioner or anything to do with this case. (Trans.286).

Thomas Peer testified that he knows Petitioner from working with her at United Therapies from 2010 through 2012-2013 as a fixed site manager. (Trans.293). He testified he took Kathleen's position when she left. (Trans.294). He testified that Petitioner reported to him. (Trans.294). Thomas testified that he was a mobile worker and worked at Respondent's both centers, Park Ridge and LaGrange. (Trans.294, 295). He testified he was mostly at the LaGrange facility, starting around 2012-2013. (Trans.295). He testified that prior to that, he went to the LaGrange facility about once or twice a week to meet with staff, keep track of operations and make sure the facilities were running correctly and schedules were on track. (Trans.295).

Thomas testified that he met with Petitioner every time he visited the [LaGrange] facility to discuss how scheduling was going with the doctors, any concerns or issues with the facilities, staff, and patients, and financial concerns. (Trans.296). He testified that Petitioner was the front desk office coordinator and also the credentialing coordinator. (Trans.296). He testified that when the [LaGrange] facility was remodeled, Petitioner shared the office with the front desk as there was no separate office. (Trans.296, 297). He testified that at the front office area, Petitioner had a desk that was up against a wall, there were patient file cabinets and a copier, and she basically shared the office with the scheduling staff who were Joanna and Zulema. (Trans.297). He testified that prior to that she had her own office with the credentialing files located there. (Trans.297, 321). He testified he did not remember how many cabinets there were, but there were cabinets in Petitioner's office and files were kept in each of the drawers. (Trans.322). He testified that he had an opportunity to open all the drawers [in the cabinets in Petitioner's office]. (Trans.322). He testified that the files would vary in thickness depending upon how long a doctor had been associated with the company, and some files were very thin if a doctor was new. (Trans.326). He testified that he did not experience files in drawers in Petitioner's office being tight. (Trans.327).

Thomas testified that he had occasion to take a file out of and put back into drawers and he never had any difficulty with same. (Trans.302). He testified he did not think any drawers in the file cabinets contained more files than they could handle. (Trans.303). He testified that when Petitioner was out for her shoulder surgery, he did the credentialing and had a reason to go into the file cabinets, but prior to that it was to review a file. (Trans.303). He testified he never noticed Petitioner at any time having difficulty taking a file out of a cabinet or putting a file back into a cabinet. (Trans.305). He testified that based on his recollection, Petitioner never told him she had difficulty with same. He testified that based on his recollection, Petitioner never told him she injured herself from anything she did at work. (Trans.205). He testified that anybody he supervised was required to tell him if they were hurt at work. (Trans.305).

Thomas testified that he believed the LaGrange facility was remodeled from 2011 through 2012 and was a one-year project. (Trans.301). He testified that the file cabinets were big, long, probably 3-foot, 4-foot file cabinets, standard that had a door to open and then pull out and push in drawers. (Trans.301). Thomas testified that the files were moved to the front office because Petitioner no longer had an office and she needed access to them [after the remodel]. (Trans.328, 329). He testified that paperwork still needed to be filed, and in addition to credentialing duties that he took over for Petitioner, he also worked with some of the patient files. (Trans.329). He testified that whenever he was there [LaGrange], he would find Petitioner working at her desk on credentialing, typing, getting physicians ready and scheduling patients through the computer and phone. (Trans.298). He testified that credentialing entailed going through many websites to verify that a physician was qualified through credentialing boards and licensed through the State of Illinois to operate. (Trans.298, 299). He testified that documents would be requested from the physician to fill out and show proficiency in skill sets. (Trans.299). He testified that Petitioner did those things. (Trans.299). Thomas testified that physician licensing and information were kept in paper form because they were printed and there was a file cabinet for those documents. (Trans.300).

Thomas testified that Respondent had a policy for reporting work-related injuries and employees were instructed to notify their supervisor if they were hurt. He further testified that the policy provided that an employee was responsible for seeking out medical care if needed, and they were to let their supervisor know if they were going to seek that out because there was paperwork to fill out. (Trans.206). He testified that policies were updated annually, and supervisors were given all policies that pertained to their departments, so they would have been required to read them and know. (Trans.307).

Thomas testified that he was always reachable by phone, text or email by anyone he supervised. (Trans.307). He testified that an accident/incident report has a section for him to fill out and a section for the employee to fill out to describe what happened an how it happened. (Trans.308). He testified that if that was given to him, he would then forward it to Patti Murphy. (Trans.307, 308). He testified that if he was notified of an accident or incident, he would then provide the paperwork to the employee for them to complete. (Trans.308, 309).

Thomas testified that he had prepared accident/incident reports during the time he worked for Respondent, but that to his recollection, Petitioner never asked him to prepare one. (Trans.309). He testified that to his recollection, no other employee told him that Petitioner had been injured while doing something at work. (Trans.309). He testified that prior to counsel for Respondent calling him and notifying him about testifying, maybe August or July of 2016, he was not aware that Petitioner had been claiming she was injured at work. (Trans.310).

Thomas testified that on average there were at least 35 to 40 physician files in any given year. (Trans.312). He testified that if they were preparing for an accreditation, all the files would be reviewed to make sure everything was accounted for in them. Aside from that, he testified, more than likely a file would just be pulled if a physician needed to be verified. (Trans.313).

Thomas testified that he had not talked with Patti Murphy since he left the company in 2013. (Trans.331). He testified he had not talked to Jackie Ladewig about Petitioner's claims since he left the company, but he had been talking with her while sitting out [in the public waiting room at the IWCC]. (Trans.332). He testified they never had a discussion about when Jackie first heard about Petitioner's injuries. (Trans.332). Thomas testified that prior to his termination from United Therapies, as Petitioner's supervisor, he had a pretty good idea of what she did for Respondent. (Trans.334).

Jackie Ladewig testified she was employed by Respondent, United Therapies, which changed its name. She testified she knew Petitioner from working for the same company [Respondent]. (Trans.343). She testified she started on November 27, 1989. (Trans.344). She testified she did not hire Petitioner and did not work side-by-side with her, but she trained her in February 1994 when the center in LaGrange was opened. (Trans.344). She testified that when she started with Respondent, she was a part-time front desk scheduler and at the present is medical staff and clinical staff credentialing and fixed site scheduling manager. (Trans.346). She testified that her duties consist of credentialing the clinical staff, nurses, mobile techs, and physicians. (Trans.346). She testified that she manages the front desk staff at Park Ridge and at LaGrange and works out of Rosemont, her permanent/physical location, on some system conversions. (Trans.347).

Jackie testified that towards the middle of 2014 through half of 2016, she was at the LaGrange office on a day-to-day basis, and then transitioned back to Rosemont. She testified she worked in Human Resources for Respondent for about 14 years. (Trans.347). She testified when she was with HR, she did payroll, benefits and records. She was the only person in HR. (Trans.348). She testified she also on-boarded new hires and maintained employee files. (Trans.348). She testified she also prepared employee documents concerning requests for leave of absence. (Trans.348, 349). She testified that sometimes a supervisor would let her know someone was going on leave and Jackie would then send the employee paperwork. (Trans.349). She testified that sometimes the employee would contact her directly and request FMLA forms, specifically the Certificate of Health Care Provider. (Trans.349). She testified that she received FMLA paperwork from Petitioner on a couple of occasions. (Trans.349). She testified she also processed short-term disability for an employee. (Trans.350). She testified that if someone was hurt on the job, that person would either notify their supervisor or her,

and depending on the injury, they would either go to "employee health" or their doctor. (Trans.351). She testified that if there was a work comp case, she would notify the [insurance] agent, who would then initiate a claim with the work comp carrier. (Trans.351). She testified that then they [work comp carrier] would then contact her for the employee's contact information and handle the rest with the employee. (Trans.351).

Jackie testified that during the time Petitioner was working at United Therapies, she was never contacted about a work comp claim by anyone concerning Petitioner. (Trans.351). She testified that she processed a lot of doctor's notes and intermittent FMLA forms for Petitioner for which she assumed were personal injuries. (Trans.352). She testified it was not brought to her attention that there were [work] accidents. (Trans.352).

Jackie testified that Petitioner was the office coordinator at LaGrange while working for Respondent. (Trans.352). She testified Petitioner managed the front desk and credentialed the physicians (urologists). (Trans.352). She testified that Petitioner oversaw all the front desk functions, then did mobile scheduling for a period of time, which was a separate division of the company. (Trans.352, 353). She testified it was a lot of scheduling, overseeing and supervising the schedulers. (Trans.353). Jackie testified that credentialing involved collecting applications, paperwork, and verifying licenses. (Trans.353). She testified she did not know how verification was done because she was not doing it at the time, but she testified it could have been on the phone or online. (Trans.353).

Jackie testified that at the LaGrange location they had patient charts, medical records and credentialing files. (Trans.354). She testified that patient charts and physician files were kept in a folder. (Trans.356). She testified that whatever holds 40 pages was kept in a file and then boxed up. Every three months the files were sent to whoever was storing them at the time. (Trans.357). She testified this occurred prior to the remodel, but at some point after the remodel, she thought they stopped keeping paper and everything became electronic. (Trans.357).

Jackie testified that before the remodel, there were file cabinets in Petitioner's office and then there was an office for mobile scheduling. She thought there were file cabinets there and there may have been some up front [office]. (Trans.358). She testified that she had been at the LaGrange facility when Petitioner was there and observed the filing cabinets that were in Petitioner's office. She testified that the cabinets were two big cabinets and had five drawers. (Trans.359). She testified she did not have occasion to open the cabinets. (Trans.360).

Jackie testified that the procedure for reporting accidents/injuries was to notify your supervisor and if the supervisor was not available, then you would notify HR. She testified that one could also call the work comp carrier and go to Employee Health, depending on the

situation. (Trans.361). She testified that the procedure was in the policy and all employees have access to the policies as they were kept in binders. (Trans.361). Jackie testified that she talked with Petitioner over the phone many times and more times than person-to-person contact, during the time Petitioner worked for Respondent. (Trans.362).

Jackie testified that during their phone conversations, they talked about aches and pains, but it did not come up that she hurt herself or hit herself on the desk or anything like that. (Trans.363). Jackie testified she used to talk about her husband's shoulder and she does not remember if Petitioner mentioned having difficulty doing some activities at work. (Trans.363). She testified that during their phone conversations, Petitioner never mentioned she was experiencing pain after doing a certain activity while at work. (Trans.364). Jackie testified that when she and Petitioner talked about her shoulder bothering her and Jackie's husband's shoulder, it was casual conversation about old age. (Trans.392, 393). Jackie testified that she did not recall Petitioner saying her shoulder was bothering her because of heavy files she has to move for credentialing. (Trans.393). Jackie testified she knew about Petitioner's elbows because it was on the FMLA forms. (Trans.394).

Jackie testified that she learned that Petitioner was claiming she had been hurt at work after Petitioner was terminated. Jackie identified at trial a notice of FMLA directed at Petitioner and letting Petitioner know how many available hours she had. (Trans.365; RX6). Jackie testified that she prepared the form. (Trans.365). She testified that two of her FMLAs [requests] might have been intermittent for physical therapy and doctor's appointments. She testified then there was another one [FMLA request] when Petitioner was out for surgery and that was short-term disability. (Trans.366). Jackie explained what intermittent FMLA was. (Trans.366).

Jackie identified at trial a letter dated March 13, 2013 from Petitioner's attorney addressed to United Therapies stating they represented her in a work comp case. (Trans.368, 369; RX11). Jackie testified that she did not see that letter in March but did see the Applications. (Trans.369). She testified that the Applications were in her box but may have gone to Respondent's COO or CFO [Bruce] first. (Trans.369, 370). She testified that her receipt of the Applications was the first time she was made aware that Petitioner was claiming she was injured at work. (Trans.370). She testified she saw them in May or June [2013]. (Trans.371).

Jackie identified at trial a document prepared by her in April 2013 letting Petitioner know that her FMLA time was exhausted. (Trans.371, 372; RX12). She testified she would have mailed that by certified mail. She testified that the letter was about granting Petitioner additional unpaid personal leave through May 14 [2013]. (Trans.373). Jackie read the last paragraph which requested that Petitioner advise of her status and ability to return to work on or before May 15, 2013. (Trans.374; RX12). Jackie testified that she received the Applications

after and was a little confused as to what they were, since she was not aware this was work comp. (Trans.374, 375). She testified that had she known she was dealing with work comp, she would not have sent the memo/letter to Petitioner discussing about FMLA and unpaid personal leave. (Trans.375).

Jackie testified that when she saw the Applications, she contacted the agent and asked what to do with them. She testified they were then sent to the insurance agent who contacted the carrier and they took it from there. (Trans.378). She testified that the insurance company had not been aware of a work comp claim before Petitioner was gone. (Trans.378).

Jackie testified that in 2013 when she received the Applications, she asked Patti Murphy if she was aware of the claims. (Trans.384). She testified that Patti told her she was not aware of any work-related injury. (Trans.384, 385). Jackie testified that she was aware that Patti had testified that she was in a meeting in 2016 where everyone expressed shock at the claim that Petitioner had a work-related claim against the Respondent. (Trans.386). However, Jackie testified that Patti had left the company in May 2016, and she did not remember any meetings discussing a work-related injury [by Petitioner]. (Trans.386). Jackie testified that what may have happened was that in 2015 Patti would have had a conversation with Nancy Kimbrell because she was the director of HR at the time. (Trans.387). She testified that she wished she had known that Petitioner claimed a work-related injury against the Respondent because she would have filed it right away for her. (Trans.388).

Jackie testified on re-direct examination that when someone gave notice of an injury at work, there was an internal incident/accident report form that is completed, and it was in existence during the time Petitioner worked for Respondent. (Trans.402).

Patti Murphy testified that she first started working for Respondent in April 1999. She testified she started out as Director of Operations and within about the first six months she became Vice President of Operations. She testified she retired on May 4, 2016. (Trans.5, 6). She testified she knew Petitioner because she was the office coordinator at Respondent's LaGrange site. She testified that Petitioner reported to her manager and then to Patti. She testified that Kathleen DuPrey-Tagge was a manager under her and then Thomas Peer took over as manager of the fixed site. (Trans.6).

Patti testified that as an office coordinator, Petitioner was responsible for the operations of the front desk, to sign patients in, get their insurance cards, give them forms to sign, get the chart together, and put charts on the rack for the nurse to proceed with the procedure. (Trans.11). She testified that at the end of the day after everybody checked the chart, the front office received the chart back, would disassemble the chart, file it away and make sure the billing office gets their forms, and physicians get their op reports. (Trans.11, 12).

Patti testified that after a few years, Petitioner was given the task of physician credentialing. (Trans.12).

Patti testified that Petitioner worked at the LaGrange facility, but Patti's office was in Rosemont. (Trans.13). Patti testified that as part of her job, she went to all of the facilities weekly and would meet with most of the staff and assure everything was running smoothly. (Trans.13). Patti testified there was an employee handbook that was signed off by employees annually. (Trans.14). Patti testified that an Employee Report of Occupational Injury or Illness was within the employee manual. (Trans.14).

Patti testified that if somebody [employee] was thinking they needed a leave of absence, it would be considered personal leave if not FMLA. (Tranas.17). Patti testified that she did not recall seeing an incident report completed by Petitioner. She testified that an employee can complete it, or their supervisor can complete it with them. (Trans.20). She testified that she was not given an incident report concerning Petitioner by any of her supervisors. (Trans.20). She testified that if Petitioner had a work injury, she would report it to her supervisor, who was Kathleen or Thomas, and then each of her supervisors would have notified Patti, because that was the policy. (Trans.21). She testified that neither Kathleen nor Thomas notified her of any injury claimed by Petitioner. (Trans.21).

Patti testified that she first learned that Petitioner was claiming a work injury in 2016 through Nancy Kimbrell, the Director of Human Resources, who came into her office and said they were notified that Petitioner stated she was injured. (Trans.21). She testified she did not remember the exact date. (Trans.40). She testified that Nancy was not the head of Human Resources in 2010, 2011 or 2012, but Jackie Ladewig was. (Trans.40, 41). Patti testified that all workers' compensation claims were supposed to be reported to Human Resources and she was surprised that Petitioner was making workers' comp claims. (Trans.40, 41).

Patti testified that Jackie Ladewig worked for Respondent in 2010, 2011 and 2012 and was the Human Resource Manager, who would have let Patti know about a work injury. (Trans.22, 23). Patti testified that to her recollection, Jackie never let her know about a work injury involving Petitioner. (Trans.23). She testified that Petitioner never mentioned being hurt at work to her. She testified that Petitioner had said she had a headache or aches and pains but not about being hurt at work. (Trans.23).

Patti testified she knew Petitioner had some kind of surgery, but she did not know what it was for and did not ask. She testified it was an abdominal type of thing initially, and Petitioner also had surgery on her shoulder before she left. She testified that Petitioner felt it had to do with lifting babies as a grandmother, as that is what Petitioner told her. (Trans.24).

Patti testified that when Petitioner came back from her surgery, she stated she was in a lot of pain, so Patti went to LaGrange and met with her. (Trans.24, 25). She testified that she told Petitioner she was concerned for her and whether she was able to be back. (Trans.25). She testified that Petitioner told her she was in a considerable amount of pain sitting there but had a release from her physician. She testified that when someone is in so much pain, there is something wrong, and Patti did not want Petitioner to continue sitting in pain. Patti testified that she asked Petitioner what she thought it was [from]. (Trans.25). Patti testified that she asked Petitioner if something happened at work, and that Petitioner told her it did not. (Trans.26). Patti testified that Petitioner told her it was not work comp, nothing from work, and that she was going to be suing her surgeon. (Trans.26).

Patti testified that she did not want Petitioner to aggravate her shoulder any more than it was. (Trans.26). Patti testified that it is a requirement that if someone is hurt at work in any way, their supervisor would inform her, and they are to have it checked out. (Trans.26, 27).

Patti testified that pursuant to HIPAA, she was not privy to any information on insurance claims or benefit payouts for treatment or anything like that. (Trans.28). She testified she would not know if somebody was going to see a doctor for whatever reason, unless the person told her. She testified that at no time did Kathleen or Thomas tell her that Petitioner had a work injury, nor did either one of them tell her that Petitioner was complaining of pain after doing certain work tasks. (Trans.28). Patti testified that during 2010, 2011, 2012 and 2013 she spoke with Petitioner on a weekly basis, and that never did Petitioner discuss hurting herself at work at any point in time during their conversations. (Trans.39).

Patti testified that she was not aware that Petitioner was treating for alleged work injuries from August 2010 up until late 2012. (Trans.57, 58). She testified that Petitioner was a private person. (Trans.59). She testified that it was her impression that before 2016, Jackie did not realize that Petitioner was making a work comp claim. (Trans.61). She testified that she wasn't aware the Petitioner's claims had been on file since 2013. (Trans.63). She testified she was not aware that an insurance company was involved in defending against Petitioner's workers' compensation claims. (Trans.67, 68).

Patti testified as to her understanding being that a first report of injury is supposed to be completed by the supervisor of an employee. (Trans.92, 93). She testified she had never seen an April 5, 2013 letter from Petitioner's attorney. (RX2, p.93). She testified that apparently two insurance carriers had notice of Petitioner's claimed work injuries in 2013, but she was not aware of them being involved. (RX2; p.94).

Dr. Gregory Nicholson examined Petitioner on September 24, 2014 and generated a report upon Respondent's request. (RX1; p.1). He testified that he reviewed records that went

back to 2010 concerning Petitioner's right elbow. He testified that he had clinical examination notes from Hinsdale Orthopaedics which recounted a shoulder surgery on the right side in 2012. He testified that Petitioner had last worked in May of 2013, when she was released from her job. (RX1; p.7). He testified that he specifically asked Petitioner if she had an injury to the right shoulder, and that Petitioner told him she did not. He testified that Petitioner told him she thought it was more from her desk job with lifting files and doing up-and-down activity with her arms. He testified that Petitioner was an office manager at a surgery center and that there was no specific injury that occurred either for the left elbow, right elbow or right shoulder. (RX1; p.7).

Dr. Nicholson testified that he examined Petitioner's elbows and shoulders. (RX1; p.8, 9). After examination and reviewing records and taking down a history from Petitioner, Dr. Nicholson testified that he felt Petitioner had tendinopathy in her elbows and right shoulder that was due to an endemic issue. (RX1; p.12). Dr. Nicholson testified that he had seen instances of repetitive movement with an upper extremity or a cumulative traumatic condition with an assembly line worker, somebody doing continuous activity the same way, such as screwing in a pipe the same way all day at a Ford plant, or a meat cutter. (RX1; p.13). Dr. Nicholson felt that Petitioner was able to do desk work, clerical work, but not repetitive assembly line activity, repetitive reach, grip or release activity and that lifting should be limited to 10 pounds from floor to chest height and limited on an occasional basis above chest height. (RX1; p.14, 15).

Dr. Nicholson testified that he generated an addendum report dated January 28, 2015. (RX1; p.16). Dr. Nicholson testified that he reviewed MRI reports and films on the right shoulder and right elbow. (RX1; p.16, 17, 18). He testified he also reviewed the operative report on the right shoulder. (RX1; p.23).

Dr. Nicholson testified pursuant to his reports that he felt there was no repetitive, cumulative disorder, trauma or specific injury that caused Petitioner's bilateral elbow pain or right shoulder issues, and that Petitioner's issues could not be discerned to be work-related. (RX1; p.25).

Dr. Jeffrey Coe examined Petitioner on August 18, 2015 and generated a report upon Petitioner's request. (PX1). Dr. Coe testified that Petitioner told him she had worked for a company [Respondent] for about 18 years and that her job was an office position where she worked eight or more hours each day for five days per week and used her upper extremities repeatedly in a variety of activities. (PX1; p.10). He testified that Petitioner described computer data entry, keyboard and mouse work, and moving files. (PX1; p.10, 11). He testified that Petitioner told him there were large files and she would take them from shelves and cabinets, she answered telephones, she wrote by hand, she filed and removed things from files.

(PX1; p.11). He testified that Petitioner described having a small desk with a computer on it and that the keyboard was in an awkward position, over on the side, because she liked to spread her files and charts out on the desk. (PX1; p.11).

He testified that Petitioner told him she had to move large and heavy files throughout the day to and from cabinets and onto and off of her desk. (PX1; p.11). He testified that Petitioner told him the first thing she noticed was some pain along the outer border of her right elbow. (PX1; p.11, 12). He testified that Petitioner told him her initial complaints began in 2010 and she was diagnosed with right lateral epicondylitis. (PX1; p.12). He testified that Petitioner told him she then developed some pain in the left side of her neck with her work activities which she related to the positioning of the computer and keyboard. (PX1; p.14). He testified that Petitioner told him with ongoing work she began to experience pain in her right shoulder which she related to forceful reaching down and pulling of files that were two to three inches thick and heavy. (PX1; p.15). He testified that Petitioner had no estimate of the weight of the files but told him they were tightly crammed into cabinets. (PX1; p.15).

Dr. Coe testified that Petitioner reported to him that with ongoing work and ongoing problems with her right shoulder and right elbow, she began to use her left arm more and developed pain in the outer border of her left elbow. (PX1; p.16). He testified that Petitioner's right shoulder symptoms were the most severe problem and she underwent surgery for it a little after Christmas 2012. (PX1; p.16).

Dr. Coe testified that Petitioner was a right-handed individual and by her description of her work requiring considerable use of her right arm, including the pinch grip, and pulling and tugging of files, that those activities caused the development of acute right lateral epicondylitis in the summer of 2010 which became a chronic condition. (PX1; p.18). Dr. Coe testified that he saw Petitioner five years after the summer of 2010. (PX1; p.22).

Dr. Coe testified that Petitioner's right shoulder problem emerged in the summer of 2012. (PX1; p.23, 24). Dr. Coe testified that as Petitioner's right elbow was hurting her, it was not uncommon for the next joint, which was the shoulder, to take the stress of activity. He testified that since it was hard to grip and pull with the right elbow because of the pain, people begin to move their arm more stiffly which begins to stress the next joint up. (PX1; p.24, 25). He testified this was based on his experience. (PX1; p.25). He testified that Dr. White diagnosed an impingement syndrome with a probable rotator cuff tear. (PX1; p.26). He testified that this diagnosis was something that could be seen in individuals who do forcefully exert their arm through the shoulder by reaching out and pulling towards them, doing things at or above shoulder height, which was something Petitioner described. (PX1; p.26).

Dr. Coe testified that it was his opinion to a reasonable degree of medical certainty that Petitioner's continued work activities as office manager and coordinator caused a breakdown in her right shoulder. (PX1; p.26). He further testified that the right shoulder surgery Petitioner had was to a reasonable degree of medical certainty causally related to the repetitive activities that Petitioner described to him. (PX1; p.27).

Dr. Coe testified that Petitioner developed the same problem in her left elbow as she had in her right elbow, which was lateral epicondylitis and that to a reasonable degree of medical certainty, continued work activities and trying to protect the right arm caused the condition in the left elbow. (PX1; p.30, 31, 34, 35). He further testified that there is a causal relationship between Petitioner's work activities with Respondent and the development of right lateral epicondylitis, left lateral epicondylitis and her right shoulder condition. (PX1; p.36).

Dr. Coe testified that he had not seen a typed job description or any other representation of Petitioner's workplace. (PX1; p.39). He testified that he relied on what Petitioner told him. (PX1; p.40). He testified that he relied on Petitioner's use of the term "overuse" which is subjective, and he had no way of measuring it. (PX1; p.40).

Dr. Coe testified that Petitioner told him that she had Type 2 diabetes for years. (PX1; p.42). Dr. Coe testified that as seen on MRI, Petitioner certainly had pre-existent degenerative arthritis in her right shoulder at the AC joint which was one of the places that Dr. White did surgery on. (PX1; p.44).

Dr. Coe testified that in some literature, repetitive meant "more often than not during the workday . . . around two-thirds of the workday." (PX1; p.47). Dr. Coe agreed that the literature states that the key to epicondylitis is the forceful and repetitive nature of a trauma. (PX1; p.55). He testified that he did review in Petitioner's medical records repeated references to the fact that she sat at her desk all day, and he testified that that was recognized as an office sedentary seated position. (PX1; p.56). Dr. Coe testified that he did not have information about the frequency in which Petitioner filed or number of times she actually moved larger files versus little files. (PX1; p.59).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issues C & D: *Accident and Date of Accident*

The Arbitrator concludes the Petitioner did not sustain any injuries arising out of and in the course of her employment with Respondent on August 19, 2010, January 14, 2011, October

17, 2011, and August 23, 2012. Petitioner has claimed her injuries were caused by repetitive activities at work and that there was no one specific accident or injury. Whether a person's work activities are sufficiently repetitive must be decided on a case-by-case basis on the particular facts in each case. In *Edward Hines Precision Components vs. Industrial Commission*, 356 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (2d Dist. 2005), the claimant's job as a tractor/trailer driver was not deemed to be repetitive in nature. He stated that he drove an 18-wheel, flatbed truck with a manual transmission an average of 200 miles a day. He shifted gears with his right arm and used his left arm to steer. He delivered trusses that were secured to the flatbed with an average of 10 straps per load. The straps were tightened with either a manual wench or a pry bar. Claimant testified that tightening the strap required application of substantial force so that the load would not shift when the truck was moving. Petitioner's work activities, as described, were not repetitive or forceful in nature, when viewed along with the activities in the *Edward Hines* case.

In *Williams vs. Industrial Commission*, 244 Ill.App.3d 204, 614 N.E.2d 177, 185 Ill.Dec. 43 (1st Dist. 1993), claimant testified that part of his job required lifting machine parts that weighed anywhere from 30 to 60 or 70 pounds apiece. He would lift such objects about two times a day and he estimated he would spend approximately 30% of his time on each shift lifting objects of this weight range. He would climb on top of a crane for approximately five or six times a day. He would also crawl under certain machinery in order to perform repairs. The crawling would involve lying on his back or stomach and crawling under the machine. He would crawl in such a manner two to three hours per day on a daily or weekly basis. He also used 8, 12, and 16-pound sledgehammers for two to three hours a day on a daily basis and was required to operate a hydraulic air hammer to break up concrete approximately once every six months. He utilized various sizes of weights and tools including pipe wrenches, chain saws, sledgehammers, and box wrenches, etc. Any one of Petitioner's work activities could not compare in forcefulness to any one of the claimant's activities in the *Williams* case. Any one of Petitioner's activities could not compare in repetitiveness to any one of the claimant's activities in the *Williams* case. In Williams, the First District Appellate Court held that claimant's job was not repetitive.

Petitioner's case can even be distinguished from *Quaker Oats Co. vs. Industrial Commission*, 414 Ill.326, 111 N.E.2d 351 (1953). In *Quaker Oats*, the claimant was found to have suffered an aggravation or acceleration of a pre-existing condition by the dropping of cans onto his left foot. In this case, Petitioner's work activities were not repetitive as depicted in *Quaker Oats*, as it is evident she had a variety of duties that were interspersed throughout her day. So, the Arbitrator cannot conclude that Petitioner suffered an aggravation or acceleration of any pre-existing conditions.

Issue E: *Notice*

The Arbitrator also finds the Petitioner did not give timely notice of the accidents of August 19, 2010, January 14, 2011, October 17, 2011, and August 23, 2012 to Respondent. Under the Act, a claimant must give notice to an employer as soon as practicable but not later than 45 days after sustaining an accidental injury arising from employment. Although a lack of notice, or a defect or inaccuracy in notice has proven to be a weak defense and would not bar a claim, sometimes a lack of notice, or defect or inaccuracy in notice can be barred if it is prejudicial to an employer. *Health & Hospitals Governing Commission of Cook County vs. Industrial Commission*, 75 Ill.2d 194, 387 N.E.2d 683, 25 Ill.Dec.807 (1979).

In this case, four witnesses testified that they did not know Petitioner was ever injured at work from her work activities. Although Petitioner testified that she provided notice to Patti Murphy, Patti Murphy testified that had she been aware or been told that Petitioner claimed she had been injured at work from work activities, she would have acted on it by contacting Human Resources. Jackie Ladewig testified that had she known, she would have contacted the insurance agent who in turn would have contacted Respondent's workers' compensation carrier. She talked with Petitioner on the phone frequently and never learned that Petitioner was claiming work-related injuries. Jackie testified had she known, she would have assisted Petitioner with the proper forms for workers' compensation. Kathleen Duprey Tagge was Petitioner's supervisor for a time and she was not aware of Petitioner claiming any injury from work activities. Thomas Peer was Petitioner's supervisor for a time and he was not aware of Petitioner claiming any injury from work activities. The evidence supports that Respondent first learned of Petitioner's claims of injury from work activities through the filing of Applications, all which were done on March 19, 2013. Petitioner worked in close proximity with Joanna Guerra for a time, and Ms. Guerra testified that she was not aware of Petitioner's claims of injury from work activities.

Petitioner was in a supervisory position with Respondent and knew of the policy of reporting work accident or injuries. She knew about reporting because she reported an accident that occurred with her in 2008. The type of form is insignificant when Petitioner knew how to report a work accident or injury. All she had to do was tell someone also employed by Respondent, but she failed to do so.

Issue F: *Causal connection*

Petitioner's current condition of ill-being is not causally related to her employment with Respondent based on the rationale set forth for issue (C) above. In addition, the Arbitrator gives more weight to Dr. Nicholson's opinions than Dr. Coe's opinions, because Dr. Coe relied

solely on what Petitioner told him and her definition of "repetitive" work. Both doctors testified that repetitive work is work that is done two-thirds of the time in a work day and involve forceful gripping. Dr. Nicholson described it as assembly line work. Petitioner worked in an office and her job was mostly sedentary. Joanna Guerra testified that she did Petitioner's filing. Petitioner's supervisor, Tom, testified that he did Petitioner's credentialing work for a time after she left, and he did not have any difficulty with pulling files out of a cabinet or putting them back in. Further, none of Petitioner's treating physicians causally related her work duties to any conditions in her elbows or right shoulder, except for Petitioner's medical expert, Dr. Coe, who saw her one time and relied on her description of her work activities. In fact, Petitioner never told any of her treating physicians that any activity at work, such as pulling files out of cabinets or putting them back in, caused pain to her elbows or right shoulder.

The Petitioner's situation is like that present in a recent Illinois Workers' Compensation Commission decision. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017). In *Cook*, the claimant, an office worker much like the Petitioner, argued her bilateral carpal tunnel syndrome was causally connected to her repetitive work for her employer. However, after the Commission reminded the Arbitrator of the proper standard of proof necessary under Illinois case law for repetitive and forceful work claims, the Commission affirmed and adopted the Arbitration Decision denying that claim. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017).

Issue J: *Medical bills*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of medical bills is moot and the Petitioner's claim for payment of the same is denied.

Issue K: *TTD*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of TTD is moot and the Petitioner's claim for payment of such benefits is denied.

Issue L: *Nature and extent of injury*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of the nature and extent of injury is moot and the Petitioner's claim for payment of such benefits is denied.

20IWCC0099

Issue N: *Respondent's credit*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of Respondent's credit is moot.

Signature of Arbitrator

OCTOBER 18, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judy Becker,
Petitioner,

20IWCC0100

vs.

NO: 13 WC 9009

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2018, is hereby affirmed and adopted.

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

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

There is no bond 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 Circuit Court.

DATED: FEB 11 2020
o1/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0100

BECKER, JUDY
Employee/Petitioner

Case# **13WC009009**

13WC009007
13WC009010
13WC009011

UNITED THERAPIES
Employer/Respondent

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5122 PORRO NIERMANN LAW GROUP
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

20IWCC0100

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

JUDY BECKER
Employee/Petitioner

v.

UNITED THERAPIES
Employer/Respondent

Case # **13** WC **9009**

Consolidated cases:
13 WC 9007, 13 9010, and 13 WC 9011

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 29, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **OCTOBER 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 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 $**59,823.40**; the average weekly wage was $**1,150.45**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

Petitioner failed to meet her burden of proving accident, notice, and causal connection. Accordingly, her claims for compensation are denied, Respondent's credit issue is moot, and Petitioner's Applications are dismissed.

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

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

Signature of Arbitrator

OCTOBER 18, 2018
Date

OCT 19 2018

20IWCC0100

JUDY BECKER v. UNITED THERAPIES

13 WC 9007, 13 WC 9009, 13 WC 9010, & 13 WC 9011

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on November 29, 2017.[1] The issues in dispute were accident and the date of accident, notice, causal connection, medical bills, TTD benefits, and the nature and extent of the injury. (Arbitrator's Exhibits 1-4). The parties requested a written decision, including findings of fact and conclusions of law, and agreed to receipt of the same via e-mail. (Arbitrator's Exhibits (*hereinafter*, AX) 1-4).

FINDINGS OF FACT

Petitioner testified that she was employed by the Respondent on *August 19, 2010* as an office coordinator and credentialing coordinator up until May 2013 (Transcript 24), when she was terminated because her FMLA period ran out. (Transcript (*hereinafter*, Trans.) 25). She testified she had worked for the Respondent for 18 years. (Trans.104). She testified that starting August 2010, she primarily did credentialing work which she described as involving heavy lifting and pulling and grasping hard copy files. (Trans.25). She testified that all of the credentialing files were for physicians. (Trans.28). She testified that she had approximately 180 to 200 of those [credentialing] physician files in her office back in 2010. (Trans.29). She testified that there were a lot of documents that needed to be filed into credentialing folders on a daily basis. (Trans.26). She explained that credentialing files were legal size, made of cardboard, with cardboard inserts. (Trans.27). She testified that some of them were quite thick – five to six inches thick and containing all types of information. (Trans.27). She testified they were kept in a filing cabinet that was probably up to her nose or the top of her head. (Trans.30). She testified she is 5'5" in height. (Trans.30). She testified she had three sets of cabinets, each with three drawers, and each of the drawers had a top that pulled open. (Trans.30). She testified that she had to pull the drawers toward her to access the files. (Trans.31).

Petitioner testified that from 2008 to 2011, she would take files out of the cabinets when she needed to file a document on a daily basis. (Trans.27, 36). She testified she would

[1] During the hearing of these matters, with all parties present and represented by counsel, the Petitioner's fifth claim, 13 WC 9008, was dismissed for want of prosecution.

open the file cabinet, reach in, pull and grasp, and sometimes struggle to pull the files out because they were tightly packed in. (Trans.33, 34). She testified she could only grasp with her fingers because it was impossible to get her fingers down in between a whole file. (Trans.34). She testified she would have to raise her arms at least shoulder height, or two, four or six inches higher than her shoulders. (Trans.35). She testified there was no other file cabinet space available. (Trans.33). She testified she did not have a step stool. (Trans.35).

Petitioner testified that she worked eight-hour days. (Trans.36). She testified that on average she would spend three to five hours a day pulling/replacing files. (Trans.37). She testified that for the remaining times, she probably ran reports from a program on the computer. (Trans.37, 38). She testified she would then have to file the reports into the physicians' folders. (Trans.38). She testified she could run dozens of reports a day but would not work on all 200 reports in a day. (Trans.38). She testified she would hole-punch the documents and place them in a physician's file by attaching them to prongs on the inside of the file. (Trans.39). She testified that she would then put the file back into an already tightly-fitted drawer. (Trans.40, 41). She testified the files were not sticking out and she could close the cabinet door. (Trans.41). She testified that no one else had credentialing responsibilities between 2008 and 2010. (Trans.42). She testified she continued to do this type of work with the files until she left. (Trans.42).

Petitioner testified that she also worked with close to 100+ patient files per week, or month. (Trans.42, 43). She testified that patient filing cabinets were also three-drawer filing cabinets and would get very crammed and full. (Trans.44). She testified that when she took over the credentialing coordinator position, she still had to work with the patient files. (Trans.44). She testified that before she got the credentialing duties added onto her job duties, she was managing the front office and helping to schedule and "put out fires." (Trans.44). She testified she made sure the office was running smoothly and that they were fully staffed. (Trans.45). She testified that she occasionally had someone assist in the patient file work. (Trans.45). She testified that her job activities were interspersed during the course of a day. (Trans.53).

Petitioner saw Dr. Roman Dreyer at Dreyer Medical Clinic on *August 4, 2010*. (Petitioner's Exhibit 4, p.1111). Dr. Dreyer noted that Petitioner's pain started three weeks prior, gradually, with no trauma or injury. He noted she had a problem lifting light weights. His assessment was severe elbow pain with a concern for severe tendonitis. He prescribed 600 mg of ibuprofen and recommended an elbow strap and no lifting of weights or repetitive motion. He opined that if there was no improvement, then he would order an MRI of the right elbow. (Petitioner's Exhibit (*hereinafter*, PX) 4, p.1112).

Petitioner testified that on *August 19, 2010*, while performing credentialing file work she noticed her [right] elbow was beginning to hurt and continued to get worse. (Trans.46). She testified that she realized when she was pulling on files is when she had the most pain that was constant, chronic, and would never go away. (Trans.47).

Petitioner testified she sought treatment with Dr. James Anderson on *August 19, 2010*. (Trans.47). She testified she had reported to Dr. Anderson that she worked as a clerk in an office and that pulling files at work was bothering her. (Trans.47, 48). She testified that she did not tell Dr. Anderson anything specific about her work duties that caused her to see him because he did not ask. (Trans.123). Dr. Anderson's note of August 19, 2010 provides that Petitioner did some weight training which may have aggravated her right elbow. (PX4; p.1127). He noted that Petitioner had treated with a tennis elbow strap but had no other specific treatment. His assessment was right lateral epicondylitis. (PX4; p.1127). He gave Petitioner a corticosteroid injection into the *right elbow* on the same date. Petitioner testified she had about two to three weeks of temporary relief from the injection. (Trans.49).

Petitioner testified that while speaking with her supervisor, Patti Murphy, in person at Respondent's LaGrange office just before her August 19, 2010 appointment, she reported that her [right] elbow was hurting, and she associated it with pulling files. (Trans.60-62). She testified she told Patti that she thought it would be a good idea if the files were scanned. (Trans.63). She testified that Patti told her to just go to the doctor and she would be fine. (Trans.63).

Petitioner saw Dr. Roy Henderson on *September 29, 2010*, also at Dreyer Medical Clinic. Dr. Henderson noted that Petitioner told him her pain started in July 2010, that she sat at a desk most of the day, and did Jazzercise and weight lifting three to five times per week. There was no mention of any other specific work activities. Dr. Henderson had the same impression as Dr. Anderson. (PX4, p.1144).

Petitioner testified she did physical therapy and reported to the therapists what she was doing at work that was causing her symptoms. (Trans.48). Petitioner did her therapy at Dreyer Medical Clinic. A progress note for a therapy visit on *October 4, 2010* provides that Petitioner was an office manager and her duties were keyboarding, filing and writing, and Jazzercise is listed as a recreational activity. (PX4, p.1152).

Petitioner next saw Dr. Roy Henderson on *November 18, 2010*. He noted that Petitioner's right elbow pain was worsened by using her hand, picking up a coffee cup, and pulling files at work/gripping. That was the extent of work activities mentioned. He had the same impression as at the last visit. Dr. Henderson provided Petitioner with a cortisone injection into the right elbow. (PX4, p.1213).

Petitioner next saw Dr. Dreyer on *January 10, 2011* for routine lab work and follow up. Dr. Dreyer noted persistent pain and swelling in the right elbow and diagnosed elbow tendonitis. He recommended an MRI. (PX4, p.1246).

Petitioner had an MRI of her right elbow done on *January 14, 2011* at Dreyer Medical Clinic upon Dr. Dreyer's order. The MRI revealed a full-thickness tear of the common extensor tendon at the origin of the extensor carpi radialis brevis tendon [lateral epicondyle] and a small elbow joint effusion. (PX4, p.1250). Petitioner testified that she believed she told Patti a few days after this MRI of the elbow was done, that the MRI showed a torn tendon. (Trans.63, 64). She testified that she told Patti because she felt it was work-related, she was in pain, and struggling to do her job. (Trans.65).

Petitioner saw Dr. Neena Szuch, also at Dreyer Medical Clinic, on *January 21, 2011* for right lateral epicondylitis. The visit note contained no specific history, other than Petitioner had some physical therapy and used a forearm brace without adequate relief of symptoms. The visit note made no mention of any of Petitioner's work activities. (PX, p.1275). An x-ray of the left elbow revealed some spurring at the distal humerus. (PX4, p.1279). Dr. Szuch diagnosed right lateral epicondylitis and offered Petitioner a wrist brace. (PX4, p.1275).

Petitioner described the brace as going through the thumb and over the hand and up to right below the elbow, which fastened on the bottom. (Trans.56). She testified the brace did not interfere with flexion of the elbow joint. (Trans.56). She testified she did not hide the brace from co-workers. (Trans.55).

Petitioner saw Dr. Brian Hubbard, also at Dreyer Medical Clinic, on *February 19, 2011* for a complaint of bilateral upper and lower back pain which had been present for one day and started when she was at rest. (PX4, p.1304). There was no mention of any of Petitioner's work activities. The diagnosis was lumbar and thoracic strain. (PX4, p.1305).

Petitioner's next right elbow related treatment was on *June 24, 2011* with Dr. Roy Henderson. He noted that there was no mechanism of injury and that, again, Petitioner sat at a desk most of the day, and did Jazzercise and weight lifting. He reviewed the right elbow MRI done on January 14, 2011 and noted the full-thickness tear at the origin of the extensor carpi radialis brevis. He noted that Petitioner had seen Dr. Szuch who recommended non-operative treatment. Dr. Henderson's impression was right lateral epicondylitis with a full thickness tear at the wrist extensor insertion. He referred Petitioner to Dr. White. (PX4, p.1380).

Petitioner testified that she did Jazzercise two to four times a week. (Trans.66, 67). She testified it involved movements with feet and it was a dance class (Trans.66). She testified that some exercises can be done with two-pound weights, which she would hold and do whatever with them. (Trans.66, 67). She testified she did not notice any problems with her elbows or

shoulders while doing Jazzercise. (Trans.67). She testified she would lift the weights up to her shoulder and put them back down. (Trans.68).

Petitioner testified that in 2011 the records for credentialing started being scanned. (Trans.58). She testified that she had been asking for files to be scanned ever since she took over the credentialing position because of the difficulty in their physical presence and her ability to access those files. (Trans.58). She testified that at that time there were still physical patient files and physician files for physicians coming up for reappointment. (Trans.59).

Petitioner first saw Dr. Thomas White, also at Dreyer Medical Clinic, on *July 14, 2011*. He noted that she was a right-handed office manager who came in with a year's worth of pain in the lateral side of her right elbow. He noted her treatment history, but no specific work activities were mentioned. He reviewed the MRI of the right elbow. His assessment was chronic lateral epicondylitis in the right elbow and provided a Depo-Medrol and Marcaine injection. (PX4, p.1386).

Petitioner's next orthopedic-related visit was on *October 17, 2011* with Dr. Sunil Malkani, also at Dreyer Medical Clinic. She testified she complained about her *left shoulder and neck*. (Trans.69, 70; PX4, p.1502). Dr. Malkani noted the visit was for acute neck pain located in the back of the neck and radiating into the left shoulder. He noted the pain was dull. He noted there was no associated trauma, but that Petitioner sat in front of a computer all day. He diagnosed musculoskeletal neck pain and trigeminal neuralgia syndrome. (PX4, p.1504). Petitioner testified that Dr. Malkani recommended some physical therapy and prescribed a muscle relaxant. (Trans.70; PX4, p.1504). An x-ray of the neck was done on the same date and revealed mild degenerative changes, moderate left-sided facet hypertrophy, moderate left neural foraminal stenosis at C4-C5, and mild left neural foraminal stenosis at C5-C6 and C6-C7. (PX4, p.1507).

A physical therapy progress note dated *November 4, 2011* provides that Petitioner complained of pain over her cervical spine and into her left upper trapezius. The onset date was October 27, 2011 with no known incident. The subjective report was that symptoms were aggravated by sitting at a desk keyboarding and driving ("at times rests elbow on window"). It is noted that Petitioner did not have therapy before for these symptoms because she never had them before. (PX4, p.1527).

Petitioner called or emailed Dreyer Medical Clinic on *November 14, 2011* and Ernestina Sanchez, a nurse, documented the message. Petitioner asked whether it was "ok" for her to continue Jazzercise and other home exercise. The message was relayed to Dr. Farah K. Hussain, and Dr. Hussain responded to Petitioner to "go ahead and resume your exercise." (PX4, p.1550).

Petitioner saw Dr. Barry Abrams at Dreyer Medical Clinic on *March 23, 2012* due to an injury to her right foot after tripping and falling the night before. She was diagnosed with a sprain of the foot. (PX4, p.1614).

Petitioner's next orthopedic-related visit was on *August 23, 2012* with Dr. Thomas White. She testified she complained about her *right shoulder and arm*. (Trans.73; PX4, p.1697). Dr. White noted that a complaint of pain in the superior aspect of the right shoulder, which bothered Petitioner claimed bothered her particularly at night, and sometimes radiated down into her right arm. He noted that Petitioner did not recall any "recent or remote injury or change in activity." Dr. White assessed impingement syndrome. He wanted to rule out a rotator cuff tear. He provided an injection of Depo-Medrol and Marcaine into the subacromial space. (PX4, p.1697). There were no work-related activities mentioned at this visit. Petitioner testified that after she made this appointment, she told Patti Murphy over the phone that she was seeking treatment for her right shoulder. (Trans.82, 83). Petitioner testified that she also told Patti the same thing she had been telling her for months – that the pulling and grasping of the files were hurting her shoulder and elbows. (Trans.84). She testified that "they" never wanted to scan the files or alleviate that or accommodate her in any way, even knowing Petitioner was having pain from it. (Trans.84).

Petitioner had an MRI of the right shoulder done at Dreyer Medical Clinic on *November 13, 2012*. The reason for the MRI listed on the report was that Petitioner had right shoulder pain for six months without antecedent injury. The MRI revealed marked supraspinatus and lesser infraspinatus tendinopathy and a partial-thickness articular surface supraspinatus tear without a full-thickness rotator cuff tear demonstrated. There were also degenerative findings. (PX4, p.1744).

Petitioner followed up with Dr. White on *November 15, 2012*. Dr. White had reviewed the MRI and noted it revealed supraspinatus and infraspinatus tendinopathy with probable partial-thickness rotator cuff tear. He discussed with Petitioner a shoulder arthroscopy, as Petitioner had decided ahead of time that she did not want therapy. Petitioner asked that the surgery be done after the holidays. (PX4, p.1763).

Petitioner had a preoperative visit with Dr. Sharon Ollee at Dreyer Medical Clinic on *December 11, 2012*. Dr. Ollee noted a history of pain located in the superior aspect of the [right] shoulder which was worse at night and sometimes radiated down into the right arm. It is noted that Petitioner denied any preceding injury or change in activity. It is noted that Petitioner worked as an office manager at a surgery center. There was no mention about any specific work activities. (PX4, p.1797).

Petitioner next saw Dr. White on *December 19, 2012*. She testified she had told Dr. White that she did not recall an injury to her *left elbow*, but that she had been using her left arm a lot trying to protect the right. (Trans.87). Dr. White noted that Petitioner did not recall any injury, but that about a month before, she began getting pain in the lateral aspect of the left elbow. Dr. White further noted that Petitioner reported she had been using her left arm a lot trying to protect the right. Dr. White diagnosed left elbow pain and lateral epicondylitis. He provided an injection of Depo-Medrol and Marcaine to Petitioner's left elbow. (PX4, p.1805).

Petitioner testified that she probably told Patti the next day after her December 19, 2012 doctor's visit, or another day after that, that she developed pain in her left side. (Trans.88). She testified that she did not have a lot of conversations with Patti about treatment on her different body parts. (Trans.88). Petitioner testified that she got a left elbow cortisone injection on December 19, 2012 by Dr. White. (Trans.89).

Petitioner had surgery on her right shoulder by Dr. White on *December 28, 2012*. (PX4, p.1814). She testified that she went off work at that time and was off until she attempted to go back to work for two weeks and a couple of days starting *March 23, 2013*. (Trans.77, 78). The surgery was a right shoulder arthroscopy with rotator cuff repair and subacromial decompression. The preoperative and postoperative findings were right shoulder impingement with rotator cuff tear. (PX4, p.1814). Petitioner testified that she thought there was some improvement from the surgery, but it took an unusually long time. (Trans.77). Petitioner testified that while recuperating from her right shoulder surgery, she was having chronic pain in her left elbow. (Trans.86).

Petitioner testified she obtained a brace for her left arm in December 2012. (Trans.57). She testified she would not cover up her braces on either the right or left when Patti came to visit the office. (Trans.85). Petitioner testified she saw Patti roughly once a week. (Trans.85). She testified that Patti never suggested filing a workers' compensation case. (Trans.85).

A Dreyer Medical Clinic physical therapy note dated *January 18, 2013* provides that Petitioner reported falling down two stairs the previous night as she was going into her garage. She had been on a cell phone while wearing her sling but did not land on her right shoulder. She went to a walk-in care facility in the morning. The note provides that Petitioner reported no increased pain to her right shoulder due to the fall. (PX4, p.1864).

Another physical therapy note dated *January 22, 2013* provides that Petitioner reported pain in the anterior lateral portion of her right shoulder, which was different than what she had experienced, and it had started between 24-48 hours earlier. She reported that she did not know if she slept wrong or did something she was not supposed to do. (PX4, p.1878).

Petitioner saw Dr. White on *January 28, 2013*. Dr. White recommended continuing physical therapy and provided a note for Petitioner to be off work for another month. Here original work status was due to run out on February 8, 2013. (PX4, p.1908).

Petitioner returned to see Dr. White on *March 18, 2013*. It is noted that Petitioner advised she needed to get back to work by the end of the week because her FMLA would run out. However, Dr. White offered to continue Petitioner's disability. The note provides that Dr. White told Petitioner that any restrictions were acceptable to him and it really depended on what was acceptable to her employer. After having Petitioner go over her job with him, Dr. White suggested a five-pound lifting limit and no overhead use. (PX4, p.2035). Petitioner testified that she did not believe Dr. White placed any restrictions on her for the time she returned to work. (Trans.80).

Petitioner testified that during the work trial period *[March 23, 2013 through April 8, 2013]*, it was very difficult to get through a whole eight-hour day, especially sitting at the desk or doing any kind of grasping or pulling or lifting. (Trans.80). She testified that keyboarding was also difficult. (Trans.80). She testified that her right shoulder and both elbows were affected by these activities. (Trans.81, 82). She testified she tried not to do any lifting with her right arm. (Trans.129).

Petitioner testified she filed her cases at the Commission in the first quarter of 2013, before she was terminated by Respondent. (Trans.102, 103). The record reflects that Petitioner's Applications were all filed on *March 19, 2013*. She testified that nobody from the Respondent contacted her before she was terminated to discuss any of the claims. (Trans.103).

Petitioner did not return to see Dr. White, but instead saw Dr. Kenneth Schiffman at Hinsdale Orthopaedics for the first time on *April 9, 2013*. Dr. Schiffman noted that Petitioner sought a second opinion on her right shoulder and bilateral elbow pain. It is noted that she complained of pain with typing and pulling. That was the extent of work activities mentioned. Dr. Schiffman diagnosed status post right rotator cuff repair and bilateral lateral epicondylitis. He suggested continued physical therapy and placed Petitioner off work. (Respondent's Exhibit 20, p.012-014).

Petitioner saw Dr. Schiffman again on *May 10, 2013* and reported that her right shoulder pain woke her up at night, but that therapy was progressing well, and she had limited range of motion due to elbow pain. Dr. Schiffman recommended continued physical therapy on the right shoulder as well as on the left elbow. He provided a referral to Dr. Kirincic for pain management program to help with sleep and manage the pain in the elbow. He kept Petitioner off work for the next five weeks. (Respondent's Exhibit (*hereinafter*, RX) 20, p.008-009).

Petitioner testified that her last visit with Dr. Schiffman was on *June 20, 2013*, when he released her from care with permanent restrictions. (Trans.78). He noted that Petitioner's right shoulder was doing well but she had persistent [left] elbow pain secondary to lateral epicondylitis. He placed restrictions of no lifting more than five pounds, no overhead reaching, no repetitive motion for the elbow or wrist, and minimal keyboard use. He advised Petitioner to return as needed. (PX2). Petitioner testified that Respondent did not offer her a position to accommodate Dr. Schiffman's permanent restrictions. (Trans.94). Petitioner testified she would not be able to return to her previous job because she does not have the stamina for it, she would be in pain, and she would not last more than an hour at most probably. (Trans.94). She testified she has been unable to do her job between December 2012 and today. (Trans.95).

Petitioner testified that she was in a supervisory position with Respondent. (Trans.105). She testified that she understood the policy was for people under her supervision to report accidents or injuries to her. (Trans.105). She testified it was not something she/they were specifically trained on. (Trans.105). She testified she was responsible for a portion of the policy manual. (Trans.105, 106). Then she testified that she would not have contributed to the policy concerning reporting accidents and injuries. (Trans.106). She testified that the policy would have been drafted by a supervisor with more authority than herself. (Trans.106).

Petitioner testified she filled out an accident report in 2000. (Trans.106, 107; RX3). She identified her handwriting on Respondent's Exhibit 3 and identified it as an Employee Report of Occupational Injury or Illness. (Trans.107; RX3). She confirmed that her manager's name, Patti Murphy, is also listed on the report, which is dated February 23, 2000. (Trans.108). Petitioner testified that she was aware that the "company" [Respondent] had procedures in place for reporting accidents and injuries, and that she followed that. (Trans.108). Petitioner testified that she did not file or complete any accident reports for the current claimed accidents/injuries, but instead requested FMLA leave for the surgery on her right shoulder. (Trans.108).

Petitioner testified that she signed a form called a Certification of Health Care Provider and dated 2007. (Trans.110; RX 5). She testified she had requested Family Medical Leave on a prior occasion due to shingles. (Trans.111). Petitioner testified that Dr. White did complete a form for her to be off work in 2012 for her right shoulder surgery. (Trans.112). She testified that Dr. Malkani completed a form for her to be off work in 2011 for injuries she claims occurred at work. (Trans.112, 113).

When asked why she requested Family Medical Leave instead of filing for workers' compensation, Petitioner testified that she did file for workers' compensation and did notify her supervisor that she was hurt at work. (Trans.113). She testified that her supervisor told her to go to the doctor. (Trans.113). Petitioner testified that she did not tell anyone else [at work] other than Patti Murphy of her injuries from work activities. (Trans.131). Petitioner testified

that she had access to accident reports that could be completed for a work-related injury. (Trans.115). When asked if it was up to her as an employee of the company to complete an accident report if there was an accident or injury that occurred at work, Petitioner testified "yes" and that the circumstances of "that particular accident report" [the 2000 accident report], were that the nurse at the center pulled that report and filled it out and she signed it, because the nurse treated her foot that hit the door. (Trans.116).

Petitioner testified that she had her own office at United Therapies up to 2011, but after that she was at a desk with other employees in the front area. (Trans.116). Petitioner testified she did not have an assistant during the time she was with Respondent. (Trans.117). Petitioner testified that Joanna Guerra was not her assistant, but her subordinate and she was Joanna's supervisor. (Trans.117). Petitioner testified she did not ask Joanna to do her filing, or to pull files and bring them to her. (Trans.118). Petitioner testified that she would not ask Joanna to pull credentialing files because no one handled the credentialing files but Petitioner. (Trans.119). Petitioner testified that she would ask Joanna to pull and bring her a patient file. (Trans.119). Petitioner testified that she had control over how many files she could put in a cabinet. (Trans.119). Petitioner testified that when she was in her own office with the file cabinets, it was only possible to pull one file at a time, but she might have pulled several files to work on so as not to have to keep pulling and cramming. (Trans.117). She testified the files may have come out of different drawers. (Trans.117). Petitioner testified she was private about her health issues and treatment at work. (Trans.120). She testified that one of the files that she worked with weighed as much as a two-pound weight. (Trans.122). She testified that it was not an eight-hour, nonstop activity of pulling out files and putting back files, and that she did not type on a keyboard eight hours a day nonstop. (Trans.122). She testified that some of her activities [at work] involved being on the phone. (Trans.123).

She testified that the activity of running reports involved entering something into a computer and the reports would be printed out on a printer. (Trans.123).

Petitioner testified that she had to move files to a temporary location while the LaGrange facility was being remodeled in 2011. (Trans.126, 127). She testified she had to pack the files into boxes herself. (Trans.25). She testified that the Respondent did not hire a moving company to move files. (Trans.127). Then she testified that some of the files that were put in boxes during the remodel were moved by a hired company. (Trans.127). Petitioner testified that boxes of files she was working on went to the new location with her. (Trans.127).

Petitioner identified at trial a letter from Star Insurance addressed to her and dated *April 3, 2013* acknowledging a report of injury. (Trans.138, 139; RX16). She identified the date of injury in the letter as December 19, 2012. (Trans.139; RX16). Petitioner testified she had not

received any letters concerning any of her claims from any other insurance company prior to the April 3, 2013 letter from Star Insurance. (Trans.139).

Petitioner identified at trial a Memo dated *April 18, 2013* from Jackie Ladewig to her concerning a grant of unpaid personal leave of absence through *May 14, 2014*. (Trans.135, 136; RX12). She testified that it concerned recovery for her right shoulder surgery and bilateral elbows, although that specific information was not in the memo. (Trans.136; RX12). Petitioner agreed that the Memo requested that Petitioner advise Respondent of her status and ability to return to work on or before *May 14, 2013*. (Trans.136; RX12). Petitioner testified she told Respondent that she did not have a doctor's appointment until June and that is when she would know. (Trans.137; RX12). She testified that Respondent had a work status from Dr. Schiffman stating she would be off. (Trans.137; RX12).

Petitioner identified at trial a letter dated *May 17, 2013* from Patti Murphy to her which was a letter of termination. (Trans.137; RX14). Petitioner confirmed that the letter notified her that she had exhausted all 12 weeks of Family Medical Leave. (Trans.137, 138; RX14). Petitioner testified she had been unable to return to work by May 17, 2013. (Trans.138). Petitioner testified that she notified Respondent in *March 2013* of her work-related injuries and was terminated two months later. (Trans.149).

Petitioner testified there is an outstanding bill from ATI Physical Therapy for therapy concerning her right shoulder and both elbows, but primarily the left elbow and right shoulder. (Trans.96, 97; PX3). Petitioner testified she wasn't aware of an outstanding charge by Dr. Schiffman at Hinsdale Orthopaedic Associates. (Trans.97; PX2). Petitioner testified she is not aware of any outstanding balance for any treatment at Dreyer Medical Clinic. (Trans.98; PX4). Petitioner testified that her personal insurance through Respondent paid for treatment. (Trans.98). She testified that the insurance stopped when she was terminated on May 17, 2013. (Trans.98, 99). Petitioner testified she received short-term disability payments from the date of her surgery [December 28, 2012] up to March 22, 2013, and then from April 9, 2013, when Dr. Schiffman released her from care, through June 20, 2013. (Trans.100, 101; RX22). She testified she thought she received the short-term disability payments as part of the FMLA process. (Trans.101).

Petitioner testified at the time of the trial that her left shoulder is better than her right shoulder. (Trans.71). She testified that sometimes she cannot unload wet clothes out of a washing machine and put them into the dryer, and she cannot load groceries into the back of her car. (Trans.71, 90). She testified her husband must go shopping with her. (Trans.71). She testified her husband carries the laundry baskets of folded clothes upstairs and he helps to load and unload groceries. (Trans.91).

She testified she cannot do any kind of scrubbing or cleaning motion or lift anything too heavy because she feels weakness and has muscle spasms in both elbows from time to time. (Trans.90). She testified she notices the pain when she keyboards for about 15 to 20 minutes. (Trans.51). She testified she still has issues with her right elbow being tremendously weak and has pain located on the outside of her elbow. (Trans.51). She testified she notices pain and swelling in her left elbow that never completely goes away. (Trans.89). She testified she is not planning to get anymore treatment for her left shoulder. (Trans.72). She testified she has no plan to go out and look for work. (Trans.103, 104).

Petitioner testified that the most she can do at a gym is the treadmill. (Trans.92). She testified she cannot participate in any kind of sports-like activities and must be careful with even what she wears sometimes if it is difficult to put on or take off because it requires over-extension of her arms. (Trans.92). When asked what sports she is unable to do that she used to do, Petitioner testified she is unable to ride a bike like she did before. (Trans.130). She testified that gripping the handlebars, squeezing the brakes, and leaning forward while bike riding is difficult on her elbows. (Trans.170). She testified that her husband had not helped her put her boots on the day of trial because they zip [up], but he had helped her with her coat. (Trans.130). Petitioner testified she is not "whole anymore." (Trans.92, 93). Petitioner testified she has good and bad days and tries not to take any pain medication stronger than Aleve or Advil. (Trans.93). Petitioner testified she has not worked in an employment setting since terminated by Respondent, and not since released by Dr. Schiffman. (Trans.93).

Joanna Guerra-Barr testified that she works for the Respondent, United Therapies and started on June 23, 2010. She testified that Petitioner was her former manager. She testified that her job duties were/are to disassemble/assemble charts, get labs, file paperwork whenever needed, and pass out faxes. She further testified that sometimes she helps patients change whenever they need it and helps with translations from Spanish to English. (Trans.178). She testified that she did filing and would file for patients and doctors. (Trans.179). She testified that prior to switching to scanning, she would pull patient charts and file any paperwork in them. (Trans.180). She testified that doctors' file cabinets were in a "mobile room" and some were in Petitioner's office, but patient files were in the front office. (Trans.181). She testified there was a time when Petitioner had an office and then she no longer had an office. (Trans.181). She testified that the reason for the change was because the building [in LaGrange] went into construction in the middle of 2011 for the purpose of becoming am ambulatory surgery center. (Trans.182).

Joanna testified that while working at United Therapies when Petitioner was her manager, Petitioner would ask her to file for her. (Trans.184). She testified that Petitioner would ask her to file some of the doctors' credentialing paperwork for her. (Trans.184, 185).

She testified that Petitioner showed her where everything went so Joanna could help her out. (Trans.185). She testified that she did all the filing. (Trans.219). Joanna testified that Petitioner would show her how to look on the computer to check whether a doctor's license was current. (Trans.185). She testified that she filed for Petitioner on a daily basis and did the majority of filing for Petitioner. (Trans.186). She testified that when Petitioner wanted files boxed, she would show Joanna where the paperwork went and tell Joanna to box them up. (Trans.231).

Joanna testified that she is 5'2" and the filing cabinets were no higher than 5'3" or 5'4". (Trans.187). She testified that there were on average 40 sheets of paper in a patient file, and around 60-70 sheets of paper in each physician file. (Trans.188). She testified that if she did not have to schedule or check in a patient, she would file. (Trans.189). She testified she never had difficulty removing a file out of or placing a file into a cabinet, whether it was a patient or physician file. (Trans.190).

Joanna testified that after moving back into a remodeled LaGrange office, her seat was at the front desk, along with Zulema, a co-worker, and Petitioner. (Trans.196). She testified that she knew that Petitioner's job duties were to supervise her and Zulema, and also to do credentialing for the doctors and anesthesiologists. (Trans.199). She testified that she had opportunities to observe Petitioner during the time she was in the front desk area. (Trans.200, 201). She testified she had observed her on the internet, using the computer keyboard, and using the phone. (Trans.201, 202). She testified that she never observed Petitioner lifting boxes full of files during the time she worked with her. Joanna testified that she did observe Petitioner putting files into and taking files out of a cabinet, but she never observed Petitioner having difficulty doing that. (Trans.202, 203).

Joanna testified that Petitioner was very quiet about whatever she felt but complained about her shoulder or whatever was hurting her at the time. (Trans.203, 219). She testified that Petitioner would not be specific as to why. (Trans.203). She testified that Petitioner never told her she injured herself by doing something at work, during the time she worked with her. (Trans.203). She testified about the procedure she was aware of in the event of an accident or injury. (Trans.204). She testified that one would have to go to their manager and let them know, and that there was an incident report to fill out. (Trans.204, 205). She testified she was made aware of the procedure because "[w]e get trained on it, and also it's in our policy." (Trans.205). She testified that if she had become injured or had an accident at work, she would tell Petitioner. (Trans.205). She testified that Patti Murphy showed up at the office once or couple of times weekly. (Trans.235).

Kathleen Duprey-Tagge testified that she knows Petitioner from working with her at United Shockwave Therapies (United Therapies/Respondent). (Trans.256). She testified she started with Respondent in January 2003 and left in September 2010. She testified she became

the fixed site manager for LaGrange, Park Ridge and the Hinsdale facility, but primarily worked in Park Ridge. (Trans.257). She testified she did not have an office in LaGrange but would go and visit and meet with employees there. (Trans.257, 258). She testified that Petitioner reported to her from about 2005 or 2006 until she left in 2010. (Trans.258). She testified she was familiar with Petitioner's duties and had an opportunity to see Petitioner working while she was there. (Trans.259). She testified that when Petitioner was in the front desk space, Petitioner would sign in patients, answer phones, schedule patients, and prepare and assemble patient charts. (Trans.259). She testified that Respondent kept physician files for credentialing. (Trans.262). She testified that patient files were kept for a little while and purged every quarter.

Kathleen testified that when Petitioner had her own office, to the right of her desk there were three tall file cabinets, each containing four drawers. (Trans.263). Kathleen testified she had occasion to open the file cabinets and take physician files out when she was looking for physician information. (Trans.263, 264). She testified that some of the files could be full at times, but she does not believe she had difficulty taking a file out. (Trans.264).

Kathleen testified that employees under her supervision were informed through regular staff meetings of what to do if they became hurt at work. (Trans.265). She testified that the meetings occurred every one to two months and she was in attendance, along with supervisors and Patti Murphy. (Trans.266). She testified that Petitioner attended those meetings. (Trans.266). Kathleen testified that she was someone who prepared an accident/incident report and she had prepared accident/incident reports during the time she worked for Respondent. (Trans.267). She testified that based on her recollection, Petitioner never told her she injured herself from something she did while working. (Trans.267, 268).

Kathleen testified she would have prepared an accident/incident report if Petitioner had told her she was injured at work, as that was her practice. (Trans.268). She testified that based on her recollection, Petitioner never asked her to prepare an accident/incident report and did not do anything at work and then complain about being injured. (Trans.268). She further testified that to her recollection, no employee with Respondent told her that Petitioner had been injured while working. (Trans.268).

Kathleen testified that Petitioner's job for part of the time was organizing and keeping the credentialing files. (Trans.272, 273). She testified that based on her recollection, she didn't recall ever seeing Petitioner's forearm brace covering the thumb and coming around the side and coming up the forearm. (Trans.282). Kathleen testified that there were accident reporting procedures for employees and managers online and a hard copy. (Trans.284). Kathleen testified that she had met with Patti Murphy once or twice after she left the company and they did not talk about Petitioner or anything to do with this case. (Trans.286).

Thomas Peer testified that he knows Petitioner from working with her at United Therapies from 2010 through 2012-2013 as a fixed site manager. (Trans.293). He testified he took Kathleen's position when she left. (Trans.294). He testified that Petitioner reported to him. (Trans.294). Thomas testified that he was a mobile worker and worked at Respondent's both centers, Park Ridge and LaGrange. (Trans.294, 295). He testified he was mostly at the LaGrange facility, starting around 2012-2013. (Trans.295). He testified that prior to that, he went to the LaGrange facility about once or twice a week to meet with staff, keep track of operations and make sure the facilities were running correctly and schedules were on track. (Trans.295).

Thomas testified that he met with Petitioner every time he visited the [LaGrange] facility to discuss how scheduling was going with the doctors, any concerns or issues with the facilities, staff, and patients, and financial concerns. (Trans.296). He testified that Petitioner was the front desk office coordinator and also the credentialing coordinator. (Trans.296). He testified that when the [LaGrange] facility was remodeled, Petitioner shared the office with the front desk as there was no separate office. (Trans.296, 297). He testified that at the front office area, Petitioner had a desk that was up against a wall, there were patient file cabinets and a copier, and she basically shared the office with the scheduling staff who were Joanna and Zulema. (Trans.297). He testified that prior to that she had her own office with the credentialing files located there. (Trans.297, 321). He testified he did not remember how many cabinets there were, but there were cabinets in Petitioner's office and files were kept in each of the drawers. (Trans.322). He testified that he had an opportunity to open all the drawers [in the cabinets in Petitioner's office]. (Trans.322). He testified that the files would vary in thickness depending upon how long a doctor had been associated with the company, and some files were very thin if a doctor was new. (Trans.326). He testified that he did not experience files in drawers in Petitioner's office being tight. (Trans.327).

Thomas testified that he had occasion to take a file out of and put back into drawers and he never had any difficulty with same. (Trans.302). He testified he did not think any drawers in the file cabinets contained more files than they could handle. (Trans.303). He testified that when Petitioner was out for her shoulder surgery, he did the credentialing and had a reason to go into the file cabinets, but prior to that it was to review a file. (Trans.303). He testified he never noticed Petitioner at any time having difficulty taking a file out of a cabinet or putting a file back into a cabinet. (Trans.305). He testified that based on his recollection, Petitioner never told him she had difficulty with same. He testified that based on his recollection, Petitioner never told him she injured herself from anything she did at work. (Trans.205). He testified that anybody he supervised was required to tell him if they were hurt at work. (Trans.305).

Thomas testified that he believed the LaGrange facility was remodeled from 2011 through 2012 and was a one-year project. (Trans.301). He testified that the file cabinets were big, long, probably 3-foot, 4-foot file cabinets, standard that had a door to open and then pull out and push in drawers. (Trans.301). Thomas testified that the files were moved to the front office because Petitioner no longer had an office and she needed access to them [after the remodel]. (Trans.328, 329). He testified that paperwork still needed to be filed, and in addition to credentialing duties that he took over for Petitioner, he also worked with some of the patient files. (Trans.329). He testified that whenever he was there [LaGrange], he would find Petitioner working at her desk on credentialing, typing, getting physicians ready and scheduling patients through the computer and phone. (Trans.298). He testified that credentialing entailed going through many websites to verify that a physician was qualified through credentialing boards and licensed through the State of Illinois to operate. (Trans.298, 299). He testified that documents would be requested from the physician to fill out and show proficiency in skill sets. (Trans.299). He testified that Petitioner did those things. (Trans.299). Thomas testified that physician licensing and information were kept in paper form because they were printed and there was a file cabinet for those documents. (Trans.300).

Thomas testified that Respondent had a policy for reporting work-related injuries and employees were instructed to notify their supervisor if they were hurt. He further testified that the policy provided that an employee was responsible for seeking out medical care if needed, and they were to let their supervisor know if they were going to seek that out because there was paperwork to fill out. (Trans.206). He testified that policies were updated annually, and supervisors were given all policies that pertained to their departments, so they would have been required to read them and know. (Trans.307).

Thomas testified that he was always reachable by phone, text or email by anyone he supervised. (Trans.307). He testified that an accident/incident report has a section for him to fill out and a section for the employee to fill out to describe what happened an how it happened. (Trans.308). He testified that if that was given to him, he would then forward it to Patti Murphy. (Trans.307, 308). He testified that if he was notified of an accident or incident, he would then provide the paperwork to the employee for them to complete. (Trans.308, 309).

Thomas testified that he had prepared accident/incident reports during the time he worked for Respondent, but that to his recollection, Petitioner never asked him to prepare one. (Trans.309). He testified that to his recollection, no other employee told him that Petitioner had been injured while doing something at work. (Trans.309). He testified that prior to counsel for Respondent calling him and notifying him about testifying, maybe August or July of 2016, he was not aware that Petitioner had been claiming she was injured at work. (Trans.310).

Thomas testified that on average there were at least 35 to 40 physician files in any given year. (Trans.312). He testified that if they were preparing for an accreditation, all the files would be reviewed to make sure everything was accounted for in them. Aside from that, he testified, more than likely a file would just be pulled if a physician needed to be verified. (Trans.313).

Thomas testified that he had not talked with Patti Murphy since he left the company in 2013. (Trans.331). He testified he had not talked to Jackie Ladewig about Petitioner's claims since he left the company, but he had been talking with her while sitting out [in the public waiting room at the IWCC]. (Trans.332). He testified they never had a discussion about when Jackie first heard about Petitioner's injuries. (Trans.332). Thomas testified that prior to his termination from United Therapies, as Petitioner's supervisor, he had a pretty good idea of what she did for Respondent. (Trans.334).

Jackie Ladewig testified she was employed by Respondent, United Therapies, which changed its name. She testified she knew Petitioner from working for the same company [Respondent]. (Trans.343). She testified she started on November 27, 1989. (Trans.344). She testified she did not hire Petitioner and did not work side-by-side with her, but she trained her in February 1994 when the center in LaGrange was opened. (Trans.344). She testified that when she started with Respondent, she was a part-time front desk scheduler and at the present is medical staff and clinical staff credentialing and fixed site scheduling manager. (Trans.346). She testified that her duties consist of credentialing the clinical staff, nurses, mobile techs, and physicians. (Trans.346). She testified that she manages the front desk staff at Park Ridge and at LaGrange and works out of Rosemont, her permanent/physical location, on some system conversions. (Trans.347).

Jackie testified that towards the middle of 2014 through half of 2016, she was at the LaGrange office on a day-to-day basis, and then transitioned back to Rosemont. She testified she worked in Human Resources for Respondent for about 14 years. (Trans.347). She testified when she was with HR, she did payroll, benefits and records. She was the only person in HR. (Trans.348). She testified she also on-boarded new hires and maintained employee files. (Trans.348). She testified she also prepared employee documents concerning requests for leave of absence. (Trans.348, 349). She testified that sometimes a supervisor would let her know someone was going on leave and Jackie would then send the employee paperwork. (Trans.349). She testified that sometimes the employee would contact her directly and request FMLA forms, specifically the Certificate of Health Care Provider. (Trans.349). She testified that she received FMLA paperwork from Petitioner on a couple of occasions. (Trans.349). She testified she also processed short-term disability for an employee. (Trans.350). She testified that if someone was hurt on the job, that person would either notify their supervisor or her,

and depending on the injury, they would either go to "employee health" or their doctor. (Trans.351). She testified that if there was a work comp case, she would notify the [insurance] agent, who would then initiate a claim with the work comp carrier. (Trans.351). She testified that then they [work comp carrier] would then contact her for the employee's contact information and handle the rest with the employee. (Trans.351).

Jackie testified that during the time Petitioner was working at United Therapies, she was never contacted about a work comp claim by anyone concerning Petitioner. (Trans.351). She testified that she processed a lot of doctor's notes and intermittent FMLA forms for Petitioner for which she assumed were personal injuries. (Trans.352). She testified it was not brought to her attention that there were [work] accidents. (Trans.352).

Jackie testified that Petitioner was the office coordinator at LaGrange while working for Respondent. (Trans.352). She testified Petitioner managed the front desk and credentialed the physicians (urologists). (Trans.352). She testified that Petitioner oversaw all the front desk functions, then did mobile scheduling for a period of time, which was a separate division of the company. (Trans.352, 353). She testified it was a lot of scheduling, overseeing and supervising the schedulers. (Trans.353). Jackie testified that credentialing involved collecting applications, paperwork, and verifying licenses. (Trans.353). She testified she did not know how verification was done because she was not doing it at the time, but she testified it could have been on the phone or online. (Trans.353).

Jackie testified that at the LaGrange location they had patient charts, medical records and credentialing files. (Trans.354). She testified that patient charts and physician files were kept in a folder. (Trans.356). She testified that whatever holds 40 pages was kept in a file and then boxed up. Every three months the files were sent to whoever was storing them at the time. (Trans.357). She testified this occurred prior to the remodel, but at some point after the remodel, she thought they stopped keeping paper and everything became electronic. (Trans.357).

Jackie testified that before the remodel, there were file cabinets in Petitioner's office and then there was an office for mobile scheduling. She thought there were file cabinets there and there may have been some up front [office]. (Trans.358). She testified that she had been at the LaGrange facility when Petitioner was there and observed the filing cabinets that were in Petitioner's office. She testified that the cabinets were two big cabinets and had five drawers. (Trans.359). She testified she did not have occasion to open the cabinets. (Trans.360).

Jackie testified that the procedure for reporting accidents/injuries was to notify your supervisor and if the supervisor was not available, then you would notify HR. She testified that one could also call the work comp carrier and go to Employee Health, depending on the

situation. (Trans.361). She testified that the procedure was in the policy and all employees have access to the policies as they were kept in binders. (Trans.361). Jackie testified that she talked with Petitioner over the phone many times and more times than person-to-person contact, during the time Petitioner worked for Respondent. (Trans.362).

Jackie testified that during their phone conversations, they talked about aches and pains, but it did not come up that she hurt herself or hit herself on the desk or anything like that. (Trans.363). Jackie testified she used to talk about her husband's shoulder and she does not remember if Petitioner mentioned having difficulty doing some activities at work. (Trans.363). She testified that during their phone conversations, Petitioner never mentioned she was experiencing pain after doing a certain activity while at work. (Trans.364). Jackie testified that when she and Petitioner talked about her shoulder bothering her and Jackie's husband's shoulder, it was casual conversation about old age. (Trans.392, 393). Jackie testified that she did not recall Petitioner saying her shoulder was bothering her because of heavy files she has to move for credentialing. (Trans.393). Jackie testified she knew about Petitioner's elbows because it was on the FMLA forms. (Trans.394).

Jackie testified that she learned that Petitioner was claiming she had been hurt at work after Petitioner was terminated. Jackie identified at trial a notice of FMLA directed at Petitioner and letting Petitioner know how many available hours she had. (Trans.365; RX6). Jackie testified that she prepared the form. (Trans.365). She testified that two of her FMLAs [requests] might have been intermittent for physical therapy and doctor's appointments. She testified then there was another one [FMLA request] when Petitioner was out for surgery and that was short-term disability. (Trans.366). Jackie explained what intermittent FMLA was. (Trans.366).

Jackie identified at trial a letter dated March 13, 2013 from Petitioner's attorney addressed to United Therapies stating they represented her in a work comp case. (Trans.368, 369; RX11). Jackie testified that she did not see that letter in March but did see the Applications. (Trans.369). She testified that the Applications were in her box but may have gone to Respondent's COO or CFO [Bruce] first. (Trans.369, 370). She testified that her receipt of the Applications was the first time she was made aware that Petitioner was claiming she was injured at work. (Trans.370). She testified she saw them in May or June [2013]. (Trans.371).

Jackie identified at trial a document prepared by her in April 2013 letting Petitioner know that her FMLA time was exhausted. (Trans.371, 372; RX12). She testified she would have mailed that by certified mail. She testified that the letter was about granting Petitioner additional unpaid personal leave through May 14 [2013]. (Trans.373). Jackie read the last paragraph which requested that Petitioner advise of her status and ability to return to work on or before May 15, 2013. (Trans.374; RX12). Jackie testified that she received the Applications

after and was a little confused as to what they were, since she was not aware this was work comp. (Trans.374, 375). She testified that had she known she was dealing with work comp, she would not have sent the memo/letter to Petitioner discussing about FMLA and unpaid personal leave. (Trans.375).

Jackie testified that when she saw the Applications, she contacted the agent and asked what to do with them. She testified they were then sent to the insurance agent who contacted the carrier and they took it from there. (Trans.378). She testified that the insurance company had not been aware of a work comp claim before Petitioner was gone. (Trans.378).

Jackie testified that in 2013 when she received the Applications, she asked Patti Murphy if she was aware of the claims. (Trans.384). She testified that Patti told her she was not aware of any work-related injury. (Trans.384, 385). Jackie testified that she was aware that Patti had testified that she was in a meeting in 2016 where everyone expressed shock at the claim that Petitioner had a work-related claim against the Respondent. (Trans.386). However, Jackie testified that Patti had left the company in May 2016, and she did not remember any meetings discussing a work-related injury [by Petitioner]. (Trans.386). Jackie testified that what may have happened was that in 2015 Patti would have had a conversation with Nancy Kimbrell because she was the director of HR at the time. (Trans.387). She testified that she wished she had known that Petitioner claimed a work-related injury against the Respondent because she would have filed it right away for her. (Trans.388).

Jackie testified on re-direct examination that when someone gave notice of an injury at work, there was an internal incident/accident report form that is completed, and it was in existence during the time Petitioner worked for Respondent. (Trans.402).

Patti Murphy testified that she first started working for Respondent in April 1999. She testified she started out as Director of Operations and within about the first six months she became Vice President of Operations. She testified she retired on May 4, 2016. (Trans.5, 6). She testified she knew Petitioner because she was the office coordinator at Respondent's LaGrange site. She testified that Petitioner reported to her manager and then to Patti. She testified that Kathleen DuPrey-Tagge was a manager under her and then Thomas Peer took over as manager of the fixed site. (Trans.6).

Patti testified that as an office coordinator, Petitioner was responsible for the operations of the front desk, to sign patients in, get their insurance cards, give them forms to sign, get the chart together, and put charts on the rack for the nurse to proceed with the procedure. (Trans.11). She testified that at the end of the day after everybody checked the chart, the front office received the chart back, would disassemble the chart, file it away and make sure the billing office gets their forms, and physicians get their op reports. (Trans.11, 12).

Patti testified that after a few years, Petitioner was given the task of physician credentialing. (Trans.12).

Patti testified that Petitioner worked at the LaGrange facility, but Patti's office was in Rosemont. (Trans.13). Patti testified that as part of her job, she went to all of the facilities weekly and would meet with most of the staff and assure everything was running smoothly. (Trans.13). Patti testified there was an employee handbook that was signed off by employees annually. (Trans.14). Patti testified that an Employee Report of Occupational Injury or Illness was within the employee manual. (Trans.14).

Patti testified that if somebody [employee] was thinking they needed a leave of absence, it would be considered personal leave if not FMLA. (Tranas.17). Patti testified that she did not recall seeing an incident report completed by Petitioner. She testified that an employee can complete it, or their supervisor can complete it with them. (Trans.20). She testified that she was not given an incident report concerning Petitioner by any of her supervisors. (Trans.20). She testified that if Petitioner had a work injury, she would report it to her supervisor, who was Kathleen or Thomas, and then each of her supervisors would have notified Patti, because that was the policy. (Trans.21). She testified that neither Kathleen nor Thomas notified her of any injury claimed by Petitioner. (Trans.21).

Patti testified that she first learned that Petitioner was claiming a work injury in 2016 through Nancy Kimbrell, the Director of Human Resources, who came into her office and said they were notified that Petitioner stated she was injured. (Trans.21). She testified she did not remember the exact date. (Trans.40). She testified that Nancy was not the head of Human Resources in 2010, 2011 or 2012, but Jackie Ladewig was. (Trans.40, 41). Patti testified that all workers' compensation claims were supposed to be reported to Human Resources and she was surprised that Petitioner was making workers' comp claims. (Trans.40, 41).

Patti testified that Jackie Ladewig worked for Respondent in 2010, 2011 and 2012 and was the Human Resource Manager, who would have let Patti know about a work injury. (Trans.22, 23). Patti testified that to her recollection, Jackie never let her know about a work injury involving Petitioner. (Trans.23). She testified that Petitioner never mentioned being hurt at work to her. She testified that Petitioner had said she had a headache or aches and pains but not about being hurt at work. (Trans.23).

Patti testified she knew Petitioner had some kind of surgery, but she did not know what it was for and did not ask. She testified it was an abdominal type of thing initially, and Petitioner also had surgery on her shoulder before she left. She testified that Petitioner felt it had to do with lifting babies as a grandmother, as that is what Petitioner told her. (Trans.24).

Patti testified that when Petitioner came back from her surgery, she stated she was in a lot of pain, so Patti went to LaGrange and met with her. (Trans.24, 25). She testified that she told Petitioner she was concerned for her and whether she was able to be back. (Trans.25). She testified that Petitioner told her she was in a considerable amount of pain sitting there but had a release from her physician. She testified that when someone is in so much pain, there is something wrong, and Patti did not want Petitioner to continue sitting in pain. Patti testified that she asked Petitioner what she thought it was [from]. (Trans.25). Patti testified that she asked Petitioner if something happened at work, and that Petitioner told her it did not. (Trans.26). Patti testified that Petitioner told her it was not work comp, nothing from work, and that she was going to be suing her surgeon. (Trans.26).

Patti testified that she did not want Petitioner to aggravate her shoulder any more than it was. (Trans.26). Patti testified that it is a requirement that if someone is hurt at work in any way, their supervisor would inform her, and they are to have it checked out. (Trans.26, 27).

Patti testified that pursuant to HIPAA, she was not privy to any information on insurance claims or benefit payouts for treatment or anything like that. (Trans.28). She testified she would not know if somebody was going to see a doctor for whatever reason, unless the person told her. She testified that at no time did Kathleen or Thomas tell her that Petitioner had a work injury, nor did either one of them tell her that Petitioner was complaining of pain after doing certain work tasks. (Trans.28). Patti testified that during 2010, 2011, 2012 and 2013 she spoke with Petitioner on a weekly basis, and that never did Petitioner discuss hurting herself at work at any point in time during their conversations. (Trans.39).

Patti testified that she was not aware that Petitioner was treating for alleged work injuries from August 2010 up until late 2012. (Trans.57, 58). She testified that Petitioner was a private person. (Trans.59). She testified that it was her impression that before 2016, Jackie did not realize that Petitioner was making a work comp claim. (Trans.61). She testified that she wasn't aware the Petitioner's claims had been on file since 2013. (Trans.63). She testified she was not aware that an insurance company was involved in defending against Petitioner's workers' compensation claims. (Trans.67, 68).

Patti testified as to her understanding being that a first report of injury is supposed to be completed by the supervisor of an employee. (Trans.92, 93). She testified she had never seen an April 5, 2013 letter from Petitioner's attorney. (RX2, p.93). She testified that apparently two insurance carriers had notice of Petitioner's claimed work injuries in 2013, but she was not aware of them being involved. (RX2; p.94).

Dr. Gregory Nicholson examined Petitioner on September 24, 2014 and generated a report upon Respondent's request. (RX1; p.1). He testified that he reviewed records that went

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back to 2010 concerning Petitioner's right elbow. He testified that he had clinical examination notes from Hinsdale Orthopaedics which recounted a shoulder surgery on the right side in 2012. He testified that Petitioner had last worked in May of 2013, when she was released from her job. (RX1; p.7). He testified that he specifically asked Petitioner if she had an injury to the right shoulder, and that Petitioner told him she did not. He testified that Petitioner told him she thought it was more from her desk job with lifting files and doing up-and-down activity with her arms. He testified that Petitioner was an office manager at a surgery center and that there was no specific injury that occurred either for the left elbow, right elbow or right shoulder. (RX1; p.7).

Dr. Nicholson testified that he examined Petitioner's elbows and shoulders. (RX1; p.8, 9). After examination and reviewing records and taking down a history from Petitioner, Dr. Nicholson testified that he felt Petitioner had tendinopathy in her elbows and right shoulder that was due to an endemic issue. (RX1; p.12). Dr. Nicholson testified that he had seen instances of repetitive movement with an upper extremity or a cumulative traumatic condition with an assembly line worker, somebody doing continuous activity the same way, such as screwing in a pipe the same way all day at a Ford plant, or a meat cutter. (RX1; p.13). Dr. Nicholson felt that Petitioner was able to do desk work, clerical work, but not repetitive assembly line activity, repetitive reach, grip or release activity and that lifting should be limited to 10 pounds from floor to chest height and limited on an occasional basis above chest height. (RX1; p.14, 15).

Dr. Nicholson testified that he generated an addendum report dated January 28, 2015. (RX1; p.16). Dr. Nicholson testified that he reviewed MRI reports and films on the right shoulder and right elbow. (RX1; p.16, 17, 18). He testified he also reviewed the operative report on the right shoulder. (RX1; p.23).

Dr. Nicholson testified pursuant to his reports that he felt there was no repetitive, cumulative disorder, trauma or specific injury that caused Petitioner's bilateral elbow pain or right shoulder issues, and that Petitioner's issues could not be discerned to be work-related. (RX1; p.25).

Dr. Jeffrey Coe examined Petitioner on August 18, 2015 and generated a report upon Petitioner's request. (PX1). Dr. Coe testified that Petitioner told him she had worked for a company [Respondent] for about 18 years and that her job was an office position where she worked eight or more hours each day for five days per week and used her upper extremities repeatedly in a variety of activities. (PX1; p.10). He testified that Petitioner described computer data entry, keyboard and mouse work, and moving files. (PX1; p.10, 11). He testified that Petitioner told him there were large files and she would take them from shelves and cabinets, she answered telephones, she wrote by hand, she filed and removed things from files.

(PX1; p.11). He testified that Petitioner described having a small desk with a computer on it and that the keyboard was in an awkward position, over on the side, because she liked to spread her files and charts out on the desk. (PX1; p.11).

He testified that Petitioner told him she had to move large and heavy files throughout the day to and from cabinets and onto and off of her desk. (PX1; p.11). He testified that Petitioner told him the first thing she noticed was some pain along the outer border of her right elbow. (PX1; p.11, 12). He testified that Petitioner told him her initial complaints began in 2010 and she was diagnosed with right lateral epicondylitis. (PX1; p.12). He testified that Petitioner told him she then developed some pain in the left side of her neck with her work activities which she related to the positioning of the computer and keyboard. (PX1; p.14). He testified that Petitioner told him with ongoing work she began to experience pain in her right shoulder which she related to forceful reaching down and pulling of files that were two to three inches thick and heavy. (PX1; p.15). He testified that Petitioner had no estimate of the weight of the files but told him they were tightly crammed into cabinets. (PX1; p.15).

Dr. Coe testified that Petitioner reported to him that with ongoing work and ongoing problems with her right shoulder and right elbow, she began to use her left arm more and developed pain in the outer border of her left elbow. (PX1; p.16). He testified that Petitioner's right shoulder symptoms were the most severe problem and she underwent surgery for it a little after Christmas 2012. (PX1; p.16).

Dr. Coe testified that Petitioner was a right-handed individual and by her description of her work requiring considerable use of her right arm, including the pinch grip, and pulling and tugging of files, that those activities caused the development of acute right lateral epicondylitis in the summer of 2010 which became a chronic condition. (PX1; p.18). Dr. Coe testified that he saw Petitioner five years after the summer of 2010. (PX1; p.22).

Dr. Coe testified that Petitioner's right shoulder problem emerged in the summer of 2012. (PX1; p.23, 24). Dr. Coe testified that as Petitioner's right elbow was hurting her, it was not uncommon for the next joint, which was the shoulder, to take the stress of activity. He testified that since it was hard to grip and pull with the right elbow because of the pain, people begin to move their arm more stiffly which begins to stress the next joint up. (PX1; p.24, 25). He testified this was based on his experience. (PX1; p.25). He testified that Dr. White diagnosed an impingement syndrome with a probable rotator cuff tear. (PX1; p.26). He testified that this diagnosis was something that could be seen in individuals who do forcefully exert their arm through the shoulder by reaching out and pulling towards them, doing things at or above shoulder height, which was something Petitioner described. (PX1; p.26).

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Dr. Coe testified that it was his opinion to a reasonable degree of medical certainty that Petitioner's continued work activities as office manager and coordinator caused a breakdown in her right shoulder. (PX1; p.26). He further testified that the right shoulder surgery Petitioner had was to a reasonable degree of medical certainty causally related to the repetitive activities that Petitioner described to him. (PX1; p.27).

Dr. Coe testified that Petitioner developed the same problem in her left elbow as she had in her right elbow, which was lateral epicondylitis and that to a reasonable degree of medical certainty, continued work activities and trying to protect the right arm caused the condition in the left elbow. (PX1; p.30, 31, 34, 35). He further testified that there is a causal relationship between Petitioner's work activities with Respondent and the development of right lateral epicondylitis, left lateral epicondylitis and her right shoulder condition. (PX1; p.36).

Dr. Coe testified that he had not seen a typed job description or any other representation of Petitioner's workplace. (PX1; p.39). He testified that he relied on what Petitioner told him. (PX1; p.40). He testified that he relied on Petitioner's use of the term "overuse" which is subjective, and he had no way of measuring it. (PX1; p.40).

Dr. Coe testified that Petitioner told him that she had Type 2 diabetes for years. (PX1; p.42). Dr. Coe testified that as seen on MRI, Petitioner certainly had pre-existent degenerative arthritis in her right shoulder at the AC joint which was one of the places that Dr. White did surgery on. (PX1; p.44).

Dr. Coe testified that in some literature, repetitive meant "more often than not during the workday . . . around two-thirds of the workday." (PX1; p.47). Dr. Coe agreed that the literature states that the key to epicondylitis is the forceful and repetitive nature of a trauma. (PX1; p.55). He testified that he did review in Petitioner's medical records repeated references to the fact that she sat at her desk all day, and he testified that that was recognized as an office sedentary seated position. (PX1; p.56). Dr. Coe testified that he did not have information about the frequency in which Petitioner filed or number of times she actually moved larger files versus little files. (PX1; p.59).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issues C & D: *Accident and Date of Accident*

The Arbitrator concludes the Petitioner did not sustain any injuries arising out of and in the course of her employment with Respondent on August 19, 2010, January 14, 2011, October

17, 2011, and August 23, 2012. Petitioner has claimed her injuries were caused by repetitive activities at work and that there was no one specific accident or injury. Whether a person's work activities are sufficiently repetitive must be decided on a case-by-case basis on the particular facts in each case. In *Edward Hines Precision Components vs. Industrial Commission*, 356 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (2d Dist. 2005), the claimant's job as a tractor/trailer driver was not deemed to be repetitive in nature. He stated that he drove an 18-wheel, flatbed truck with a manual transmission an average of 200 miles a day. He shifted gears with his right arm and used his left arm to steer. He delivered trusses that were secured to the flatbed with an average of 10 straps per load. The straps were tightened with either a manual wench or a pry bar. Claimant testified that tightening the strap required application of substantial force so that the load would not shift when the truck was moving. Petitioner's work activities, as described, were not repetitive or forceful in nature, when viewed along with the activities in the *Edward Hines* case.

In *Williams vs. Industrial Commission*, 244 Ill.App.3d 204, 614 N.E.2d 177, 185 Ill.Dec. 43 (1st Dist. 1993), claimant testified that part of his job required lifting machine parts that weighed anywhere from 30 to 60 or 70 pounds apiece. He would lift such objects about two times a day and he estimated he would spend approximately 30% of his time on each shift lifting objects of this weight range. He would climb on top of a crane for approximately five or six times a day. He would also crawl under certain machinery in order to perform repairs. The crawling would involve lying on his back or stomach and crawling under the machine. He would crawl in such a manner two to three hours per day on a daily or weekly basis. He also used 8, 12, and 16-pound sledgehammers for two to three hours a day on a daily basis and was required to operate a hydraulic air hammer to break up concrete approximately once every six months. He utilized various sizes of weights and tools including pipe wrenches, chain saws, sledgehammers, and box wrenches, etc. Any one of Petitioner's work activities could not compare in forcefulness to any one of the claimant's activities in the *Williams* case. Any one of Petitioner's activities could not compare in repetitiveness to any one of the claimant's activities in the *Williams* case. In Williams, the First District Appellate Court held that claimant's job was not repetitive.

Petitioner's case can even be distinguished from *Quaker Oats Co. vs. Industrial Commission*, 414 Ill.326, 111 N.E.2d 351 (1953). In *Quaker Oats*, the claimant was found to have suffered an aggravation or acceleration of a pre-existing condition by the dropping of cans onto his left foot. In this case, Petitioner's work activities were not repetitive as depicted in *Quaker Oats*, as it is evident she had a variety of duties that were interspersed throughout her day. So, the Arbitrator cannot conclude that Petitioner suffered an aggravation or acceleration of any pre-existing conditions.

Issue E: *Notice*

The Arbitrator also finds the Petitioner did not give timely notice of the accidents of August 19, 2010, January 14, 2011, October 17, 2011, and August 23, 2012 to Respondent. Under the Act, a claimant must give notice to an employer as soon as practicable but not later than 45 days after sustaining an accidental injury arising from employment. Although a lack of notice, or a defect or inaccuracy in notice has proven to be a weak defense and would not bar a claim, sometimes a lack of notice, or defect or inaccuracy in notice can be barred if it is prejudicial to an employer. *Health & Hospitals Governing Commission of Cook County vs. Industrial Commission*, 75 Ill.2d 194, 387 N.E.2d 683, 25 Ill.Dec.807 (1979).

In this case, four witnesses testified that they did not know Petitioner was ever injured at work from her work activities. Although Petitioner testified that she provided notice to Patti Murphy, Patti Murphy testified that had she been aware or been told that Petitioner claimed she had been injured at work from work activities, she would have acted on it by contacting Human Resources. Jackie Ladewig testified that had she known, she would have contacted the insurance agent who in turn would have contacted Respondent's workers' compensation carrier. She talked with Petitioner on the phone frequently and never learned that Petitioner was claiming work-related injuries. Jackie testified had she known, she would have assisted Petitioner with the proper forms for workers' compensation. Kathleen Duprey Tagge was Petitioner's supervisor for a time and she was not aware of Petitioner claiming any injury from work activities. Thomas Peer was Petitioner's supervisor for a time and he was not aware of Petitioner claiming any injury from work activities. The evidence supports that Respondent first learned of Petitioner's claims of injury from work activities through the filing of Applications, all which were done on March 19, 2013. Petitioner worked in close proximity with Joanna Guerra for a time, and Ms. Guerra testified that she was not aware of Petitioner's claims of injury from work activities.

Petitioner was in a supervisory position with Respondent and knew of the policy of reporting work accident or injuries. She knew about reporting because she reported an accident that occurred with her in 2008. The type of form is insignificant when Petitioner knew how to report a work accident or injury. All she had to do was tell someone also employed by Respondent, but she failed to do so.

Issue F: *Causal connection*

Petitioner's current condition of ill-being is not causally related to her employment with Respondent based on the rationale set forth for issue (C) above. In addition, the Arbitrator gives more weight to Dr. Nicholson's opinions than Dr. Coe's opinions, because Dr. Coe relied

solely on what Petitioner told him and her definition of "repetitive" work. Both doctors testified that repetitive work is work that is done two-thirds of the time in a work day and involve forceful gripping. Dr. Nicholson described it as assembly line work. Petitioner worked in an office and her job was mostly sedentary. Joanna Guerra testified that she did Petitioner's filing. Petitioner's supervisor, Tom, testified that he did Petitioner's credentialing work for a time after she left, and he did not have any difficulty with pulling files out of a cabinet or putting them back in. Further, none of Petitioner's treating physicians causally related her work duties to any conditions in her elbows or right shoulder, except for Petitioner's medical expert, Dr. Coe, who saw her one time and relied on her description of her work activities. In fact, Petitioner never told any of her treating physicians that any activity at work, such as pulling files out of cabinets or putting them back in, caused pain to her elbows or right shoulder.

The Petitioner's situation is like that present in a recent Illinois Workers' Compensation Commission decision. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017). In *Cook*, the claimant, an office worker much like the Petitioner, argued her bilateral carpal tunnel syndrome was causally connected to her repetitive work for her employer. However, after the Commission reminded the Arbitrator of the proper standard of proof necessary under Illinois case law for repetitive and forceful work claims, the Commission affirmed and adopted the Arbitration Decision denying that claim. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017).

Issue J: *Medical bills*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of medical bills is moot and the Petitioner's claim for payment of the same is denied.

Issue K: *TTD*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of TTD is moot and the Petitioner's claim for payment of such benefits is denied.

Issue L: *Nature and extent of injury*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of the nature and extent of injury is moot and the Petitioner's claim for payment of such benefits is denied.

Issue N: *Respondent's credit*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of Respondent's credit is moot.

Signature of Arbitrator

OCTOBER 18, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judy Becker,
Petitioner,

20IWCC0101

vs.

NO: 13 WC 9010

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2018, is hereby affirmed and adopted.

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

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

There is no bond 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 Circuit Court.

DATED: FEB 1 1 2020
o1/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0101

BECKER, JUDY
Employee/Petitioner

Case# **13WC009010**

13WC009007
13WC009009
13WC009011

UNITED THERAPIES
Employer/Respondent

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5122 PORRO NIERMANN LAW GROUP
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JUDY BECKER
Employee/Petitioner

v.

UNITED THERAPIES
Employer/Respondent

Case # **13** WC **9010**

Consolidated cases:
13 WC 9007, 13 9009, and 13 WC 9011

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 29, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

20IWCC0101

FINDINGS

On **AUGUST 19, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**57,682.56**; the average weekly wage was $**1,109.28**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

ORDER

The Arbitrator refers all orders relating to temporary total disability benefits, medical expenses and permanent partial disability benefits to the Arbitration Decision for Application 13 WC 9007.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 18, 2018
Date

OCT 19 2018

20IWCC0101

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JUDY BECKER v. UNITED THERAPIES

13 WC 9007, 13 WC 9009, 13 WC 9010, & 13 WC 9011

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on November 29, 2017.[1] The issues in dispute were accident and the date of accident, notice, causal connection, medical bills, TTD benefits, and the nature and extent of the injury. (Arbitrator's Exhibits 1-4). The parties requested a written decision, including findings of fact and conclusions of law, and agreed to receipt of the same via e-mail. (Arbitrator's Exhibits (*hereinafter*, AX) 1-4).

FINDINGS OF FACT

Petitioner testified that she was employed by the Respondent on *August 19, 2010* as an office coordinator and credentialing coordinator up until May 2013 (Transcript 24), when she was terminated because her FMLA period ran out. (Transcript (*hereinafter*, Trans.) 25). She testified she had worked for the Respondent for 18 years. (Trans.104). She testified that starting August 2010, she primarily did credentialing work which she described as involving heavy lifting and pulling and grasping hard copy files. (Trans.25). She testified that all of the credentialing files were for physicians. (Trans.28). She testified that she had approximately 180 to 200 of those [credentialing] physician files in her office back in 2010. (Trans.29). She testified that there were a lot of documents that needed to be filed into credentialing folders on a daily basis. (Trans.26). She explained that credentialing files were legal size, made of cardboard, with cardboard inserts. (Trans.27). She testified that some of them were quite thick – five to six inches thick and containing all types of information. (Trans.27). She testified they were kept in a filing cabinet that was probably up to her nose or the top of her head. (Trans.30). She testified she is 5'5" in height. (Trans.30). She testified she had three sets of cabinets, each with three drawers, and each of the drawers had a top that pulled open. (Trans.30). She testified that she had to pull the drawers toward her to access the files. (Trans.31).

Petitioner testified that from 2008 to 2011, she would take files out of the cabinets when she needed to file a document on a daily basis. (Trans.27, 36). She testified she would

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[1] During the hearing of these matters, with all parties present and represented by counsel, the Petitioner's fifth claim, 13 WC 9008, was dismissed for want of prosecution.

open the file cabinet, reach in, pull and grasp, and sometimes struggle to pull the files out because they were tightly packed in. (Trans.33, 34). She testified she could only grasp with her fingers because it was impossible to get her fingers down in between a whole file. (Trans.34). She testified she would have to raise her arms at least shoulder height, or two, four or six inches higher than her shoulders. (Trans.35). She testified there was no other file cabinet space available. (Trans.33). She testified she did not have a step stool. (Trans.35).

Petitioner testified that she worked eight-hour days. (Trans.36). She testified that on average she would spend three to five hours a day pulling/replacing files. (Trans.37). She testified that for the remaining times, she probably ran reports from a program on the computer. (Trans.37, 38). She testified she would then have to file the reports into the physicians' folders. (Trans.38). She testified she could run dozens of reports a day but would not work on all 200 reports in a day. (Trans.38). She testified she would hole-punch the documents and place them in a physician's file by attaching them to prongs on the inside of the file. (Trans.39). She testified that she would then put the file back into an already tightly-fitted drawer. (Trans.40, 41). She testified the files were not sticking out and she could close the cabinet door. (Trans.41). She testified that no one else had credentialing responsibilities between 2008 and 2010. (Trans.42). She testified she continued to do this type of work with the files until she left. (Trans.42).

Petitioner testified that she also worked with close to 100+ patient files per week, or month. (Trans.42, 43). She testified that patient filing cabinets were also three-drawer filing cabinets and would get very crammed and full. (Trans.44). She testified that when she took over the credentialing coordinator position, she still had to work with the patient files. (Trans.44). She testified that before she got the credentialing duties added onto her job duties, she was managing the front office and helping to schedule and "put out fires." (Trans.44). She testified she made sure the office was running smoothly and that they were fully staffed. (Trans.45). She testified that she occasionally had someone assist in the patient file work. (Trans.45). She testified that her job activities were interspersed during the course of a day. (Trans.53).

Petitioner saw Dr. Roman Dreyer at Dreyer Medical Clinic on _August 4, 2010_. (Petitioner's Exhibit 4, p.1111). Dr. Dreyer noted that Petitioner's pain started three weeks prior, gradually, with no trauma or injury. He noted she had a problem lifting light weights. His assessment was severe elbow pain with a concern for severe tendonitis. He prescribed 600 mg of ibuprofen and recommended an elbow strap and no lifting of weights or repetitive motion. He opined that if there was no improvement, then he would order an MRI of the right elbow. (Petitioner's Exhibit (*hereinafter*, PX) 4, p.1112).

Petitioner testified that on *August 19, 2010*, while performing credentialing file work she noticed her [right] elbow was beginning to hurt and continued to get worse. (Trans.46). She testified that she realized when she was pulling on files is when she had the most pain that was constant, chronic, and would never go away. (Trans.47).

Petitioner testified she sought treatment with Dr. James Anderson on *August 19, 2010*. (Trans.47). She testified she had reported to Dr. Anderson that she worked as a clerk in an office and that pulling files at work was bothering her. (Trans.47, 48). She testified that she did not tell Dr. Anderson anything specific about her work duties that caused her to see him because he did not ask. (Trans.123). Dr. Anderson's note of August 19, 2010 provides that Petitioner did some weight training which may have aggravated her right elbow. (PX4; p.1127). He noted that Petitioner had treated with a tennis elbow strap but had no other specific treatment. His assessment was right lateral epicondylitis. (PX4; p.1127). He gave Petitioner a corticosteroid injection into the *right elbow* on the same date. Petitioner testified she had about two to three weeks of temporary relief from the injection. (Trans.49).

Petitioner testified that while speaking with her supervisor, Patti Murphy, in person at Respondent's LaGrange office just before her August 19, 2010 appointment, she reported that her [right] elbow was hurting, and she associated it with pulling files. (Trans.60-62). She testified she told Patti that she thought it would be a good idea if the files were scanned. (Trans.63). She testified that Patti told her to just go to the doctor and she would be fine. (Trans.63).

Petitioner saw Dr. Roy Henderson on *September 29, 2010*, also at Dreyer Medical Clinic. Dr. Henderson noted that Petitioner told him her pain started in July 2010, that she sat at a desk most of the day, and did Jazzercise and weight lifting three to five times per week. There was no mention of any other specific work activities. Dr. Henderson had the same impression as Dr. Anderson. (PX4, p.1144).

Petitioner testified she did physical therapy and reported to the therapists what she was doing at work that was causing her symptoms. (Trans.48). Petitioner did her therapy at Dreyer Medical Clinic. A progress note for a therapy visit on *October 4, 2010* provides that Petitioner was an office manager and her duties were keyboarding, filing and writing, and Jazzercise is listed as a recreational activity. (PX4, p.1152).

Petitioner next saw Dr. Roy Henderson on *November 18, 2010*. He noted that Petitioner's right elbow pain was worsened by using her hand, picking up a coffee cup, and pulling files at work/gripping. That was the extent of work activities mentioned. He had the same impression as at the last visit. Dr. Henderson provided Petitioner with a cortisone injection into the right elbow. (PX4, p.1213).

Petitioner next saw Dr. Dreyer on *January 10, 2011* for routine lab work and follow up. Dr. Dreyer noted persistent pain and swelling in the right elbow and diagnosed elbow tendonitis. He recommended an MRI. (PX4, p.1246).

Petitioner had an MRI of her right elbow done on *January 14, 2011* at Dreyer Medical Clinic upon Dr. Dreyer's order. The MRI revealed a full-thickness tear of the common extensor tendon at the origin of the extensor carpi radialis brevis tendon [lateral epicondyle] and a small elbow joint effusion. (PX4, p.1250). Petitioner testified that she believed she told Patti a few days after this MRI of the elbow was done, that the MRI showed a torn tendon. (Trans.63, 64). She testified that she told Patti because she felt it was work-related, she was in pain, and struggling to do her job. (Trans.65).

Petitioner saw Dr. Neena Szuch, also at Dreyer Medical Clinic, on *January 21, 2011* for right lateral epicondylitis. The visit note contained no specific history, other than Petitioner had some physical therapy and used a forearm brace without adequate relief of symptoms. The visit note made no mention of any of Petitioner's work activities. (PX, p.1275). An x-ray of the left elbow revealed some spurring at the distal humerus. (PX4, p.1279). Dr. Szuch diagnosed right lateral epicondylitis and offered Petitioner a wrist brace. (PX4, p.1275).

Petitioner described the brace as going through the thumb and over the hand and up to right below the elbow, which fastened on the bottom. (Trans.56). She testified the brace did not interfere with flexion of the elbow joint. (Trans.56). She testified she did not hide the brace from co-workers. (Trans.55).

Petitioner saw Dr. Brian Hubbard, also at Dreyer Medical Clinic, on *February 19, 2011* for a complaint of bilateral upper and lower back pain which had been present for one day and started when she was at rest. (PX4, p.1304). There was no mention of any of Petitioner's work activities. The diagnosis was lumbar and thoracic strain. (PX4, p.1305).

Petitioner's next right elbow related treatment was on *June 24, 2011* with Dr. Roy Henderson. He noted that there was no mechanism of injury and that, again, Petitioner sat at a desk most of the day, and did Jazzercise and weight lifting. He reviewed the right elbow MRI done on January 14, 2011 and noted the full-thickness tear at the origin of the extensor carpi radialis brevis. He noted that Petitioner had seen Dr. Szuch who recommended non-operative treatment. Dr. Henderson's impression was right lateral epicondylitis with a full thickness tear at the wrist extensor insertion. He referred Petitioner to Dr. White. (PX4, p.1380).

Petitioner testified that she did Jazzercise two to four times a week. (Trans.66, 67). She testified it involved movements with feet and it was a dance class (Trans.66). She testified that some exercises can be done with two-pound weights, which she would hold and do whatever with them. (Trans.66, 67). She testified she did not notice any problems with her elbows or

shoulders while doing Jazzercise. (Trans.67). She testified she would lift the weights up to her shoulder and put them back down. (Trans.68).

Petitioner testified that in 2011 the records for credentialing started being scanned. (Trans.58). She testified that she had been asking for files to be scanned ever since she took over the credentialing position because of the difficulty in their physical presence and her ability to access those files. (Trans.58). She testified that at that time there were still physical patient files and physician files for physicians coming up for reappointment. (Trans.59).

Petitioner first saw Dr. Thomas White, also at Dreyer Medical Clinic, on *July 14, 2011*. He noted that she was a right-handed office manager who came in with a year's worth of pain in the lateral side of her right elbow. He noted her treatment history, but no specific work activities were mentioned. He reviewed the MRI of the right elbow. His assessment was chronic lateral epicondylitis in the right elbow and provided a Depo-Medrol and Marcaine injection. (PX4, p.1386).

Petitioner's next orthopedic-related visit was on *October 17, 2011* with Dr. Sunil Malkani, also at Dreyer Medical Clinic. She testified she complained about her *left shoulder and neck*. (Trans.69, 70; PX4, p.1502). Dr. Malkani noted the visit was for acute neck pain located in the back of the neck and radiating into the left shoulder. He noted the pain was dull. He noted there was no associated trauma, but that Petitioner sat in front of a computer all day. He diagnosed musculoskeletal neck pain and trigeminal neuralgia syndrome. (PX4, p.1504). Petitioner testified that Dr. Malkani recommended some physical therapy and prescribed a muscle relaxant. (Trans.70; PX4, p.1504). An x-ray of the neck was done on the same date and revealed mild degenerative changes, moderate left-sided facet hypertrophy, moderate left neural foraminal stenosis at C4-C5, and mild left neural foraminal stenosis at C5-C6 and C6-C7. (PX4, p.1507).

A physical therapy progress note dated *November 4, 2011* provides that Petitioner complained of pain over her cervical spine and into her left upper trapezius. The onset date was October 27, 2011 with no known incident. The subjective report was that symptoms were aggravated by sitting at a desk keyboarding and driving ("at times rests elbow on window"). It is noted that Petitioner did not have therapy before for these symptoms because she never had them before. (PX4, p.1527).

Petitioner called or emailed Dreyer Medical Clinic on *November 14, 2011* and Ernestina Sanchez, a nurse, documented the message. Petitioner asked whether it was "ok" for her to continue Jazzercise and other home exercise. The message was relayed to Dr. Farah K. Hussain, and Dr. Hussain responded to Petitioner to "go ahead and resume your exercise." (PX4, p.1550).

Petitioner saw Dr. Barry Abrams at Dreyer Medical Clinic on *March 23, 2012* due to an injury to her right foot after tripping and falling the night before. She was diagnosed with a sprain of the foot. (PX4, p.1614).

Petitioner's next orthopedic-related visit was on *August 23, 2012* with Dr. Thomas White. She testified she complained about her *right shoulder and arm*. (Trans.73; PX4, p.1697). Dr. White noted that a complaint of pain in the superior aspect of the right shoulder, which bothered Petitioner claimed bothered her particularly at night, and sometimes radiated down into her right arm. He noted that Petitioner did not recall any "recent or remote injury or change in activity." Dr. White assessed impingement syndrome. He wanted to rule out a rotator cuff tear. He provided an injection of Depo-Medrol and Marcaine into the subacromial space. (PX4, p.1697). There were no work-related activities mentioned at this visit. Petitioner testified that after she made this appointment, she told Patti Murphy over the phone that she was seeking treatment for her right shoulder. (Trans.82, 83). Petitioner testified that she also told Patti the same thing she had been telling her for months – that the pulling and grasping of the files were hurting her shoulder and elbows. (Trans.84). She testified that "they" never wanted to scan the files or alleviate that or accommodate her in any way, even knowing Petitioner was having pain from it. (Trans.84).

Petitioner had an MRI of the right shoulder done at Dreyer Medical Clinic on *November 13, 2012*. The reason for the MRI listed on the report was that Petitioner had right shoulder pain for six months without antecedent injury. The MRI revealed marked supraspinatus and lesser infraspinatus tendinopathy and a partial-thickness articular surface supraspinatus tear without a full-thickness rotator cuff tear demonstrated. There were also degenerative findings. (PX4, p.1744).

Petitioner followed up with Dr. White on *November 15, 2012*. Dr. White had reviewed the MRI and noted it revealed supraspinatus and infraspinatus tendinopathy with probable partial-thickness rotator cuff tear. He discussed with Petitioner a shoulder arthroscopy, as Petitioner had decided ahead of time that she did not want therapy. Petitioner asked that the surgery be done after the holidays. (PX4, p.1763).

Petitioner had a preoperative visit with Dr. Sharon Ollee at Dreyer Medical Clinic on *December 11, 2012*. Dr. Ollee noted a history of pain located in the superior aspect of the [right] shoulder which was worse at night and sometimes radiated down into the right arm. It is noted that Petitioner denied any preceding injury or change in activity. It is noted that Petitioner worked as an office manager at a surgery center. There was no mention about any specific work activities. (PX4, p.1797).

Petitioner next saw Dr. White on *December 19, 2012*. She testified she had told Dr. White that she did not recall an injury to her *left elbow*, but that she had been using her left arm a lot trying to protect the right. (Trans.87). Dr. White noted that Petitioner did not recall any injury, but that about a month before, she began getting pain in the lateral aspect of the left elbow. Dr. White further noted that Petitioner reported she had been using her left arm a lot trying to protect the right. Dr. White diagnosed left elbow pain and lateral epicondylitis. He provided an injection of Depo-Medrol and Marcaine to Petitioner's left elbow. (PX4, p.1805).

Petitioner testified that she probably told Patti the next day after her December 19, 2012 doctor's visit, or another day after that, that she developed pain in her left side. (Trans.88). She testified that she did not have a lot of conversations with Patti about treatment on her different body parts. (Trans.88). Petitioner testified that she got a left elbow cortisone injection on December 19, 2012 by Dr. White. (Trans.89).

Petitioner had surgery on her right shoulder by Dr. White on *December 28, 2012*. (PX4, p.1814). She testified that she went off work at that time and was off until she attempted to go back to work for two weeks and a couple of days starting *March 23, 2013*. (Trans.77, 78). The surgery was a right shoulder arthroscopy with rotator cuff repair and subacromial decompression. The preoperative and postoperative findings were right shoulder impingement with rotator cuff tear. (PX4, p.1814). Petitioner testified that she thought there was some improvement from the surgery, but it took an unusually long time. (Trans.77). Petitioner testified that while recuperating from her right shoulder surgery, she was having chronic pain in her left elbow. (Trans.86).

Petitioner testified she obtained a brace for her left arm in December 2012. (Trans.57). She testified she would not cover up her braces on either the right or left when Patti came to visit the office. (Trans.85). Petitioner testified she saw Patti roughly once a week. (Trans.85). She testified that Patti never suggested filing a workers' compensation case. (Trans.85).

A Dreyer Medical Clinic physical therapy note dated *January 18, 2013* provides that Petitioner reported falling down two stairs the previous night as she was going into her garage. She had been on a cell phone while wearing her sling but did not land on her right shoulder. She went to a walk-in care facility in the morning. The note provides that Petitioner reported no increased pain to her right shoulder due to the fall. (PX4, p.1864).

Another physical therapy note dated *January 22, 2013* provides that Petitioner reported pain in the anterior lateral portion of her right shoulder, which was different than what she had experienced, and it had started between 24-48 hours earlier. She reported that she did not know if she slept wrong or did something she was not supposed to do. (PX4, p.1878).

Petitioner saw Dr. White on *January 28, 2013*. Dr. White recommended continuing physical therapy and provided a note for Petitioner to be off work for another month. Here original work status was due to run out on February 8, 2013. (PX4, p.1908).

Petitioner returned to see Dr. White on *March 18, 2013*. It is noted that Petitioner advised she needed to get back to work by the end of the week because her FMLA would run out. However, Dr. White offered to continue Petitioner's disability. The note provides that Dr. White told Petitioner that any restrictions were acceptable to him and it really depended on what was acceptable to her employer. After having Petitioner go over her job with him, Dr. White suggested a five-pound lifting limit and no overhead use. (PX4, p.2035). Petitioner testified that she did not believe Dr. White placed any restrictions on her for the time she returned to work. (Trans.80).

Petitioner testified that during the work trial period *[March 23, 2013 through April 8, 2013]*, it was very difficult to get through a whole eight-hour day, especially sitting at the desk or doing any kind of grasping or pulling or lifting. (Trans.80). She testified that keyboarding was also difficult. (Trans.80). She testified that her right shoulder and both elbows were affected by these activities. (Trans.81, 82). She testified she tried not to do any lifting with her right arm. (Trans.129).

Petitioner testified she filed her cases at the Commission in the first quarter of 2013, before she was terminated by Respondent. (Trans.102, 103). The record reflects that Petitioner's Applications were all filed on *March 19, 2013*. She testified that nobody from the Respondent contacted her before she was terminated to discuss any of the claims. (Trans.103).

Petitioner did not return to see Dr. White, but instead saw Dr. Kenneth Schiffman at Hinsdale Orthopaedics for the first time on *April 9, 2013*. Dr. Schiffman noted that Petitioner sought a second opinion on her right shoulder and bilateral elbow pain. It is noted that she complained of pain with typing and pulling. That was the extent of work activities mentioned. Dr. Schiffman diagnosed status post right rotator cuff repair and bilateral lateral epicondylitis. He suggested continued physical therapy and placed Petitioner off work. (Respondent's Exhibit 20, p.012-014).

Petitioner saw Dr. Schiffman again on *May 10, 2013* and reported that her right shoulder pain woke her up at night, but that therapy was progressing well, and she had limited range of motion due to elbow pain. Dr. Schiffman recommended continued physical therapy on the right shoulder as well as on the left elbow. He provided a referral to Dr. Kirincic for pain management program to help with sleep and manage the pain in the elbow. He kept Petitioner off work for the next five weeks. (Respondent's Exhibit (*hereinafter*, RX) 20, p.008-009).

Petitioner testified that her last visit with Dr. Schiffman was on *June 20, 2013*, when he released her from care with permanent restrictions. (Trans.78). He noted that Petitioner's right shoulder was doing well but she had persistent [left] elbow pain secondary to lateral epicondylitis. He placed restrictions of no lifting more than five pounds, no overhead reaching, no repetitive motion for the elbow or wrist, and minimal keyboard use. He advised Petitioner to return as needed. (PX2). Petitioner testified that Respondent did not offer her a position to accommodate Dr. Schiffman's permanent restrictions. (Trans.94). Petitioner testified she would not be able to return to her previous job because she does not have the stamina for it, she would be in pain, and she would not last more than an hour at most probably. (Trans.94). She testified she has been unable to do her job between December 2012 and today. (Trans.95).

Petitioner testified that she was in a supervisory position with Respondent. (Trans.105). She testified that she understood the policy was for people under her supervision to report accidents or injuries to her. (Trans.105). She testified it was not something she/they were specifically trained on. (Trans.105). She testified she was responsible for a portion of the policy manual. (Trans.105, 106). Then she testified that she would not have contributed to the policy concerning reporting accidents and injuries. (Trans.106). She testified that the policy would have been drafted by a supervisor with more authority than herself. (Trans.106).

Petitioner testified she filled out an accident report in 2000. (Trans.106, 107; RX3). She identified her handwriting on Respondent's Exhibit 3 and identified it as an Employee Report of Occupational Injury or Illness. (Trans.107; RX3). She confirmed that her manager's name, Patti Murphy, is also listed on the report, which is dated February 23, 2000. (Trans.108). Petitioner testified that she was aware that the "company" [Respondent] had procedures in place for reporting accidents and injuries, and that she followed that. (Trans.108). Petitioner testified that she did not file or complete any accident reports for the current claimed accidents/injuries, but instead requested FMLA leave for the surgery on her right shoulder. (Trans.108).

Petitioner testified that she signed a form called a Certification of Health Care Provider and dated 2007. (Trans.110; RX 5). She testified she had requested Family Medical Leave on a prior occasion due to shingles. (Trans.111). Petitioner testified that Dr. White did complete a form for her to be off work in 2012 for her right shoulder surgery. (Trans.112). She testified that Dr. Malkani completed a form for her to be off work in 2011 for injuries she claims occurred at work. (Trans.112, 113).

When asked why she requested Family Medical Leave instead of filing for workers' compensation, Petitioner testified that she did file for workers' compensation and did notify her supervisor that she was hurt at work. (Trans.113). She testified that her supervisor told her to go to the doctor. (Trans.113). Petitioner testified that she did not tell anyone else [at work] other than Patti Murphy of her injuries from work activities. (Trans.131). Petitioner testified

that she had access to accident reports that could be completed for a work-related injury. (Trans.115). When asked if it was up to her as an employee of the company to complete an accident report if there was an accident or injury that occurred at work, Petitioner testified "yes" and that the circumstances of "that particular accident report" [the 2000 accident report], were that the nurse at the center pulled that report and filled it out and she signed it, because the nurse treated her foot that hit the door. (Trans.116).

Petitioner testified that she had her own office at United Therapies up to 2011, but after that she was at a desk with other employees in the front area. (Trans.116). Petitioner testified she did not have an assistant during the time she was with Respondent. (Trans.117). Petitioner testified that Joanna Guerra was not her assistant, but her subordinate and she was Joanna's supervisor. (Trans.117). Petitioner testified she did not ask Joanna to do her filing, or to pull files and bring them to her. (Trans.118). Petitioner testified that she would not ask Joanna to pull credentialing files because no one handled the credentialing files but Petitioner. (Trans.119). Petitioner testified that she would ask Joanna to pull and bring her a patient file. (Trans.119). Petitioner testified that she had control over how many files she could put in a cabinet. (Trans.119). Petitioner testified that when she was in her own office with the file cabinets, it was only possible to pull one file at a time, but she might have pulled several files to work on so as not to have to keep pulling and cramming. (Trans.117). She testified the files may have come out of different drawers. (Trans.117). Petitioner testified she was private about her health issues and treatment at work. (Trans.120). She testified that one of the files that she worked with weighed as much as a two-pound weight. (Trans.122). She testified that it was not an eight-hour, nonstop activity of pulling out files and putting back files, and that she did not type on a keyboard eight hours a day nonstop. (Trans.122). She testified that some of her activities [at work] involved being on the phone. (Trans.123).

She testified that the activity of running reports involved entering something into a computer and the reports would be printed out on a printer. (Trans.123).

Petitioner testified that she had to move files to a temporary location while the LaGrange facility was being remodeled in 2011. (Trans.126, 127). She testified she had to pack the files into boxes herself. (Trans.25). She testified that the Respondent did not hire a moving company to move files. (Trans.127). Then she testified that some of the files that were put in boxes during the remodel were moved by a hired company. (Trans.127). Petitioner testified that boxes of files she was working on went to the new location with her. (Trans.127).

Petitioner identified at trial a letter from Star Insurance addressed to her and dated *April 3, 2013* acknowledging a report of injury. (Trans.138, 139; RX16). She identified the date of injury in the letter as December 19, 2012. (Trans.139; RX16). Petitioner testified she had not

received any letters concerning any of her claims from any other insurance company prior to the April 3, 2013 letter from Star Insurance. (Trans.139).

Petitioner identified at trial a Memo dated *April 18, 2013* from Jackie Ladewig to her concerning a grant of unpaid personal leave of absence through *May 14, 2014*. (Trans.135, 136; RX12). She testified that it concerned recovery for her right shoulder surgery and bilateral elbows, although that specific information was not in the memo. (Trans.136; RX12). Petitioner agreed that the Memo requested that Petitioner advise Respondent of her status and ability to return to work on or before *May 14, 2013*. (Trans.136; RX12). Petitioner testified she told Respondent that she did not have a doctor's appointment until June and that is when she would know. (Trans.137; RX12). She testified that Respondent had a work status from Dr. Schiffman stating she would be off. (Trans.137; RX12).

Petitioner identified at trial a letter dated *May 17, 2013* from Patti Murphy to her which was a letter of termination. (Trans.137; RX14). Petitioner confirmed that the letter notified her that she had exhausted all 12 weeks of Family Medical Leave. (Trans.137, 138; RX14). Petitioner testified she had been unable to return to work by May 17, 2013. (Trans.138). Petitioner testified that she notified Respondent in *March 2013* of her work-related injuries and was terminated two months later. (Trans.149).

Petitioner testified there is an outstanding bill from ATI Physical Therapy for therapy concerning her right shoulder and both elbows, but primarily the left elbow and right shoulder. (Trans.96, 97; PX3). Petitioner testified she wasn't aware of an outstanding charge by Dr. Schiffman at Hinsdale Orthopaedic Associates. (Trans.97; PX2). Petitioner testified she is not aware of any outstanding balance for any treatment at Dreyer Medical Clinic. (Trans.98; PX4). Petitioner testified that her personal insurance through Respondent paid for treatment. (Trans.98). She testified that the insurance stopped when she was terminated on May 17, 2013. (Trans.98, 99). Petitioner testified she received short-term disability payments from the date of her surgery [December 28, 2012] up to March 22, 2013, and then from April 9, 2013, when Dr. Schiffman released her from care, through June 20, 2013. (Trans.100, 101; RX22). She testified she thought she received the short-term disability payments as part of the FMLA process. (Trans.101).

Petitioner testified at the time of the trial that her left shoulder is better than her right shoulder. (Trans.71). She testified that sometimes she cannot unload wet clothes out of a washing machine and put them into the dryer, and she cannot load groceries into the back of her car. (Trans.71, 90). She testified her husband must go shopping with her. (Trans.71). She testified her husband carries the laundry baskets of folded clothes upstairs and he helps to load and unload groceries. (Trans.91).

She testified she cannot do any kind of scrubbing or cleaning motion or lift anything too heavy because she feels weakness and has muscle spasms in both elbows from time to time. (Trans.90). She testified she notices the pain when she keyboards for about 15 to 20 minutes. (Trans.51). She testified she still has issues with her right elbow being tremendously weak and has pain located on the outside of her elbow. (Trans.51). She testified she notices pain and swelling in her left elbow that never completely goes away. (Trans.89). She testified she is not planning to get anymore treatment for her left shoulder. (Trans.72). She testified she has no plan to go out and look for work. (Trans.103, 104).

Petitioner testified that the most she can do at a gym is the treadmill. (Trans.92). She testified she cannot participate in any kind of sports-like activities and must be careful with even what she wears sometimes if it is difficult to put on or take off because it requires over-extension of her arms. (Trans.92). When asked what sports she is unable to do that she used to do, Petitioner testified she is unable to ride a bike like she did before. (Trans.130). She testified that gripping the handlebars, squeezing the brakes, and leaning forward while bike riding is difficult on her elbows. (Trans.170). She testified that her husband had not helped her put her boots on the day of trial because they zip [up], but he had helped her with her coat. (Trans.130). Petitioner testified she is not "whole anymore." (Trans.92, 93). Petitioner testified she has good and bad days and tries not to take any pain medication stronger than Aleve or Advil. (Trans.93). Petitioner testified she has not worked in an employment setting since terminated by Respondent, and not since released by Dr. Schiffman. (Trans.93).

Joanna Guerra-Barr testified that she works for the Respondent, United Therapies and started on June 23, 2010. She testified that Petitioner was her former manager. She testified that her job duties were/are to disassemble/assemble charts, get labs, file paperwork whenever needed, and pass out faxes. She further testified that sometimes she helps patients change whenever they need it and helps with translations from Spanish to English. (Trans.178). She testified that she did filing and would file for patients and doctors. (Trans.179). She testified that prior to switching to scanning, she would pull patient charts and file any paperwork in them. (Trans.180). She testified that doctors' file cabinets were in a "mobile room" and some were in Petitioner's office, but patient files were in the front office. (Trans.181). She testified there was a time when Petitioner had an office and then she no longer had an office. (Trans.181). She testified that the reason for the change was because the building [in LaGrange] went into construction in the middle of 2011 for the purpose of becoming am ambulatory surgery center. (Trans.182).

Joanna testified that while working at United Therapies when Petitioner was her manager, Petitioner would ask her to file for her. (Trans.184). She testified that Petitioner would ask her to file some of the doctors' credentialing paperwork for her. (Trans.184, 185).

She testified that Petitioner showed her where everything went so Joanna could help her out. (Trans.185). She testified that she did all the filing. (Trans.219). Joanna testified that Petitioner would show her how to look on the computer to check whether a doctor's license was current. (Trans.185). She testified that she filed for Petitioner on a daily basis and did the majority of filing for Petitioner. (Trans.186). She testified that when Petitioner wanted files boxed, she would show Joanna where the paperwork went and tell Joanna to box them up. (Trans.231).

Joanna testified that she is 5'2" and the filing cabinets were no higher than 5'3" or 5'4". (Trans.187). She testified that there were on average 40 sheets of paper in a patient file, and around 60-70 sheets of paper in each physician file. (Trans.188). She testified that if she did not have to schedule or check in a patient, she would file. (Trans.189). She testified she never had difficulty removing a file out of or placing a file into a cabinet, whether it was a patient or physician file. (Trans.190).

Joanna testified that after moving back into a remodeled LaGrange office, her seat was at the front desk, along with Zulema, a co-worker, and Petitioner. (Trans.196). She testified that she knew that Petitioner's job duties were to supervise her and Zulema, and also to do credentialing for the doctors and anesthesiologists. (Trans.199). She testified that she had opportunities to observe Petitioner during the time she was in the front desk area. (Trans.200, 201). She testified she had observed her on the internet, using the computer keyboard, and using the phone. (Trans.201, 202). She testified that she never observed Petitioner lifting boxes full of files during the time she worked with her. Joanna testified that she did observe Petitioner putting files into and taking files out of a cabinet, but she never observed Petitioner having difficulty doing that. (Trans.202, 203).

Joanna testified that Petitioner was very quiet about whatever she felt but complained about her shoulder or whatever was hurting her at the time. (Trans.203, 219). She testified that Petitioner would not be specific as to why. (Trans.203). She testified that Petitioner never told her she injured herself by doing something at work, during the time she worked with her. (Trans.203). She testified about the procedure she was aware of in the event of an accident or injury. (Trans.204). She testified that one would have to go to their manager and let them know, and that there was an incident report to fill out. (Trans.204, 205). She testified she was made aware of the procedure because "[w]e get trained on it, and also it's in our policy." (Trans.205). She testified that if she had become injured or had an accident at work, she would tell Petitioner. (Trans.205). She testified that Patti Murphy showed up at the office once or couple of times weekly. (Trans.235).

Kathleen Duprey-Tagge testified that she knows Petitioner from working with her at United Shockwave Therapies (United Therapies/Respondent). (Trans.256). She testified she started with Respondent in January 2003 and left in September 2010. She testified she became

the fixed site manager for LaGrange, Park Ridge and the Hinsdale facility, but primarily worked in Park Ridge. (Trans.257). She testified she did not have an office in LaGrange but would go and visit and meet with employees there. (Trans.257, 258). She testified that Petitioner reported to her from about 2005 or 2006 until she left in 2010. (Trans.258). She testified she was familiar with Petitioner's duties and had an opportunity to see Petitioner working while she was there. (Trans.259). She testified that when Petitioner was in the front desk space, Petitioner would sign in patients, answer phones, schedule patients, and prepare and assemble patient charts. (Trans.259). She testified that Respondent kept physician files for credentialing. (Trans.262). She testified that patient files were kept for a little while and purged every quarter.

Kathleen testified that when Petitioner had her own office, to the right of her desk there were three tall file cabinets, each containing four drawers. (Trans.263). Kathleen testified she had occasion to open the file cabinets and take physician files out when she was looking for physician information. (Trans.263, 264). She testified that some of the files could be full at times, but she does not believe she had difficulty taking a file out. (Trans.264).

Kathleen testified that employees under her supervision were informed through regular staff meetings of what to do if they became hurt at work. (Trans.265). She testified that the meetings occurred every one to two months and she was in attendance, along with supervisors and Patti Murphy. (Trans.266). She testified that Petitioner attended those meetings. (Trans.266). Kathleen testified that she was someone who prepared an accident/incident report and she had prepared accident/incident reports during the time she worked for Respondent. (Trans.267). She testified that based on her recollection, Petitioner never told her she injured herself from something she did while working. (Trans.267, 268).

Kathleen testified she would have prepared an accident/incident report if Petitioner had told her she was injured at work, as that was her practice. (Trans.268). She testified that based on her recollection, Petitioner never asked her to prepare an accident/incident report and did not do anything at work and then complain about being injured. (Trans.268). She further testified that to her recollection, no employee with Respondent told her that Petitioner had been injured while working. (Trans.268).

Kathleen testified that Petitioner's job for part of the time was organizing and keeping the credentialing files. (Trans.272, 273). She testified that based on her recollection, she didn't recall ever seeing Petitioner's forearm brace covering the thumb and coming around the side and coming up the forearm. (Trans.282). Kathleen testified that there were accident reporting procedures for employees and managers online and a hard copy. (Trans.284). Kathleen testified that she had met with Patti Murphy once or twice after she left the company and they did not talk about Petitioner or anything to do with this case. (Trans.286).

Thomas Peer testified that he knows Petitioner from working with her at United Therapies from 2010 through 2012-2013 as a fixed site manager. (Trans.293). He testified he took Kathleen's position when she left. (Trans.294). He testified that Petitioner reported to him. (Trans.294). Thomas testified that he was a mobile worker and worked at Respondent's both centers, Park Ridge and LaGrange. (Trans.294, 295). He testified he was mostly at the LaGrange facility, starting around 2012-2013. (Trans.295). He testified that prior to that, he went to the LaGrange facility about once or twice a week to meet with staff, keep track of operations and make sure the facilities were running correctly and schedules were on track. (Trans.295).

Thomas testified that he met with Petitioner every time he visited the [LaGrange] facility to discuss how scheduling was going with the doctors, any concerns or issues with the facilities, staff, and patients, and financial concerns. (Trans.296). He testified that Petitioner was the front desk office coordinator and also the credentialing coordinator. (Trans.296). He testified that when the [LaGrange] facility was remodeled, Petitioner shared the office with the front desk as there was no separate office. (Trans.296, 297). He testified that at the front office area, Petitioner had a desk that was up against a wall, there were patient file cabinets and a copier, and she basically shared the office with the scheduling staff who were Joanna and Zulema. (Trans.297). He testified that prior to that she had her own office with the credentialing files located there. (Trans.297, 321). He testified he did not remember how many cabinets there were, but there were cabinets in Petitioner's office and files were kept in each of the drawers. (Trans.322). He testified that he had an opportunity to open all the drawers [in the cabinets in Petitioner's office]. (Trans.322). He testified that the files would vary in thickness depending upon how long a doctor had been associated with the company, and some files were very thin if a doctor was new. (Trans.326). He testified that he did not experience files in drawers in Petitioner's office being tight. (Trans.327).

Thomas testified that he had occasion to take a file out of and put back into drawers and he never had any difficulty with same. (Trans.302). He testified he did not think any drawers in the file cabinets contained more files than they could handle. (Trans.303). He testified that when Petitioner was out for her shoulder surgery, he did the credentialing and had a reason to go into the file cabinets, but prior to that it was to review a file. (Trans.303). He testified he never noticed Petitioner at any time having difficulty taking a file out of a cabinet or putting a file back into a cabinet. (Trans.305). He testified that based on his recollection, Petitioner never told him she had difficulty with same. He testified that based on his recollection, Petitioner never told him she injured herself from anything she did at work. (Trans.205). He testified that anybody he supervised was required to tell him if they were hurt at work. (Trans.305).

Thomas testified that he believed the LaGrange facility was remodeled from 2011 through 2012 and was a one-year project. (Trans.301). He testified that the file cabinets were big, long, probably 3-foot, 4-foot file cabinets, standard that had a door to open and then pull out and push in drawers. (Trans.301). Thomas testified that the files were moved to the front office because Petitioner no longer had an office and she needed access to them [after the remodel]. (Trans.328, 329). He testified that paperwork still needed to be filed, and in addition to credentialing duties that he took over for Petitioner, he also worked with some of the patient files. (Trans.329). He testified that whenever he was there [LaGrange], he would find Petitioner working at her desk on credentialing, typing, getting physicians ready and scheduling patients through the computer and phone. (Trans.298). He testified that credentialing entailed going through many websites to verify that a physician was qualified through credentialing boards and licensed through the State of Illinois to operate. (Trans.298, 299). He testified that documents would be requested from the physician to fill out and show proficiency in skill sets. (Trans.299). He testified that Petitioner did those things. (Trans.299). Thomas testified that physician licensing and information were kept in paper form because they were printed and there was a file cabinet for those documents. (Trans.300).

Thomas testified that Respondent had a policy for reporting work-related injuries and employees were instructed to notify their supervisor if they were hurt. He further testified that the policy provided that an employee was responsible for seeking out medical care if needed, and they were to let their supervisor know if they were going to seek that out because there was paperwork to fill out. (Trans.206). He testified that policies were updated annually, and supervisors were given all policies that pertained to their departments, so they would have been required to read them and know. (Trans.307).

Thomas testified that he was always reachable by phone, text or email by anyone he supervised. (Trans.307). He testified that an accident/incident report has a section for him to fill out and a section for the employee to fill out to describe what happened an how it happened. (Trans.308). He testified that if that was given to him, he would then forward it to Patti Murphy. (Trans.307, 308). He testified that if he was notified of an accident or incident, he would then provide the paperwork to the employee for them to complete. (Trans.308, 309).

Thomas testified that he had prepared accident/incident reports during the time he worked for Respondent, but that to his recollection, Petitioner never asked him to prepare one. (Trans.309). He testified that to his recollection, no other employee told him that Petitioner had been injured while doing something at work. (Trans.309). He testified that prior to counsel for Respondent calling him and notifying him about testifying, maybe August or July of 2016, he was not aware that Petitioner had been claiming she was injured at work. (Trans.310).

Thomas testified that on average there were at least 35 to 40 physician files in any given year. (Trans.312). He testified that if they were preparing for an accreditation, all the files would be reviewed to make sure everything was accounted for in them. Aside from that, he testified, more than likely a file would just be pulled if a physician needed to be verified. (Trans.313).

Thomas testified that he had not talked with Patti Murphy since he left the company in 2013. (Trans.331). He testified he had not talked to Jackie Ladewig about Petitioner's claims since he left the company, but he had been talking with her while sitting out [in the public waiting room at the IWCC]. (Trans.332). He testified they never had a discussion about when Jackie first heard about Petitioner's injuries. (Trans.332). Thomas testified that prior to his termination from United Therapies, as Petitioner's supervisor, he had a pretty good idea of what she did for Respondent. (Trans.334).

Jackie Ladewig testified she was employed by Respondent, United Therapies, which changed its name. She testified she knew Petitioner from working for the same company [Respondent]. (Trans.343). She testified she started on November 27, 1989. (Trans.344). She testified she did not hire Petitioner and did not work side-by-side with her, but she trained her in February 1994 when the center in LaGrange was opened. (Trans.344). She testified that when she started with Respondent, she was a part-time front desk scheduler and at the present is medical staff and clinical staff credentialing and fixed site scheduling manager. (Trans.346). She testified that her duties consist of credentialing the clinical staff, nurses, mobile techs, and physicians. (Trans.346). She testified that she manages the front desk staff at Park Ridge and at LaGrange and works out of Rosemont, her permanent/physical location, on some system conversions. (Trans.347).

Jackie testified that towards the middle of 2014 through half of 2016, she was at the LaGrange office on a day-to-day basis, and then transitioned back to Rosemont. She testified she worked in Human Resources for Respondent for about 14 years. (Trans.347). She testified when she was with HR, she did payroll, benefits and records. She was the only person in HR. (Trans.348). She testified she also on-boarded new hires and maintained employee files. (Trans.348). She testified she also prepared employee documents concerning requests for leave of absence. (Trans.348, 349). She testified that sometimes a supervisor would let her know someone was going on leave and Jackie would then send the employee paperwork. (Trans.349). She testified that sometimes the employee would contact her directly and request FMLA forms, specifically the Certificate of Health Care Provider. (Trans.349). She testified that she received FMLA paperwork from Petitioner on a couple of occasions. (Trans.349). She testified she also processed short-term disability for an employee. (Trans.350). She testified that if someone was hurt on the job, that person would either notify their supervisor or her,

and depending on the injury, they would either go to "employee health" or their doctor. (Trans.351). She testified that if there was a work comp case, she would notify the [insurance] agent, who would then initiate a claim with the work comp carrier. (Trans.351). She testified that then they [work comp carrier] would then contact her for the employee's contact information and handle the rest with the employee. (Trans.351).

Jackie testified that during the time Petitioner was working at United Therapies, she was never contacted about a work comp claim by anyone concerning Petitioner. (Trans.351). She testified that she processed a lot of doctor's notes and intermittent FMLA forms for Petitioner for which she assumed were personal injuries. (Trans.352). She testified it was not brought to her attention that there were [work] accidents. (Trans.352).

Jackie testified that Petitioner was the office coordinator at LaGrange while working for Respondent. (Trans.352). She testified Petitioner managed the front desk and credentialed the physicians (urologists). (Trans.352). She testified that Petitioner oversaw all the front desk functions, then did mobile scheduling for a period of time, which was a separate division of the company. (Trans.352, 353). She testified it was a lot of scheduling, overseeing and supervising the schedulers. (Trans.353). Jackie testified that credentialing involved collecting applications, paperwork, and verifying licenses. (Trans.353). She testified she did not know how verification was done because she was not doing it at the time, but she testified it could have been on the phone or online. (Trans.353).

Jackie testified that at the LaGrange location they had patient charts, medical records and credentialing files. (Trans.354). She testified that patient charts and physician files were kept in a folder. (Trans.356). She testified that whatever holds 40 pages was kept in a file and then boxed up. Every three months the files were sent to whoever was storing them at the time. (Trans.357). She testified this occurred prior to the remodel, but at some point after the remodel, she thought they stopped keeping paper and everything became electronic. (Trans.357).

Jackie testified that before the remodel, there were file cabinets in Petitioner's office and then there was an office for mobile scheduling. She thought there were file cabinets there and there may have been some up front [office]. (Trans.358). She testified that she had been at the LaGrange facility when Petitioner was there and observed the filing cabinets that were in Petitioner's office. She testified that the cabinets were two big cabinets and had five drawers. (Trans.359). She testified she did not have occasion to open the cabinets. (Trans.360).

Jackie testified that the procedure for reporting accidents/injuries was to notify your supervisor and if the supervisor was not available, then you would notify HR. She testified that one could also call the work comp carrier and go to Employee Health, depending on the

situation. (Trans.361). She testified that the procedure was in the policy and all employees have access to the policies as they were kept in binders. (Trans.361). Jackie testified that she talked with Petitioner over the phone many times and more times than person-to-person contact, during the time Petitioner worked for Respondent. (Trans.362).

Jackie testified that during their phone conversations, they talked about aches and pains, but it did not come up that she hurt herself or hit herself on the desk or anything like that. (Trans.363). Jackie testified she used to talk about her husband's shoulder and she does not remember if Petitioner mentioned having difficulty doing some activities at work. (Trans.363). She testified that during their phone conversations, Petitioner never mentioned she was experiencing pain after doing a certain activity while at work. (Trans.364). Jackie testified that when she and Petitioner talked about her shoulder bothering her and Jackie's husband's shoulder, it was casual conversation about old age. (Trans.392, 393). Jackie testified that she did not recall Petitioner saying her shoulder was bothering her because of heavy files she has to move for credentialing. (Trans.393). Jackie testified she knew about Petitioner's elbows because it was on the FMLA forms. (Trans.394).

Jackie testified that she learned that Petitioner was claiming she had been hurt at work after Petitioner was terminated. Jackie identified at trial a notice of FMLA directed at Petitioner and letting Petitioner know how many available hours she had. (Trans.365; RX6). Jackie testified that she prepared the form. (Trans.365). She testified that two of her FMLAs [requests] might have been intermittent for physical therapy and doctor's appointments. She testified then there was another one [FMLA request] when Petitioner was out for surgery and that was short-term disability. (Trans.366). Jackie explained what intermittent FMLA was. (Trans.366).

Jackie identified at trial a letter dated March 13, 2013 from Petitioner's attorney addressed to United Therapies stating they represented her in a work comp case. (Trans.368, 369; RX11). Jackie testified that she did not see that letter in March but did see the Applications. (Trans.369). She testified that the Applications were in her box but may have gone to Respondent's COO or CFO [Bruce] first. (Trans.369, 370). She testified that her receipt of the Applications was the first time she was made aware that Petitioner was claiming she was injured at work. (Trans.370). She testified she saw them in May or June [2013]. (Trans.371).

Jackie identified at trial a document prepared by her in April 2013 letting Petitioner know that her FMLA time was exhausted. (Trans.371, 372; RX12). She testified she would have mailed that by certified mail. She testified that the letter was about granting Petitioner additional unpaid personal leave through May 14 [2013]. (Trans.373). Jackie read the last paragraph which requested that Petitioner advise of her status and ability to return to work on or before May 15, 2013. (Trans.374; RX12). Jackie testified that she received the Applications

after and was a little confused as to what they were, since she was not aware this was work comp. (Trans.374, 375). She testified that had she known she was dealing with work comp, she would not have sent the memo/letter to Petitioner discussing about FMLA and unpaid personal leave. (Trans.375).

Jackie testified that when she saw the Applications, she contacted the agent and asked what to do with them. She testified they were then sent to the insurance agent who contacted the carrier and they took it from there. (Trans.378). She testified that the insurance company had not been aware of a work comp claim before Petitioner was gone. (Trans.378).

Jackie testified that in 2013 when she received the Applications, she asked Patti Murphy if she was aware of the claims. (Trans.384). She testified that Patti told her she was not aware of any work-related injury. (Trans.384, 385). Jackie testified that she was aware that Patti had testified that she was in a meeting in 2016 where everyone expressed shock at the claim that Petitioner had a work-related claim against the Respondent. (Trans.386). However, Jackie testified that Patti had left the company in May 2016, and she did not remember any meetings discussing a work-related injury [by Petitioner]. (Trans.386). Jackie testified that what may have happened was that in 2015 Patti would have had a conversation with Nancy Kimbrell because she was the director of HR at the time. (Trans.387). She testified that she wished she had known that Petitioner claimed a work-related injury against the Respondent because she would have filed it right away for her. (Trans.388).

Jackie testified on re-direct examination that when someone gave notice of an injury at work, there was an internal incident/accident report form that is completed, and it was in existence during the time Petitioner worked for Respondent. (Trans.402).

Patti Murphy testified that she first started working for Respondent in April 1999. She testified she started out as Director of Operations and within about the first six months she became Vice President of Operations. She testified she retired on May 4, 2016. (Trans.5, 6). She testified she knew Petitioner because she was the office coordinator at Respondent's LaGrange site. She testified that Petitioner reported to her manager and then to Patti. She testified that Kathleen DuPrey-Tagge was a manager under her and then Thomas Peer took over as manager of the fixed site. (Trans.6).

Patti testified that as an office coordinator, Petitioner was responsible for the operations of the front desk, to sign patients in, get their insurance cards, give them forms to sign, get the chart together, and put charts on the rack for the nurse to proceed with the procedure. (Trans.11). She testified that at the end of the day after everybody checked the chart, the front office received the chart back, would disassemble the chart, file it away and make sure the billing office gets their forms, and physicians get their op reports. (Trans.11, 12).

Patti testified that after a few years, Petitioner was given the task of physician credentialing. (Trans.12).

Patti testified that Petitioner worked at the LaGrange facility, but Patti's office was in Rosemont. (Trans.13). Patti testified that as part of her job, she went to all of the facilities weekly and would meet with most of the staff and assure everything was running smoothly. (Trans.13). Patti testified there was an employee handbook that was signed off by employees annually. (Trans.14). Patti testified that an Employee Report of Occupational Injury or Illness was within the employee manual. (Trans.14).

Patti testified that if somebody [employee] was thinking they needed a leave of absence, it would be considered personal leave if not FMLA. (Tranas.17). Patti testified that she did not recall seeing an incident report completed by Petitioner. She testified that an employee can complete it, or their supervisor can complete it with them. (Trans.20). She testified that she was not given an incident report concerning Petitioner by any of her supervisors. (Trans.20). She testified that if Petitioner had a work injury, she would report it to her supervisor, who was Kathleen or Thomas, and then each of her supervisors would have notified Patti, because that was the policy. (Trans.21). She testified that neither Kathleen nor Thomas notified her of any injury claimed by Petitioner. (Trans.21).

Patti testified that she first learned that Petitioner was claiming a work injury in 2016 through Nancy Kimbrell, the Director of Human Resources, who came into her office and said they were notified that Petitioner stated she was injured. (Trans.21). She testified she did not remember the exact date. (Trans.40). She testified that Nancy was not the head of Human Resources in 2010, 2011 or 2012, but Jackie Ladewig was. (Trans.40, 41). Patti testified that all workers' compensation claims were supposed to be reported to Human Resources and she was surprised that Petitioner was making workers' comp claims. (Trans.40, 41).

Patti testified that Jackie Ladewig worked for Respondent in 2010, 2011 and 2012 and was the Human Resource Manager, who would have let Patti know about a work injury. (Trans.22, 23). Patti testified that to her recollection, Jackie never let her know about a work injury involving Petitioner. (Trans.23). She testified that Petitioner never mentioned being hurt at work to her. She testified that Petitioner had said she had a headache or aches and pains but not about being hurt at work. (Trans.23).

Patti testified she knew Petitioner had some kind of surgery, but she did not know what it was for and did not ask. She testified it was an abdominal type of thing initially, and Petitioner also had surgery on her shoulder before she left. She testified that Petitioner felt it had to do with lifting babies as a grandmother, as that is what Petitioner told her. (Trans.24).

Patti testified that when Petitioner came back from her surgery, she stated she was in a lot of pain, so Patti went to LaGrange and met with her. (Trans.24, 25). She testified that she told Petitioner she was concerned for her and whether she was able to be back. (Trans.25). She testified that Petitioner told her she was in a considerable amount of pain sitting there but had a release from her physician. She testified that when someone is in so much pain, there is something wrong, and Patti did not want Petitioner to continue sitting in pain. Patti testified that she asked Petitioner what she thought it was [from]. (Trans.25). Patti testified that she asked Petitioner if something happened at work, and that Petitioner told her it did not. (Trans.26). Patti testified that Petitioner told her it was not work comp, nothing from work, and that she was going to be suing her surgeon. (Trans.26).

Patti testified that she did not want Petitioner to aggravate her shoulder any more than it was. (Trans.26). Patti testified that it is a requirement that if someone is hurt at work in any way, their supervisor would inform her, and they are to have it checked out. (Trans.26, 27).

Patti testified that pursuant to HIPAA, she was not privy to any information on insurance claims or benefit payouts for treatment or anything like that. (Trans.28). She testified she would not know if somebody was going to see a doctor for whatever reason, unless the person told her. She testified that at no time did Kathleen or Thomas tell her that Petitioner had a work injury, nor did either one of them tell her that Petitioner was complaining of pain after doing certain work tasks. (Trans.28). Patti testified that during 2010, 2011, 2012 and 2013 she spoke with Petitioner on a weekly basis, and that never did Petitioner discuss hurting herself at work at any point in time during their conversations. (Trans.39).

Patti testified that she was not aware that Petitioner was treating for alleged work injuries from August 2010 up until late 2012. (Trans.57, 58). She testified that Petitioner was a private person. (Trans.59). She testified that it was her impression that before 2016, Jackie did not realize that Petitioner was making a work comp claim. (Trans.61). She testified that she wasn't aware the Petitioner's claims had been on file since 2013. (Trans.63). She testified she was not aware that an insurance company was involved in defending against Petitioner's workers' compensation claims. (Trans.67, 68).

Patti testified as to her understanding being that a first report of injury is supposed to be completed by the supervisor of an employee. (Trans.92, 93). She testified she had never seen an April 5, 2013 letter from Petitioner's attorney. (RX2, p.93). She testified that apparently two insurance carriers had notice of Petitioner's claimed work injuries in 2013, but she was not aware of them being involved. (RX2; p.94).

Dr. Gregory Nicholson examined Petitioner on September 24, 2014 and generated a report upon Respondent's request. (RX1; p.1). He testified that he reviewed records that went

back to 2010 concerning Petitioner's right elbow. He testified that he had clinical examination notes from Hinsdale Orthopaedics which recounted a shoulder surgery on the right side in 2012. He testified that Petitioner had last worked in May of 2013, when she was released from her job. (RX1; p.7). He testified that he specifically asked Petitioner if she had an injury to the right shoulder, and that Petitioner told him she did not. He testified that Petitioner told him she thought it was more from her desk job with lifting files and doing up-and-down activity with her arms. He testified that Petitioner was an office manager at a surgery center and that there was no specific injury that occurred either for the left elbow, right elbow or right shoulder. (RX1; p.7).

Dr. Nicholson testified that he examined Petitioner's elbows and shoulders. (RX1; p.8, 9). After examination and reviewing records and taking down a history from Petitioner, Dr. Nicholson testified that he felt Petitioner had tendinopathy in her elbows and right shoulder that was due to an endemic issue. (RX1; p.12). Dr. Nicholson testified that he had seen instances of repetitive movement with an upper extremity or a cumulative traumatic condition with an assembly line worker, somebody doing continuous activity the same way, such as screwing in a pipe the same way all day at a Ford plant, or a meat cutter. (RX1; p.13). Dr. Nicholson felt that Petitioner was able to do desk work, clerical work, but not repetitive assembly line activity, repetitive reach, grip or release activity and that lifting should be limited to 10 pounds from floor to chest height and limited on an occasional basis above chest height. (RX1; p.14, 15).

Dr. Nicholson testified that he generated an addendum report dated January 28, 2015. (RX1; p.16). Dr. Nicholson testified that he reviewed MRI reports and films on the right shoulder and right elbow. (RX1; p.16, 17, 18). He testified he also reviewed the operative report on the right shoulder. (RX1; p.23).

Dr. Nicholson testified pursuant to his reports that he felt there was no repetitive, cumulative disorder, trauma or specific injury that caused Petitioner's bilateral elbow pain or right shoulder issues, and that Petitioner's issues could not be discerned to be work-related. (RX1; p.25).

Dr. Jeffrey Coe examined Petitioner on August 18, 2015 and generated a report upon Petitioner's request. (PX1). Dr. Coe testified that Petitioner told him she had worked for a company [Respondent] for about 18 years and that her job was an office position where she worked eight or more hours each day for five days per week and used her upper extremities repeatedly in a variety of activities. (PX1; p.10). He testified that Petitioner described computer data entry, keyboard and mouse work, and moving files. (PX1; p.10, 11). He testified that Petitioner told him there were large files and she would take them from shelves and cabinets, she answered telephones, she wrote by hand, she filed and removed things from files.

(PX1; p.11). He testified that Petitioner described having a small desk with a computer on it and that the keyboard was in an awkward position, over on the side, because she liked to spread her files and charts out on the desk. (PX1; p.11).

He testified that Petitioner told him she had to move large and heavy files throughout the day to and from cabinets and onto and off of her desk. (PX1; p.11). He testified that Petitioner told him the first thing she noticed was some pain along the outer border of her right elbow. (PX1; p.11, 12). He testified that Petitioner told him her initial complaints began in 2010 and she was diagnosed with right lateral epicondylitis. (PX1; p.12). He testified that Petitioner told him she then developed some pain in the left side of her neck with her work activities which she related to the positioning of the computer and keyboard. (PX1; p.14). He testified that Petitioner told him with ongoing work she began to experience pain in her right shoulder which she related to forceful reaching down and pulling of files that were two to three inches thick and heavy. (PX1; p.15). He testified that Petitioner had no estimate of the weight of the files but told him they were tightly crammed into cabinets. (PX1; p.15).

Dr. Coe testified that Petitioner reported to him that with ongoing work and ongoing problems with her right shoulder and right elbow, she began to use her left arm more and developed pain in the outer border of her left elbow. (PX1; p.16). He testified that Petitioner's right shoulder symptoms were the most severe problem and she underwent surgery for it a little after Christmas 2012. (PX1; p.16).

Dr. Coe testified that Petitioner was a right-handed individual and by her description of her work requiring considerable use of her right arm, including the pinch grip, and pulling and tugging of files, that those activities caused the development of acute right lateral epicondylitis in the summer of 2010 which became a chronic condition. (PX1; p.18). Dr. Coe testified that he saw Petitioner five years after the summer of 2010. (PX1; p.22).

Dr. Coe testified that Petitioner's right shoulder problem emerged in the summer of 2012. (PX1; p.23, 24). Dr. Coe testified that as Petitioner's right elbow was hurting her, it was not uncommon for the next joint, which was the shoulder, to take the stress of activity. He testified that since it was hard to grip and pull with the right elbow because of the pain, people begin to move their arm more stiffly which begins to stress the next joint up. (PX1; p.24, 25). He testified this was based on his experience. (PX1; p.25). He testified that Dr. White diagnosed an impingement syndrome with a probable rotator cuff tear. (PX1; p.26). He testified that this diagnosis was something that could be seen in individuals who do forcefully exert their arm through the shoulder by reaching out and pulling towards them, doing things at or above shoulder height, which was something Petitioner described. (PX1; p.26).

Dr. Coe testified that it was his opinion to a reasonable degree of medical certainty that Petitioner's continued work activities as office manager and coordinator caused a breakdown in her right shoulder. (PX1; p.26). He further testified that the right shoulder surgery Petitioner had was to a reasonable degree of medical certainty causally related to the repetitive activities that Petitioner described to him. (PX1; p.27).

Dr. Coe testified that Petitioner developed the same problem in her left elbow as she had in her right elbow, which was lateral epicondylitis and that to a reasonable degree of medical certainty, continued work activities and trying to protect the right arm caused the condition in the left elbow. (PX1; p.30, 31, 34, 35). He further testified that there is a causal relationship between Petitioner's work activities with Respondent and the development of right lateral epicondylitis, left lateral epicondylitis and her right shoulder condition. (PX1; p.36).

Dr. Coe testified that he had not seen a typed job description or any other representation of Petitioner's workplace. (PX1; p.39). He testified that he relied on what Petitioner told him. (PX1; p.40). He testified that he relied on Petitioner's use of the term "overuse" which is subjective, and he had no way of measuring it. (PX1; p.40).

Dr. Coe testified that Petitioner told him that she had Type 2 diabetes for years. (PX1; p.42). Dr. Coe testified that as seen on MRI, Petitioner certainly had pre-existent degenerative arthritis in her right shoulder at the AC joint which was one of the places that Dr. White did surgery on. (PX1; p.44).

Dr. Coe testified that in some literature, repetitive meant "more often than not during the workday . . . around two-thirds of the workday." (PX1; p.47). Dr. Coe agreed that the literature states that the key to epicondylitis is the forceful and repetitive nature of a trauma. (PX1; p.55). He testified that he did review in Petitioner's medical records repeated references to the fact that she sat at her desk all day, and he testified that that was recognized as an office sedentary seated position. (PX1; p.56). Dr. Coe testified that he did not have information about the frequency in which Petitioner filed or number of times she actually moved larger files versus little files. (PX1; p.59).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issues C & D: *Accident and Date of Accident*

The Arbitrator concludes the Petitioner did not sustain any injuries arising out of and in the course of her employment with Respondent on August 19, 2010, January 14, 2011, October

17, 2011, and August 23, 2012. Petitioner has claimed her injuries were caused by repetitive activities at work and that there was no one specific accident or injury. Whether a person's work activities are sufficiently repetitive must be decided on a case-by-case basis on the particular facts in each case. In Edward Hines Precision Components vs. Industrial Commission, 356 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (2d Dist. 2005), the claimant's job as a tractor/trailer driver was not deemed to be repetitive in nature. He stated that he drove an 18-wheel, flatbed truck with a manual transmission an average of 200 miles a day. He shifted gears with his right arm and used his left arm to steer. He delivered trusses that were secured to the flatbed with an average of 10 straps per load. The straps were tightened with either a manual wench or a pry bar. Claimant testified that tightening the strap required application of substantial force so that the load would not shift when the truck was moving. Petitioner's work activities, as described, were not repetitive or forceful in nature, when viewed along with the activities in the Edward Hines case.

In Williams vs. Industrial Commission, 244 Ill.App.3d 204, 614 N.E.2d 177, 185 Ill.Dec. 43 (1st Dist. 1993), claimant testified that part of his job required lifting machine parts that weighed anywhere from 30 to 60 or 70 pounds apiece. He would lift such objects about two times a day and he estimated he would spend approximately 30% of his time on each shift lifting objects of this weight range. He would climb on top of a crane for approximately five or six times a day. He would also crawl under certain machinery in order to perform repairs. The crawling would involve lying on his back or stomach and crawling under the machine. He would crawl in such a manner two to three hours per day on a daily or weekly basis. He also used 8, 12, and 16-pound sledgehammers for two to three hours a day on a daily basis and was required to operate a hydraulic air hammer to break up concrete approximately once every six months. He utilized various sizes of weights and tools including pipe wrenches, chain saws, sledgehammers, and box wrenches, etc. Any one of Petitioner's work activities could not compare in forcefulness to any one of the claimant's activities in the Williams case. Any one of Petitioner's activities could not compare in repetitiveness to any one of the claimant's activities in the Williams case. In Williams, the First District Appellate Court held that claimant's job was not repetitive.

Petitioner's case can even be distinguished from Quaker Oats Co. vs. Industrial Commission, 414 Ill.326, 111 N.E.2d 351 (1953). In Quaker Oats, the claimant was found to have suffered an aggravation or acceleration of a pre-existing condition by the dropping of cans onto his left foot. In this case, Petitioner's work activities were not repetitive as depicted in Quaker Oats, as it is evident she had a variety of duties that were interspersed throughout her day. So, the Arbitrator cannot conclude that Petitioner suffered an aggravation or acceleration of any pre-existing conditions.

Issue E: *Notice*

The Arbitrator also finds the Petitioner did not give timely notice of the accidents of August 19, 2010, January 14, 2011, October 17, 2011, and August 23, 2012 to Respondent. Under the Act, a claimant must give notice to an employer as soon as practicable but not later than 45 days after sustaining an accidental injury arising from employment. Although a lack of notice, or a defect or inaccuracy in notice has proven to be a weak defense and would not bar a claim, sometimes a lack of notice, or defect or inaccuracy in notice can be barred if it is prejudicial to an employer. *Health & Hospitals Governing Commission of Cook County vs. Industrial Commission*, 75 Ill.2d 194, 387 N.E.2d 683, 25 Ill.Dec.807 (1979).

In this case, four witnesses testified that they did not know Petitioner was ever injured at work from her work activities. Although Petitioner testified that she provided notice to Patti Murphy, Patti Murphy testified that had she been aware or been told that Petitioner claimed she had been injured at work from work activities, she would have acted on it by contacting Human Resources. Jackie Ladewig testified that had she known, she would have contacted the insurance agent who in turn would have contacted Respondent's workers' compensation carrier. She talked with Petitioner on the phone frequently and never learned that Petitioner was claiming work-related injuries. Jackie testified had she known, she would have assisted Petitioner with the proper forms for workers' compensation. Kathleen Duprey Tagge was Petitioner's supervisor for a time and she was not aware of Petitioner claiming any injury from work activities. Thomas Peer was Petitioner's supervisor for a time and he was not aware of Petitioner claiming any injury from work activities. The evidence supports that Respondent first learned of Petitioner's claims of injury from work activities through the filing of Applications, all which were done on March 19, 2013. Petitioner worked in close proximity with Joanna Guerra for a time, and Ms. Guerra testified that she was not aware of Petitioner's claims of injury from work activities.

Petitioner was in a supervisory position with Respondent and knew of the policy of reporting work accident or injuries. She knew about reporting because she reported an accident that occurred with her in 2008. The type of form is insignificant when Petitioner knew how to report a work accident or injury. All she had to do was tell someone also employed by Respondent, but she failed to do so.

Issue F: *Causal connection*

Petitioner's current condition of ill-being is not causally related to her employment with Respondent based on the rationale set forth for issue (C) above. In addition, the Arbitrator gives more weight to Dr. Nicholson's opinions than Dr. Coe's opinions, because Dr. Coe relied

solely on what Petitioner told him and her definition of "repetitive" work. Both doctors testified that repetitive work is work that is done two-thirds of the time in a work day and involve forceful gripping. Dr. Nicholson described it as assembly line work. Petitioner worked in an office and her job was mostly sedentary. Joanna Guerra testified that she did Petitioner's filing. Petitioner's supervisor, Tom, testified that he did Petitioner's credentialing work for a time after she left, and he did not have any difficulty with pulling files out of a cabinet or putting them back in. Further, none of Petitioner's treating physicians causally related her work duties to any conditions in her elbows or right shoulder, except for Petitioner's medical expert, Dr. Coe, who saw her one time and relied on her description of her work activities. In fact, Petitioner never told any of her treating physicians that any activity at work, such as pulling files out of cabinets or putting them back in, caused pain to her elbows or right shoulder.

The Petitioner's situation is like that present in a recent Illinois Workers' Compensation Commission decision. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017). In *Cook*, the claimant, an office worker much like the Petitioner, argued her bilateral carpal tunnel syndrome was causally connected to her repetitive work for her employer. However, after the Commission reminded the Arbitrator of the proper standard of proof necessary under Illinois case law for repetitive and forceful work claims, the Commission affirmed and adopted the Arbitration Decision denying that claim. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017).

Issue J: *Medical bills*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of medical bills is moot and the Petitioner's claim for payment of the same is denied.

Issue K: *TTD*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of TTD is moot and the Petitioner's claim for payment of such benefits is denied.

Issue L: *Nature and extent of injury*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of the nature and extent of injury is moot and the Petitioner's claim for payment of such benefits is denied.

20 I W C C 0 1 0 1

Issue N: *Respondent's credit*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of Respondent's credit is moot.

Signature of Arbitrator

OCTOBER 18, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judy Becker,
Petitioner,

20IWCC0102

vs.

NO: 13 WC 9011

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2018, is hereby affirmed and adopted.

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

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

There is no bond 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 Circuit Court.

DATED: FEB 11 2020
o1/23/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0102

BECKER, JUDY
Employee/Petitioner

Case# **13WC009011**

13WC009007
13WC009009
13WC009010

UNITED THERAPIES
Employer/Respondent

On 10/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5122 PORRO NIERMANN LAW GROUP
KURT NIERMANN
821 W GELANA BLVD
AURORA, IL 60506

1454 THOMAS & PORTELA
DANA DJOKIC
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

20IWCC0102

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

JUDY BECKER
Employee/Petitioner

v.

UNITED THERAPIES
Employer/Respondent

Case # **13** WC **9011**

Consolidated cases:
13 WC 9007, 13 9009, and 13 WC 9010

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 29, 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. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **AUGUST 23, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**59,062.64**; the average weekly wage was $**1,135.82**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

ORDER

The Arbitrator refers all orders relating to temporary total disability benefits, medical expenses, permanent partial disability benefits, and Respondent's credit to the Arbitration Decision for Application 13 WC 9007.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 18, 2018
Date

OCT 19 2018

20IWCC0102

JUDY BECKER v. UNITED THERAPIES

13 WC 9007, 13 WC 9009, 13 WC 9010, & 13 WC 9011

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

These matters were tried before Arbitrator Steffenson on November 29, 2017.[1] The issues in dispute were accident and the date of accident, notice, causal connection, medical bills, TTD benefits, and the nature and extent of the injury. (Arbitrator's Exhibits 1-4). The parties requested a written decision, including findings of fact and conclusions of law, and agreed to receipt of the same via e-mail. (Arbitrator's Exhibits (*hereinafter*, AX) 1-4).

FINDINGS OF FACT

Petitioner testified that she was employed by the Respondent on *August 19, 2010* as an office coordinator and credentialing coordinator up until May 2013 (Transcript 24), when she was terminated because her FMLA period ran out. (Transcript (*hereinafter*, Trans.) 25). She testified she had worked for the Respondent for 18 years. (Trans.104). She testified that starting August 2010, she primarily did credentialing work which she described as involving heavy lifting and pulling and grasping hard copy files. (Trans.25). She testified that all of the credentialing files were for physicians. (Trans.28). She testified that she had approximately 180 to 200 of those [credentialing] physician files in her office back in 2010. (Trans.29). She testified that there were a lot of documents that needed to be filed into credentialing folders on a daily basis. (Trans.26). She explained that credentialing files were legal size, made of cardboard, with cardboard inserts. (Trans.27). She testified that some of them were quite thick – five to six inches thick and containing all types of information. (Trans.27). She testified they were kept in a filing cabinet that was probably up to her nose or the top of her head. (Trans.30). She testified she is 5'5" in height. (Trans.30). She testified she had three sets of cabinets, each with three drawers, and each of the drawers had a top that pulled open. (Trans.30). She testified that she had to pull the drawers toward her to access the files. (Trans.31).

Petitioner testified that from 2008 to 2011, she would take files out of the cabinets when she needed to file a document on a daily basis. (Trans.27, 36). She testified she would

[1] During the hearing of these matters, with all parties present and represented by counsel, the Petitioner's fifth claim, 13 WC 9008, was dismissed for want of prosecution.

open the file cabinet, reach in, pull and grasp, and sometimes struggle to pull the files out because they were tightly packed in. (Trans.33, 34). She testified she could only grasp with her fingers because it was impossible to get her fingers down in between a whole file. (Trans.34). She testified she would have to raise her arms at least shoulder height, or two, four or six inches higher than her shoulders. (Trans.35). She testified there was no other file cabinet space available. (Trans.33). She testified she did not have a step stool. (Trans.35).

Petitioner testified that she worked eight-hour days. (Trans.36). She testified that on average she would spend three to five hours a day pulling/replacing files. (Trans.37). She testified that for the remaining times, she probably ran reports from a program on the computer. (Trans.37, 38). She testified she would then have to file the reports into the physicians' folders. (Trans.38). She testified she could run dozens of reports a day but would not work on all 200 reports in a day. (Trans.38). She testified she would hole-punch the documents and place them in a physician's file by attaching them to prongs on the inside of the file. (Trans.39). She testified that she would then put the file back into an already tightly-fitted drawer. (Trans.40, 41). She testified the files were not sticking out and she could close the cabinet door. (Trans.41). She testified that no one else had credentialing responsibilities between 2008 and 2010. (Trans.42). She testified she continued to do this type of work with the files until she left. (Trans.42).

Petitioner testified that she also worked with close to 100+ patient files per week, or month. (Trans.42, 43). She testified that patient filing cabinets were also three-drawer filing cabinets and would get very crammed and full. (Trans.44). She testified that when she took over the credentialing coordinator position, she still had to work with the patient files. (Trans.44). She testified that before she got the credentialing duties added onto her job duties, she was managing the front office and helping to schedule and "put out fires." (Trans.44). She testified she made sure the office was running smoothly and that they were fully staffed. (Trans.45). She testified that she occasionally had someone assist in the patient file work. (Trans.45). She testified that her job activities were interspersed during the course of a day. (Trans.53).

Petitioner saw Dr. Roman Dreyer at Dreyer Medical Clinic on ***August 4, 2010***. (Petitioner's Exhibit 4, p.1111). Dr. Dreyer noted that Petitioner's pain started three weeks prior, gradually, with no trauma or injury. He noted she had a problem lifting light weights. His assessment was severe elbow pain with a concern for severe tendonitis. He prescribed 600 mg of ibuprofen and recommended an elbow strap and no lifting of weights or repetitive motion. He opined that if there was no improvement, then he would order an MRI of the right elbow. (Petitioner's Exhibit (*hereinafter*, PX) 4, p.1112).

Petitioner testified that on *August 19, 2010*, while performing credentialing file work she noticed her [right] elbow was beginning to hurt and continued to get worse. (Trans.46). She testified that she realized when she was pulling on files is when she had the most pain that was constant, chronic, and would never go away. (Trans.47).

Petitioner testified she sought treatment with Dr. James Anderson on *August 19, 2010*. (Trans.47). She testified she had reported to Dr. Anderson that she worked as a clerk in an office and that pulling files at work was bothering her. (Trans.47, 48). She testified that she did not tell Dr. Anderson anything specific about her work duties that caused her to see him because he did not ask. (Trans.123). Dr. Anderson's note of August 19, 2010 provides that Petitioner did some weight training which may have aggravated her right elbow. (PX4; p.1127). He noted that Petitioner had treated with a tennis elbow strap but had no other specific treatment. His assessment was right lateral epicondylitis. (PX4; p.1127). He gave Petitioner a corticosteroid injection into the *right elbow* on the same date. Petitioner testified she had about two to three weeks of temporary relief from the injection. (Trans.49).

Petitioner testified that while speaking with her supervisor, Patti Murphy, in person at Respondent's LaGrange office just before her August 19, 2010 appointment, she reported that her [right] elbow was hurting, and she associated it with pulling files. (Trans.60-62). She testified she told Patti that she thought it would be a good idea if the files were scanned. (Trans.63). She testified that Patti told her to just go to the doctor and she would be fine. (Trans.63).

Petitioner saw Dr. Roy Henderson on *September 29, 2010*, also at Dreyer Medical Clinic. Dr. Henderson noted that Petitioner told him her pain started in July 2010, that she sat at a desk most of the day, and did Jazzercise and weight lifting three to five times per week. There was no mention of any other specific work activities. Dr. Henderson had the same impression as Dr. Anderson. (PX4, p.1144).

Petitioner testified she did physical therapy and reported to the therapists what she was doing at work that was causing her symptoms. (Trans.48). Petitioner did her therapy at Dreyer Medical Clinic. A progress note for a therapy visit on *October 4, 2010* provides that Petitioner was an office manager and her duties were keyboarding, filing and writing, and Jazzercise is listed as a recreational activity. (PX4, p.1152).

Petitioner next saw Dr. Roy Henderson on *November 18, 2010*. He noted that Petitioner's right elbow pain was worsened by using her hand, picking up a coffee cup, and pulling files at work/gripping. That was the extent of work activities mentioned. He had the same impression as at the last visit. Dr. Henderson provided Petitioner with a cortisone injection into the right elbow. (PX4, p.1213).

Petitioner next saw Dr. Dreyer on *January 10, 2011* for routine lab work and follow up. Dr. Dreyer noted persistent pain and swelling in the right elbow and diagnosed elbow tendonitis. He recommended an MRI. (PX4, p.1246).

Petitioner had an MRI of her right elbow done on *January 14, 2011* at Dreyer Medical Clinic upon Dr. Dreyer's order. The MRI revealed a full-thickness tear of the common extensor tendon at the origin of the extensor carpi radialis brevis tendon [lateral epicondyle] and a small elbow joint effusion. (PX4, p.1250). Petitioner testified that she believed she told Patti a few days after this MRI of the elbow was done, that the MRI showed a torn tendon. (Trans.63, 64). She testified that she told Patti because she felt it was work-related, she was in pain, and struggling to do her job. (Trans.65).

Petitioner saw Dr. Neena Szuch, also at Dreyer Medical Clinic, on *January 21, 2011* for right lateral epicondylitis. The visit note contained no specific history, other than Petitioner had some physical therapy and used a forearm brace without adequate relief of symptoms. The visit note made no mention of any of Petitioner's work activities. (PX, p.1275). An x-ray of the left elbow revealed some spurring at the distal humerus. (PX4, p.1279). Dr. Szuch diagnosed right lateral epicondylitis and offered Petitioner a wrist brace. (PX4, p.1275).

Petitioner described the brace as going through the thumb and over the hand and up to right below the elbow, which fastened on the bottom. (Trans.56). She testified the brace did not interfere with flexion of the elbow joint. (Trans.56). She testified she did not hide the brace from co-workers. (Trans.55).

Petitioner saw Dr. Brian Hubbard, also at Dreyer Medical Clinic, on *February 19, 2011* for a complaint of bilateral upper and lower back pain which had been present for one day and started when she was at rest. (PX4, p.1304). There was no mention of any of Petitioner's work activities. The diagnosis was lumbar and thoracic strain. (PX4, p.1305).

Petitioner's next right elbow related treatment was on *June 24, 2011* with Dr. Roy Henderson. He noted that there was no mechanism of injury and that, again, Petitioner sat at a desk most of the day, and did Jazzercise and weight lifting. He reviewed the right elbow MRI done on January 14, 2011 and noted the full-thickness tear at the origin of the extensor carpi radialis brevis. He noted that Petitioner had seen Dr. Szuch who recommended non-operative treatment. Dr. Henderson's impression was right lateral epicondylitis with a full thickness tear at the wrist extensor insertion. He referred Petitioner to Dr. White. (PX4, p.1380).

Petitioner testified that she did Jazzercise two to four times a week. (Trans.66, 67). She testified it involved movements with feet and it was a dance class (Trans.66). She testified that some exercises can be done with two-pound weights, which she would hold and do whatever with them. (Trans.66, 67). She testified she did not notice any problems with her elbows or

shoulders while doing Jazzercise. (Trans.67). She testified she would lift the weights up to her shoulder and put them back down. (Trans.68).

Petitioner testified that in 2011 the records for credentialing started being scanned. (Trans.58). She testified that she had been asking for files to be scanned ever since she took over the credentialing position because of the difficulty in their physical presence and her ability to access those files. (Trans.58). She testified that at that time there were still physical patient files and physician files for physicians coming up for reappointment. (Trans.59).

Petitioner first saw Dr. Thomas White, also at Dreyer Medical Clinic, on *July 14, 2011*. He noted that she was a right-handed office manager who came in with a year's worth of pain in the lateral side of her right elbow. He noted her treatment history, but no specific work activities were mentioned. He reviewed the MRI of the right elbow. His assessment was chronic lateral epicondylitis in the right elbow and provided a Depo-Medrol and Marcaine injection. (PX4, p.1386).

Petitioner's next orthopedic-related visit was on *October 17, 2011* with Dr. Sunil Malkani, also at Dreyer Medical Clinic. She testified she complained about her *left shoulder and neck*. (Trans.69, 70; PX4, p.1502). Dr. Malkani noted the visit was for acute neck pain located in the back of the neck and radiating into the left shoulder. He noted the pain was dull. He noted there was no associated trauma, but that Petitioner sat in front of a computer all day. He diagnosed musculoskeletal neck pain and trigeminal neuralgia syndrome. (PX4, p.1504). Petitioner testified that Dr. Malkani recommended some physical therapy and prescribed a muscle relaxant. (Trans.70; PX4, p.1504). An x-ray of the neck was done on the same date and revealed mild degenerative changes, moderate left-sided facet hypertrophy, moderate left neural foraminal stenosis at C4-C5, and mild left neural foraminal stenosis at C5-C6 and C6-C7. (PX4, p.1507).

A physical therapy progress note dated *November 4, 2011* provides that Petitioner complained of pain over her cervical spine and into her left upper trapezius. The onset date was October 27, 2011 with no known incident. The subjective report was that symptoms were aggravated by sitting at a desk keyboarding and driving ("at times rests elbow on window"). It is noted that Petitioner did not have therapy before for these symptoms because she never had them before. (PX4, p.1527).

Petitioner called or emailed Dreyer Medical Clinic on *November 14, 2011* and Ernestina Sanchez, a nurse, documented the message. Petitioner asked whether it was "ok" for her to continue Jazzercise and other home exercise. The message was relayed to Dr. Farah K. Hussain, and Dr. Hussain responded to Petitioner to "go ahead and resume your exercise." (PX4, p.1550).

Petitioner saw Dr. Barry Abrams at Dreyer Medical Clinic on *March 23, 2012* due to an injury to her right foot after tripping and falling the night before. She was diagnosed with a sprain of the foot. (PX4, p.1614).

Petitioner's next orthopedic-related visit was on *August 23, 2012* with Dr. Thomas White. She testified she complained about her *right shoulder and arm*. (Trans.73; PX4, p.1697). Dr. White noted that a complaint of pain in the superior aspect of the right shoulder, which bothered Petitioner claimed bothered her particularly at night, and sometimes radiated down into her right arm. He noted that Petitioner did not recall any "recent or remote injury or change in activity." Dr. White assessed impingement syndrome. He wanted to rule out a rotator cuff tear. He provided an injection of Depo-Medrol and Marcaine into the subacromial space. (PX4, p.1697). There were no work-related activities mentioned at this visit. Petitioner testified that after she made this appointment, she told Patti Murphy over the phone that she was seeking treatment for her right shoulder. (Trans.82, 83). Petitioner testified that she also told Patti the same thing she had been telling her for months – that the pulling and grasping of the files were hurting her shoulder and elbows. (Trans.84). She testified that "they" never wanted to scan the files or alleviate that or accommodate her in any way, even knowing Petitioner was having pain from it. (Trans.84).

Petitioner had an MRI of the right shoulder done at Dreyer Medical Clinic on *November 13, 2012*. The reason for the MRI listed on the report was that Petitioner had right shoulder pain for six months without antecedent injury. The MRI revealed marked supraspinatus and lesser infraspinatus tendinopathy and a partial-thickness articular surface supraspinatus tear without a full-thickness rotator cuff tear demonstrated. There were also degenerative findings. (PX4, p.1744).

Petitioner followed up with Dr. White on *November 15, 2012*. Dr. White had reviewed the MRI and noted it revealed supraspinatus and infraspinatus tendinopathy with probable partial-thickness rotator cuff tear. He discussed with Petitioner a shoulder arthroscopy, as Petitioner had decided ahead of time that she did not want therapy. Petitioner asked that the surgery be done after the holidays. (PX4, p.1763).

Petitioner had a preoperative visit with Dr. Sharon Ollee at Dreyer Medical Clinic on *December 11, 2012*. Dr. Ollee noted a history of pain located in the superior aspect of the [right] shoulder which was worse at night and sometimes radiated down into the right arm. It is noted that Petitioner denied any preceding injury or change in activity. It is noted that Petitioner worked as an office manager at a surgery center. There was no mention about any specific work activities. (PX4, p.1797).

Petitioner next saw Dr. White on *December 19, 2012*. She testified she had told Dr. White that she did not recall an injury to her *left elbow*, but that she had been using her left arm a lot trying to protect the right. (Trans.87). Dr. White noted that Petitioner did not recall any injury, but that about a month before, she began getting pain in the lateral aspect of the left elbow. Dr. White further noted that Petitioner reported she had been using her left arm a lot trying to protect the right. Dr. White diagnosed left elbow pain and lateral epicondylitis. He provided an injection of Depo-Medrol and Marcaine to Petitioner's left elbow. (PX4, p.1805).

Petitioner testified that she probably told Patti the next day after her December 19, 2012 doctor's visit, or another day after that, that she developed pain in her left side. (Trans.88). She testified that she did not have a lot of conversations with Patti about treatment on her different body parts. (Trans.88). Petitioner testified that she got a left elbow cortisone injection on December 19, 2012 by Dr. White. (Trans.89).

Petitioner had surgery on her right shoulder by Dr. White on *December 28, 2012*. (PX4, p.1814). She testified that she went off work at that time and was off until she attempted to go back to work for two weeks and a couple of days starting *March 23, 2013*. (Trans.77, 78). The surgery was a right shoulder arthroscopy with rotator cuff repair and subacromial decompression. The preoperative and postoperative findings were right shoulder impingement with rotator cuff tear. (PX4, p.1814). Petitioner testified that she thought there was some improvement from the surgery, but it took an unusually long time. (Trans.77). Petitioner testified that while recuperating from her right shoulder surgery, she was having chronic pain in her left elbow. (Trans.86).

Petitioner testified she obtained a brace for her left arm in December 2012. (Trans.57). She testified she would not cover up her braces on either the right or left when Patti came to visit the office. (Trans.85). Petitioner testified she saw Patti roughly once a week. (Trans.85). She testified that Patti never suggested filing a workers' compensation case. (Trans.85).

A Dreyer Medical Clinic physical therapy note dated *January 18, 2013* provides that Petitioner reported falling down two stairs the previous night as she was going into her garage. She had been on a cell phone while wearing her sling but did not land on her right shoulder. She went to a walk-in care facility in the morning. The note provides that Petitioner reported no increased pain to her right shoulder due to the fall. (PX4, p.1864).

Another physical therapy note dated *January 22, 2013* provides that Petitioner reported pain in the anterior lateral portion of her right shoulder, which was different than what she had experienced, and it had started between 24-48 hours earlier. She reported that she did not know if she slept wrong or did something she was not supposed to do. (PX4, p.1878).

Petitioner saw Dr. White on *January 28, 2013*. Dr. White recommended continuing physical therapy and provided a note for Petitioner to be off work for another month. Here original work status was due to run out on February 8, 2013. (PX4, p.1908).

Petitioner returned to see Dr. White on *March 18, 2013*. It is noted that Petitioner advised she needed to get back to work by the end of the week because her FMLA would run out. However, Dr. White offered to continue Petitioner's disability. The note provides that Dr. White told Petitioner that any restrictions were acceptable to him and it really depended on what was acceptable to her employer. After having Petitioner go over her job with him, Dr. White suggested a five-pound lifting limit and no overhead use. (PX4, p.2035). Petitioner testified that she did not believe Dr. White placed any restrictions on her for the time she returned to work. (Trans.80).

Petitioner testified that during the work trial period *[March 23, 2013 through April 8, 2013]*, it was very difficult to get through a whole eight-hour day, especially sitting at the desk or doing any kind of grasping or pulling or lifting. (Trans.80). She testified that keyboarding was also difficult. (Trans.80). She testified that her right shoulder and both elbows were affected by these activities. (Trans.81, 82). She testified she tried not to do any lifting with her right arm. (Trans.129).

Petitioner testified she filed her cases at the Commission in the first quarter of 2013, before she was terminated by Respondent. (Trans.102, 103). The record reflects that Petitioner's Applications were all filed on *March 19, 2013*. She testified that nobody from the Respondent contacted her before she was terminated to discuss any of the claims. (Trans.103).

Petitioner did not return to see Dr. White, but instead saw Dr. Kenneth Schiffman at Hinsdale Orthopaedics for the first time on *April 9, 2013*. Dr. Schiffman noted that Petitioner sought a second opinion on her right shoulder and bilateral elbow pain. It is noted that she complained of pain with typing and pulling. That was the extent of work activities mentioned. Dr. Schiffman diagnosed status post right rotator cuff repair and bilateral lateral epicondylitis. He suggested continued physical therapy and placed Petitioner off work. (Respondent's Exhibit 20, p.012-014).

Petitioner saw Dr. Schiffman again on *May 10, 2013* and reported that her right shoulder pain woke her up at night, but that therapy was progressing well, and she had limited range of motion due to elbow pain. Dr. Schiffman recommended continued physical therapy on the right shoulder as well as on the left elbow. He provided a referral to Dr. Kirincic for pain management program to help with sleep and manage the pain in the elbow. He kept Petitioner off work for the next five weeks. (Respondent's Exhibit (*hereinafter*, RX) 20, p.008-009).

Petitioner testified that her last visit with Dr. Schiffman was on *June 20, 2013*, when he released her from care with permanent restrictions. (Trans.78). He noted that Petitioner's right shoulder was doing well but she had persistent [left] elbow pain secondary to lateral epicondylitis. He placed restrictions of no lifting more than five pounds, no overhead reaching, no repetitive motion for the elbow or wrist, and minimal keyboard use. He advised Petitioner to return as needed. (PX2). Petitioner testified that Respondent did not offer her a position to accommodate Dr. Schiffman's permanent restrictions. (Trans.94). Petitioner testified she would not be able to return to her previous job because she does not have the stamina for it, she would be in pain, and she would not last more than an hour at most probably. (Trans.94). She testified she has been unable to do her job between December 2012 and today. (Trans.95).

Petitioner testified that she was in a supervisory position with Respondent. (Trans.105). She testified that she understood the policy was for people under her supervision to report accidents or injuries to her. (Trans.105). She testified it was not something she/they were specifically trained on. (Trans.105). She testified she was responsible for a portion of the policy manual. (Trans.105, 106). Then she testified that she would not have contributed to the policy concerning reporting accidents and injuries. (Trans.106). She testified that the policy would have been drafted by a supervisor with more authority than herself. (Trans.106).

Petitioner testified she filled out an accident report in 2000. (Trans.106, 107; RX3). She identified her handwriting on Respondent's Exhibit 3 and identified it as an Employee Report of Occupational Injury or Illness. (Trans.107; RX3). She confirmed that her manager's name, Patti Murphy, is also listed on the report, which is dated February 23, 2000. (Trans.108). Petitioner testified that she was aware that the "company" [Respondent] had procedures in place for reporting accidents and injuries, and that she followed that. (Trans.108). Petitioner testified that she did not file or complete any accident reports for the current claimed accidents/injuries, but instead requested FMLA leave for the surgery on her right shoulder. (Trans.108).

Petitioner testified that she signed a form called a Certification of Health Care Provider and dated 2007. (Trans.110; RX 5). She testified she had requested Family Medical Leave on a prior occasion due to shingles. (Trans.111). Petitioner testified that Dr. White did complete a form for her to be off work in 2012 for her right shoulder surgery. (Trans.112). She testified that Dr. Malkani completed a form for her to be off work in 2011 for injuries she claims occurred at work. (Trans.112, 113).

When asked why she requested Family Medical Leave instead of filing for workers' compensation, Petitioner testified that she did file for workers' compensation and did notify her supervisor that she was hurt at work. (Trans.113). She testified that her supervisor told her to go to the doctor. (Trans.113). Petitioner testified that she did not tell anyone else [at work] other than Patti Murphy of her injuries from work activities. (Trans.131). Petitioner testified

that she had access to accident reports that could be completed for a work-related injury. (Trans.115). When asked if it was up to her as an employee of the company to complete an accident report if there was an accident or injury that occurred at work, Petitioner testified "yes" and that the circumstances of "that particular accident report" [the 2000 accident report], were that the nurse at the center pulled that report and filled it out and she signed it, because the nurse treated her foot that hit the door. (Trans.116).

Petitioner testified that she had her own office at United Therapies up to 2011, but after that she was at a desk with other employees in the front area. (Trans.116). Petitioner testified she did not have an assistant during the time she was with Respondent. (Trans.117). Petitioner testified that Joanna Guerra was not her assistant, but her subordinate and she was Joanna's supervisor. (Trans.117). Petitioner testified she did not ask Joanna to do her filing, or to pull files and bring them to her. (Trans.118). Petitioner testified that she would not ask Joanna to pull credentialing files because no one handled the credentialing files but Petitioner. (Trans.119). Petitioner testified that she would ask Joanna to pull and bring her a patient file. (Trans.119). Petitioner testified that she had control over how many files she could put in a cabinet. (Trans.119). Petitioner testified that when she was in her own office with the file cabinets, it was only possible to pull one file at a time, but she might have pulled several files to work on so as not to have to keep pulling and cramming. (Trans.117). She testified the files may have come out of different drawers. (Trans.117). Petitioner testified she was private about her health issues and treatment at work. (Trans.120). She testified that one of the files that she worked with weighed as much as a two-pound weight. (Trans.122). She testified that it was not an eight-hour, nonstop activity of pulling out files and putting back files, and that she did not type on a keyboard eight hours a day nonstop. (Trans.122). She testified that some of her activities [at work] involved being on the phone. (Trans.123).

She testified that the activity of running reports involved entering something into a computer and the reports would be printed out on a printer. (Trans.123).

Petitioner testified that she had to move files to a temporary location while the LaGrange facility was being remodeled in 2011. (Trans.126, 127). She testified she had to pack the files into boxes herself. (Trans.25). She testified that the Respondent did not hire a moving company to move files. (Trans.127). Then she testified that some of the files that were put in boxes during the remodel were moved by a hired company. (Trans.127). Petitioner testified that boxes of files she was working on went to the new location with her. (Trans.127).

Petitioner identified at trial a letter from Star Insurance addressed to her and dated _April 3, 2013_ acknowledging a report of injury. (Trans.138, 139; RX16). She identified the date of injury in the letter as December 19, 2012. (Trans.139; RX16). Petitioner testified she had not

received any letters concerning any of her claims from any other insurance company prior to the April 3, 2013 letter from Star Insurance. (Trans.139).

Petitioner identified at trial a Memo dated *April 18, 2013* from Jackie Ladewig to her concerning a grant of unpaid personal leave of absence through *May 14, 2014*. (Trans.135, 136; RX12). She testified that it concerned recovery for her right shoulder surgery and bilateral elbows, although that specific information was not in the memo. (Trans.136; RX12). Petitioner agreed that the Memo requested that Petitioner advise Respondent of her status and ability to return to work on or before *May 14, 2013*. (Trans.136; RX12). Petitioner testified she told Respondent that she did not have a doctor's appointment until June and that is when she would know. (Trans.137; RX12). She testified that Respondent had a work status from Dr. Schiffman stating she would be off. (Trans.137; RX12).

Petitioner identified at trial a letter dated *May 17, 2013* from Patti Murphy to her which was a letter of termination. (Trans.137; RX14). Petitioner confirmed that the letter notified her that she had exhausted all 12 weeks of Family Medical Leave. (Trans.137, 138; RX14). Petitioner testified she had been unable to return to work by May 17, 2013. (Trans.138). Petitioner testified that she notified Respondent in *March 2013* of her work-related injuries and was terminated two months later. (Trans.149).

Petitioner testified there is an outstanding bill from ATI Physical Therapy for therapy concerning her right shoulder and both elbows, but primarily the left elbow and right shoulder. (Trans.96, 97; PX3). Petitioner testified she wasn't aware of an outstanding charge by Dr. Schiffman at Hinsdale Orthopaedic Associates. (Trans.97; PX2). Petitioner testified she is not aware of any outstanding balance for any treatment at Dreyer Medical Clinic. (Trans.98; PX4). Petitioner testified that her personal insurance through Respondent paid for treatment. (Trans.98). She testified that the insurance stopped when she was terminated on May 17, 2013. (Trans.98, 99). Petitioner testified she received short-term disability payments from the date of her surgery [December 28, 2012] up to March 22, 2013, and then from April 9, 2013, when Dr. Schiffman released her from care, through June 20, 2013. (Trans.100, 101; RX22). She testified she thought she received the short-term disability payments as part of the FMLA process. (Trans.101).

Petitioner testified at the time of the trial that her left shoulder is better than her right shoulder. (Trans.71). She testified that sometimes she cannot unload wet clothes out of a washing machine and put them into the dryer, and she cannot load groceries into the back of her car. (Trans.71, 90). She testified her husband must go shopping with her. (Trans.71). She testified her husband carries the laundry baskets of folded clothes upstairs and he helps to load and unload groceries. (Trans.91).

She testified she cannot do any kind of scrubbing or cleaning motion or lift anything too heavy because she feels weakness and has muscle spasms in both elbows from time to time. (Trans.90). She testified she notices the pain when she keyboards for about 15 to 20 minutes. (Trans.51). She testified she still has issues with her right elbow being tremendously weak and has pain located on the outside of her elbow. (Trans.51). She testified she notices pain and swelling in her left elbow that never completely goes away. (Trans.89). She testified she is not planning to get anymore treatment for her left shoulder. (Trans.72). She testified she has no plan to go out and look for work. (Trans.103, 104).

Petitioner testified that the most she can do at a gym is the treadmill. (Trans.92). She testified she cannot participate in any kind of sports-like activities and must be careful with even what she wears sometimes if it is difficult to put on or take off because it requires over-extension of her arms. (Trans.92). When asked what sports she is unable to do that she used to do, Petitioner testified she is unable to ride a bike like she did before. (Trans.130). She testified that gripping the handlebars, squeezing the brakes, and leaning forward while bike riding is difficult on her elbows. (Trans.170). She testified that her husband had not helped her put her boots on the day of trial because they zip [up], but he had helped her with her coat. (Trans.130). Petitioner testified she is not "whole anymore." (Trans.92, 93). Petitioner testified she has good and bad days and tries not to take any pain medication stronger than Aleve or Advil. (Trans.93). Petitioner testified she has not worked in an employment setting since terminated by Respondent, and not since released by Dr. Schiffman. (Trans.93).

Joanna Guerra-Barr testified that she works for the Respondent, United Therapies and started on June 23, 2010. She testified that Petitioner was her former manager. She testified that her job duties were/are to disassemble/assemble charts, get labs, file paperwork whenever needed, and pass out faxes. She further testified that sometimes she helps patients change whenever they need it and helps with translations from Spanish to English. (Trans.178). She testified that she did filing and would file for patients and doctors. (Trans.179). She testified that prior to switching to scanning, she would pull patient charts and file any paperwork in them. (Trans.180). She testified that doctors' file cabinets were in a "mobile room" and some were in Petitioner's office, but patient files were in the front office. (Trans.181). She testified there was a time when Petitioner had an office and then she no longer had an office. (Trans.181). She testified that the reason for the change was because the building [in LaGrange] went into construction in the middle of 2011 for the purpose of becoming am ambulatory surgery center. (Trans.182).

Joanna testified that while working at United Therapies when Petitioner was her manager, Petitioner would ask her to file for her. (Trans.184). She testified that Petitioner would ask her to file some of the doctors' credentialing paperwork for her. (Trans.184, 185).

She testified that Petitioner showed her where everything went so Joanna could help her out. (Trans.185). She testified that she did all the filing. (Trans.219). Joanna testified that Petitioner would show her how to look on the computer to check whether a doctor's license was current. (Trans.185). She testified that she filed for Petitioner on a daily basis and did the majority of filing for Petitioner. (Trans.186). She testified that when Petitioner wanted files boxed, she would show Joanna where the paperwork went and tell Joanna to box them up. (Trans.231).

Joanna testified that she is 5'2" and the filing cabinets were no higher than 5'3" or 5'4". (Trans.187). She testified that there were on average 40 sheets of paper in a patient file, and around 60-70 sheets of paper in each physician file. (Trans.188). She testified that if she did not have to schedule or check in a patient, she would file. (Trans.189). She testified she never had difficulty removing a file out of or placing a file into a cabinet, whether it was a patient or physician file. (Trans.190).

Joanna testified that after moving back into a remodeled LaGrange office, her seat was at the front desk, along with Zulema, a co-worker, and Petitioner. (Trans.196). She testified that she knew that Petitioner's job duties were to supervise her and Zulema, and also to do credentialing for the doctors and anesthesiologists. (Trans.199). She testified that she had opportunities to observe Petitioner during the time she was in the front desk area. (Trans.200, 201). She testified she had observed her on the internet, using the computer keyboard, and using the phone. (Trans.201, 202). She testified that she never observed Petitioner lifting boxes full of files during the time she worked with her. Joanna testified that she did observe Petitioner putting files into and taking files out of a cabinet, but she never observed Petitioner having difficulty doing that. (Trans.202, 203).

Joanna testified that Petitioner was very quiet about whatever she felt but complained about her shoulder or whatever was hurting her at the time. (Trans.203, 219). She testified that Petitioner would not be specific as to why. (Trans.203). She testified that Petitioner never told her she injured herself by doing something at work, during the time she worked with her. (Trans.203). She testified about the procedure she was aware of in the event of an accident or injury. (Trans.204). She testified that one would have to go to their manager and let them know, and that there was an incident report to fill out. (Trans.204, 205). She testified she was made aware of the procedure because "[w]e get trained on it, and also it's in our policy." (Trans.205). She testified that if she had become injured or had an accident at work, she would tell Petitioner. (Trans.205). She testified that Patti Murphy showed up at the office once or couple of times weekly. (Trans.235).

Kathleen Duprey-Tagge testified that she knows Petitioner from working with her at United Shockwave Therapies (United Therapies/Respondent). (Trans.256). She testified she started with Respondent in January 2003 and left in September 2010. She testified she became

the fixed site manager for LaGrange, Park Ridge and the Hinsdale facility, but primarily worked in Park Ridge. (Trans.257). She testified she did not have an office in LaGrange but would go and visit and meet with employees there. (Trans.257, 258). She testified that Petitioner reported to her from about 2005 or 2006 until she left in 2010. (Trans.258). She testified she was familiar with Petitioner's duties and had an opportunity to see Petitioner working while she was there. (Trans.259). She testified that when Petitioner was in the front desk space, Petitioner would sign in patients, answer phones, schedule patients, and prepare and assemble patient charts. (Trans.259). She testified that Respondent kept physician files for credentialing. (Trans.262). She testified that patient files were kept for a little while and purged every quarter.

Kathleen testified that when Petitioner had her own office, to the right of her desk there were three tall file cabinets, each containing four drawers. (Trans.263). Kathleen testified she had occasion to open the file cabinets and take physician files out when she was looking for physician information. (Trans.263, 264). She testified that some of the files could be full at times, but she does not believe she had difficulty taking a file out. (Trans.264).

Kathleen testified that employees under her supervision were informed through regular staff meetings of what to do if they became hurt at work. (Trans.265). She testified that the meetings occurred every one to two months and she was in attendance, along with supervisors and Patti Murphy. (Trans.266). She testified that Petitioner attended those meetings. (Trans.266). Kathleen testified that she was someone who prepared an accident/incident report and she had prepared accident/incident reports during the time she worked for Respondent. (Trans.267). She testified that based on her recollection, Petitioner never told her she injured herself from something she did while working. (Trans.267, 268).

Kathleen testified she would have prepared an accident/incident report if Petitioner had told her she was injured at work, as that was her practice. (Trans.268). She testified that based on her recollection, Petitioner never asked her to prepare an accident/incident report and did not do anything at work and then complain about being injured. (Trans.268). She further testified that to her recollection, no employee with Respondent told her that Petitioner had been injured while working. (Trans.268).

Kathleen testified that Petitioner's job for part of the time was organizing and keeping the credentialing files. (Trans.272, 273). She testified that based on her recollection, she didn't recall ever seeing Petitioner's forearm brace covering the thumb and coming around the side and coming up the forearm. (Trans.282). Kathleen testified that there were accident reporting procedures for employees and managers online and a hard copy. (Trans.284). Kathleen testified that she had met with Patti Murphy once or twice after she left the company and they did not talk about Petitioner or anything to do with this case. (Trans.286).

Thomas Peer testified that he knows Petitioner from working with her at United Therapies from 2010 through 2012-2013 as a fixed site manager. (Trans.293). He testified he took Kathleen's position when she left. (Trans.294). He testified that Petitioner reported to him. (Trans.294). Thomas testified that he was a mobile worker and worked at Respondent's both centers, Park Ridge and LaGrange. (Trans.294, 295). He testified he was mostly at the LaGrange facility, starting around 2012-2013. (Trans.295). He testified that prior to that, he went to the LaGrange facility about once or twice a week to meet with staff, keep track of operations and make sure the facilities were running correctly and schedules were on track. (Trans.295).

Thomas testified that he met with Petitioner every time he visited the [LaGrange] facility to discuss how scheduling was going with the doctors, any concerns or issues with the facilities, staff, and patients, and financial concerns. (Trans.296). He testified that Petitioner was the front desk office coordinator and also the credentialing coordinator. (Trans.296). He testified that when the [LaGrange] facility was remodeled, Petitioner shared the office with the front desk as there was no separate office. (Trans.296, 297). He testified that at the front office area, Petitioner had a desk that was up against a wall, there were patient file cabinets and a copier, and she basically shared the office with the scheduling staff who were Joanna and Zulema. (Trans.297). He testified that prior to that she had her own office with the credentialing files located there. (Trans.297, 321). He testified he did not remember how many cabinets there were, but there were cabinets in Petitioner's office and files were kept in each of the drawers. (Trans.322). He testified that he had an opportunity to open all the drawers [in the cabinets in Petitioner's office]. (Trans.322). He testified that the files would vary in thickness depending upon how long a doctor had been associated with the company, and some files were very thin if a doctor was new. (Trans.326). He testified that he did not experience files in drawers in Petitioner's office being tight. (Trans.327).

Thomas testified that he had occasion to take a file out of and put back into drawers and he never had any difficulty with same. (Trans.302). He testified he did not think any drawers in the file cabinets contained more files than they could handle. (Trans.303). He testified that when Petitioner was out for her shoulder surgery, he did the credentialing and had a reason to go into the file cabinets, but prior to that it was to review a file. (Trans.303). He testified he never noticed Petitioner at any time having difficulty taking a file out of a cabinet or putting a file back into a cabinet. (Trans.305). He testified that based on his recollection, Petitioner never told him she had difficulty with same. He testified that based on his recollection, Petitioner never told him she injured herself from anything she did at work. (Trans.205). He testified that anybody he supervised was required to tell him if they were hurt at work. (Trans.305).

Thomas testified that he believed the LaGrange facility was remodeled from 2011 through 2012 and was a one-year project. (Trans.301). He testified that the file cabinets were big, long, probably 3-foot, 4-foot file cabinets, standard that had a door to open and then pull out and push in drawers. (Trans.301). Thomas testified that the files were moved to the front office because Petitioner no longer had an office and she needed access to them [after the remodel]. (Trans.328, 329). He testified that paperwork still needed to be filed, and in addition to credentialing duties that he took over for Petitioner, he also worked with some of the patient files. (Trans.329). He testified that whenever he was there [LaGrange], he would find Petitioner working at her desk on credentialing, typing, getting physicians ready and scheduling patients through the computer and phone. (Trans.298). He testified that credentialing entailed going through many websites to verify that a physician was qualified through credentialing boards and licensed through the State of Illinois to operate. (Trans.298, 299). He testified that documents would be requested from the physician to fill out and show proficiency in skill sets. (Trans.299). He testified that Petitioner did those things. (Trans.299). Thomas testified that physician licensing and information were kept in paper form because they were printed and there was a file cabinet for those documents. (Trans.300).

Thomas testified that Respondent had a policy for reporting work-related injuries and employees were instructed to notify their supervisor if they were hurt. He further testified that the policy provided that an employee was responsible for seeking out medical care if needed, and they were to let their supervisor know if they were going to seek that out because there was paperwork to fill out. (Trans.206). He testified that policies were updated annually, and supervisors were given all policies that pertained to their departments, so they would have been required to read them and know. (Trans.307).

Thomas testified that he was always reachable by phone, text or email by anyone he supervised. (Trans.307). He testified that an accident/incident report has a section for him to fill out and a section for the employee to fill out to describe what happened an how it happened. (Trans.308). He testified that if that was given to him, he would then forward it to Patti Murphy. (Trans.307, 308). He testified that if he was notified of an accident or incident, he would then provide the paperwork to the employee for them to complete. (Trans.308, 309).

Thomas testified that he had prepared accident/incident reports during the time he worked for Respondent, but that to his recollection, Petitioner never asked him to prepare one. (Trans.309). He testified that to his recollection, no other employee told him that Petitioner had been injured while doing something at work. (Trans.309). He testified that prior to counsel for Respondent calling him and notifying him about testifying, maybe August or July of 2016, he was not aware that Petitioner had been claiming she was injured at work. (Trans.310).

Thomas testified that on average there were at least 35 to 40 physician files in any given year. (Trans.312). He testified that if they were preparing for an accreditation, all the files would be reviewed to make sure everything was accounted for in them. Aside from that, he testified, more than likely a file would just be pulled if a physician needed to be verified. (Trans.313).

Thomas testified that he had not talked with Patti Murphy since he left the company in 2013. (Trans.331). He testified he had not talked to Jackie Ladewig about Petitioner's claims since he left the company, but he had been talking with her while sitting out [in the public waiting room at the IWCC]. (Trans.332). He testified they never had a discussion about when Jackie first heard about Petitioner's injuries. (Trans.332). Thomas testified that prior to his termination from United Therapies, as Petitioner's supervisor, he had a pretty good idea of what she did for Respondent. (Trans.334).

Jackie Ladewig testified she was employed by Respondent, United Therapies, which changed its name. She testified she knew Petitioner from working for the same company [Respondent]. (Trans.343). She testified she started on November 27, 1989. (Trans.344). She testified she did not hire Petitioner and did not work side-by-side with her, but she trained her in February 1994 when the center in LaGrange was opened. (Trans.344). She testified that when she started with Respondent, she was a part-time front desk scheduler and at the present is medical staff and clinical staff credentialing and fixed site scheduling manager. (Trans.346). She testified that her duties consist of credentialing the clinical staff, nurses, mobile techs, and physicians. (Trans.346). She testified that she manages the front desk staff at Park Ridge and at LaGrange and works out of Rosemont, her permanent/physical location, on some system conversions. (Trans.347).

Jackie testified that towards the middle of 2014 through half of 2016, she was at the LaGrange office on a day-to-day basis, and then transitioned back to Rosemont. She testified she worked in Human Resources for Respondent for about 14 years. (Trans.347). She testified when she was with HR, she did payroll, benefits and records. She was the only person in HR. (Trans.348). She testified she also on-boarded new hires and maintained employee files. (Trans.348). She testified she also prepared employee documents concerning requests for leave of absence. (Trans.348, 349). She testified that sometimes a supervisor would let her know someone was going on leave and Jackie would then send the employee paperwork. (Trans.349). She testified that sometimes the employee would contact her directly and request FMLA forms, specifically the Certificate of Health Care Provider. (Trans.349). She testified that she received FMLA paperwork from Petitioner on a couple of occasions. (Trans.349). She testified she also processed short-term disability for an employee. (Trans.350). She testified that if someone was hurt on the job, that person would either notify their supervisor or her,

and depending on the injury, they would either go to "employee health" or their doctor. (Trans.351). She testified that if there was a work comp case, she would notify the [insurance] agent, who would then initiate a claim with the work comp carrier. (Trans.351). She testified that then they [work comp carrier] would then contact her for the employee's contact information and handle the rest with the employee. (Trans.351).

Jackie testified that during the time Petitioner was working at United Therapies, she was never contacted about a work comp claim by anyone concerning Petitioner. (Trans.351). She testified that she processed a lot of doctor's notes and intermittent FMLA forms for Petitioner for which she assumed were personal injuries. (Trans.352). She testified it was not brought to her attention that there were [work] accidents. (Trans.352).

Jackie testified that Petitioner was the office coordinator at LaGrange while working for Respondent. (Trans.352). She testified Petitioner managed the front desk and credentialed the physicians (urologists). (Trans.352). She testified that Petitioner oversaw all the front desk functions, then did mobile scheduling for a period of time, which was a separate division of the company. (Trans.352, 353). She testified it was a lot of scheduling, overseeing and supervising the schedulers. (Trans.353). Jackie testified that credentialing involved collecting applications, paperwork, and verifying licenses. (Trans.353). She testified she did not know how verification was done because she was not doing it at the time, but she testified it could have been on the phone or online. (Trans.353).

Jackie testified that at the LaGrange location they had patient charts, medical records and credentialing files. (Trans.354). She testified that patient charts and physician files were kept in a folder. (Trans.356). She testified that whatever holds 40 pages was kept in a file and then boxed up. Every three months the files were sent to whoever was storing them at the time. (Trans.357). She testified this occurred prior to the remodel, but at some point after the remodel, she thought they stopped keeping paper and everything became electronic. (Trans.357).

Jackie testified that before the remodel, there were file cabinets in Petitioner's office and then there was an office for mobile scheduling. She thought there were file cabinets there and there may have been some up front [office]. (Trans.358). She testified that she had been at the LaGrange facility when Petitioner was there and observed the filing cabinets that were in Petitioner's office. She testified that the cabinets were two big cabinets and had five drawers. (Trans.359). She testified she did not have occasion to open the cabinets. (Trans.360).

Jackie testified that the procedure for reporting accidents/injuries was to notify your supervisor and if the supervisor was not available, then you would notify HR. She testified that one could also call the work comp carrier and go to Employee Health, depending on the

situation. (Trans.361). She testified that the procedure was in the policy and all employees have access to the policies as they were kept in binders. (Trans.361). Jackie testified that she talked with Petitioner over the phone many times and more times than person-to-person contact, during the time Petitioner worked for Respondent. (Trans.362).

Jackie testified that during their phone conversations, they talked about aches and pains, but it did not come up that she hurt herself or hit herself on the desk or anything like that. (Trans.363). Jackie testified she used to talk about her husband's shoulder and she does not remember if Petitioner mentioned having difficulty doing some activities at work. (Trans.363). She testified that during their phone conversations, Petitioner never mentioned she was experiencing pain after doing a certain activity while at work. (Trans.364). Jackie testified that when she and Petitioner talked about her shoulder bothering her and Jackie's husband's shoulder, it was casual conversation about old age. (Trans.392, 393). Jackie testified that she did not recall Petitioner saying her shoulder was bothering her because of heavy files she has to move for credentialing. (Trans.393). Jackie testified she knew about Petitioner's elbows because it was on the FMLA forms. (Trans.394).

Jackie testified that she learned that Petitioner was claiming she had been hurt at work after Petitioner was terminated. Jackie identified at trial a notice of FMLA directed at Petitioner and letting Petitioner know how many available hours she had. (Trans.365; RX6). Jackie testified that she prepared the form. (Trans.365). She testified that two of her FMLAs [requests] might have been intermittent for physical therapy and doctor's appointments. She testified then there was another one [FMLA request] when Petitioner was out for surgery and that was short-term disability. (Trans.366). Jackie explained what intermittent FMLA was. (Trans.366).

Jackie identified at trial a letter dated March 13, 2013 from Petitioner's attorney addressed to United Therapies stating they represented her in a work comp case. (Trans.368, 369; RX11). Jackie testified that she did not see that letter in March but did see the Applications. (Trans.369). She testified that the Applications were in her box but may have gone to Respondent's COO or CFO [Bruce] first. (Trans.369, 370). She testified that her receipt of the Applications was the first time she was made aware that Petitioner was claiming she was injured at work. (Trans.370). She testified she saw them in May or June [2013]. (Trans.371).

Jackie identified at trial a document prepared by her in April 2013 letting Petitioner know that her FMLA time was exhausted. (Trans.371, 372; RX12). She testified she would have mailed that by certified mail. She testified that the letter was about granting Petitioner additional unpaid personal leave through May 14 [2013]. (Trans.373). Jackie read the last paragraph which requested that Petitioner advise of her status and ability to return to work on or before May 15, 2013. (Trans.374; RX12). Jackie testified that she received the Applications

after and was a little confused as to what they were, since she was not aware this was work comp. (Trans.374, 375). She testified that had she known she was dealing with work comp, she would not have sent the memo/letter to Petitioner discussing about FMLA and unpaid personal leave. (Trans.375).

Jackie testified that when she saw the Applications, she contacted the agent and asked what to do with them. She testified they were then sent to the insurance agent who contacted the carrier and they took it from there. (Trans.378). She testified that the insurance company had not been aware of a work comp claim before Petitioner was gone. (Trans.378).

Jackie testified that in 2013 when she received the Applications, she asked Patti Murphy if she was aware of the claims. (Trans.384). She testified that Patti told her she was not aware of any work-related injury. (Trans.384, 385). Jackie testified that she was aware that Patti had testified that she was in a meeting in 2016 where everyone expressed shock at the claim that Petitioner had a work-related claim against the Respondent. (Trans.386). However, Jackie testified that Patti had left the company in May 2016, and she did not remember any meetings discussing a work-related injury [by Petitioner]. (Trans.386). Jackie testified that what may have happened was that in 2015 Patti would have had a conversation with Nancy Kimbrell because she was the director of HR at the time. (Trans.387). She testified that she wished she had known that Petitioner claimed a work-related injury against the Respondent because she would have filed it right away for her. (Trans.388).

Jackie testified on re-direct examination that when someone gave notice of an injury at work, there was an internal incident/accident report form that is completed, and it was in existence during the time Petitioner worked for Respondent. (Trans.402).

Patti Murphy testified that she first started working for Respondent in April 1999. She testified she started out as Director of Operations and within about the first six months she became Vice President of Operations. She testified she retired on May 4, 2016. (Trans.5, 6). She testified she knew Petitioner because she was the office coordinator at Respondent's LaGrange site. She testified that Petitioner reported to her manager and then to Patti. She testified that Kathleen DuPrey-Tagge was a manager under her and then Thomas Peer took over as manager of the fixed site. (Trans.6).

Patti testified that as an office coordinator, Petitioner was responsible for the operations of the front desk, to sign patients in, get their insurance cards, give them forms to sign, get the chart together, and put charts on the rack for the nurse to proceed with the procedure. (Trans.11). She testified that at the end of the day after everybody checked the chart, the front office received the chart back, would disassemble the chart, file it away and make sure the billing office gets their forms, and physicians get their op reports. (Trans.11, 12).

Patti testified that after a few years, Petitioner was given the task of physician credentialing. (Trans.12).

Patti testified that Petitioner worked at the LaGrange facility, but Patti's office was in Rosemont. (Trans.13). Patti testified that as part of her job, she went to all of the facilities weekly and would meet with most of the staff and assure everything was running smoothly. (Trans.13). Patti testified there was an employee handbook that was signed off by employees annually. (Trans.14). Patti testified that an Employee Report of Occupational Injury or Illness was within the employee manual. (Trans.14).

Patti testified that if somebody [employee] was thinking they needed a leave of absence, it would be considered personal leave if not FMLA. (Tranas.17). Patti testified that she did not recall seeing an incident report completed by Petitioner. She testified that an employee can complete it, or their supervisor can complete it with them. (Trans.20). She testified that she was not given an incident report concerning Petitioner by any of her supervisors. (Trans.20). She testified that if Petitioner had a work injury, she would report it to her supervisor, who was Kathleen or Thomas, and then each of her supervisors would have notified Patti, because that was the policy. (Trans.21). She testified that neither Kathleen nor Thomas notified her of any injury claimed by Petitioner. (Trans.21).

Patti testified that she first learned that Petitioner was claiming a work injury in 2016 through Nancy Kimbrell, the Director of Human Resources, who came into her office and said they were notified that Petitioner stated she was injured. (Trans.21). She testified she did not remember the exact date. (Trans.40). She testified that Nancy was not the head of Human Resources in 2010, 2011 or 2012, but Jackie Ladewig was. (Trans.40, 41). Patti testified that all workers' compensation claims were supposed to be reported to Human Resources and she was surprised that Petitioner was making workers' comp claims. (Trans.40, 41).

Patti testified that Jackie Ladewig worked for Respondent in 2010, 2011 and 2012 and was the Human Resource Manager, who would have let Patti know about a work injury. (Trans.22, 23). Patti testified that to her recollection, Jackie never let her know about a work injury involving Petitioner. (Trans.23). She testified that Petitioner never mentioned being hurt at work to her. She testified that Petitioner had said she had a headache or aches and pains but not about being hurt at work. (Trans.23).

Patti testified she knew Petitioner had some kind of surgery, but she did not know what it was for and did not ask. She testified it was an abdominal type of thing initially, and Petitioner also had surgery on her shoulder before she left. She testified that Petitioner felt it had to do with lifting babies as a grandmother, as that is what Petitioner told her. (Trans.24).

Patti testified that when Petitioner came back from her surgery, she stated she was in a lot of pain, so Patti went to LaGrange and met with her. (Trans.24, 25). She testified that she told Petitioner she was concerned for her and whether she was able to be back. (Trans.25). She testified that Petitioner told her she was in a considerable amount of pain sitting there but had a release from her physician. She testified that when someone is in so much pain, there is something wrong, and Patti did not want Petitioner to continue sitting in pain. Patti testified that she asked Petitioner what she thought it was [from]. (Trans.25). Patti testified that she asked Petitioner if something happened at work, and that Petitioner told her it did not. (Trans.26). Patti testified that Petitioner told her it was not work comp, nothing from work, and that she was going to be suing her surgeon. (Trans.26).

Patti testified that she did not want Petitioner to aggravate her shoulder any more than it was. (Trans.26). Patti testified that it is a requirement that if someone is hurt at work in any way, their supervisor would inform her, and they are to have it checked out. (Trans.26, 27).

Patti testified that pursuant to HIPAA, she was not privy to any information on insurance claims or benefit payouts for treatment or anything like that. (Trans.28). She testified she would not know if somebody was going to see a doctor for whatever reason, unless the person told her. She testified that at no time did Kathleen or Thomas tell her that Petitioner had a work injury, nor did either one of them tell her that Petitioner was complaining of pain after doing certain work tasks. (Trans.28). Patti testified that during 2010, 2011, 2012 and 2013 she spoke with Petitioner on a weekly basis, and that never did Petitioner discuss hurting herself at work at any point in time during their conversations. (Trans.39).

Patti testified that she was not aware that Petitioner was treating for alleged work injuries from August 2010 up until late 2012. (Trans.57, 58). She testified that Petitioner was a private person. (Trans.59). She testified that it was her impression that before 2016, Jackie did not realize that Petitioner was making a work comp claim. (Trans.61). She testified that she wasn't aware the Petitioner's claims had been on file since 2013. (Trans.63). She testified she was not aware that an insurance company was involved in defending against Petitioner's workers' compensation claims. (Trans.67, 68).

Patti testified as to her understanding being that a first report of injury is supposed to be completed by the supervisor of an employee. (Trans.92, 93). She testified she had never seen an April 5, 2013 letter from Petitioner's attorney. (RX2, p.93). She testified that apparently two insurance carriers had notice of Petitioner's claimed work injuries in 2013, but she was not aware of them being involved. (RX2; p.94).

Dr. Gregory Nicholson examined Petitioner on September 24, 2014 and generated a report upon Respondent's request. (RX1; p.1). He testified that he reviewed records that went

back to 2010 concerning Petitioner's right elbow. He testified that he had clinical examination notes from Hinsdale Orthopaedics which recounted a shoulder surgery on the right side in 2012. He testified that Petitioner had last worked in May of 2013, when she was released from her job. (RX1; p.7). He testified that he specifically asked Petitioner if she had an injury to the right shoulder, and that Petitioner told him she did not. He testified that Petitioner told him she thought it was more from her desk job with lifting files and doing up-and-down activity with her arms. He testified that Petitioner was an office manager at a surgery center and that there was no specific injury that occurred either for the left elbow, right elbow or right shoulder. (RX1; p.7).

Dr. Nicholson testified that he examined Petitioner's elbows and shoulders. (RX1; p.8, 9). After examination and reviewing records and taking down a history from Petitioner, Dr. Nicholson testified that he felt Petitioner had tendinopathy in her elbows and right shoulder that was due to an endemic issue. (RX1; p.12). Dr. Nicholson testified that he had seen instances of repetitive movement with an upper extremity or a cumulative traumatic condition with an assembly line worker, somebody doing continuous activity the same way, such as screwing in a pipe the same way all day at a Ford plant, or a meat cutter. (RX1; p.13). Dr. Nicholson felt that Petitioner was able to do desk work, clerical work, but not repetitive assembly line activity, repetitive reach, grip or release activity and that lifting should be limited to 10 pounds from floor to chest height and limited on an occasional basis above chest height. (RX1; p.14, 15).

Dr. Nicholson testified that he generated an addendum report dated January 28, 2015. (RX1; p.16). Dr. Nicholson testified that he reviewed MRI reports and films on the right shoulder and right elbow. (RX1; p.16, 17, 18). He testified he also reviewed the operative report on the right shoulder. (RX1; p.23).

Dr. Nicholson testified pursuant to his reports that he felt there was no repetitive, cumulative disorder, trauma or specific injury that caused Petitioner's bilateral elbow pain or right shoulder issues, and that Petitioner's issues could not be discerned to be work-related. (RX1; p.25).

Dr. Jeffrey Coe examined Petitioner on August 18, 2015 and generated a report upon Petitioner's request. (PX1). Dr. Coe testified that Petitioner told him she had worked for a company [Respondent] for about 18 years and that her job was an office position where she worked eight or more hours each day for five days per week and used her upper extremities repeatedly in a variety of activities. (PX1; p.10). He testified that Petitioner described computer data entry, keyboard and mouse work, and moving files. (PX1; p.10, 11). He testified that Petitioner told him there were large files and she would take them from shelves and cabinets, she answered telephones, she wrote by hand, she filed and removed things from files.

(PX1; p.11). He testified that Petitioner described having a small desk with a computer on it and that the keyboard was in an awkward position, over on the side, because she liked to spread her files and charts out on the desk. (PX1; p.11).

He testified that Petitioner told him she had to move large and heavy files throughout the day to and from cabinets and onto and off of her desk. (PX1; p.11). He testified that Petitioner told him the first thing she noticed was some pain along the outer border of her right elbow. (PX1; p.11, 12). He testified that Petitioner told him her initial complaints began in 2010 and she was diagnosed with right lateral epicondylitis. (PX1; p.12). He testified that Petitioner told him she then developed some pain in the left side of her neck with her work activities which she related to the positioning of the computer and keyboard. (PX1; p.14). He testified that Petitioner told him with ongoing work she began to experience pain in her right shoulder which she related to forceful reaching down and pulling of files that were two to three inches thick and heavy. (PX1; p.15). He testified that Petitioner had no estimate of the weight of the files but told him they were tightly crammed into cabinets. (PX1; p.15).

Dr. Coe testified that Petitioner reported to him that with ongoing work and ongoing problems with her right shoulder and right elbow, she began to use her left arm more and developed pain in the outer border of her left elbow. (PX1; p.16). He testified that Petitioner's right shoulder symptoms were the most severe problem and she underwent surgery for it a little after Christmas 2012. (PX1; p.16).

Dr. Coe testified that Petitioner was a right-handed individual and by her description of her work requiring considerable use of her right arm, including the pinch grip, and pulling and tugging of files, that those activities caused the development of acute right lateral epicondylitis in the summer of 2010 which became a chronic condition. (PX1; p.18). Dr. Coe testified that he saw Petitioner five years after the summer of 2010. (PX1; p.22).

Dr. Coe testified that Petitioner's right shoulder problem emerged in the summer of 2012. (PX1; p.23, 24). Dr. Coe testified that as Petitioner's right elbow was hurting her, it was not uncommon for the next joint, which was the shoulder, to take the stress of activity. He testified that since it was hard to grip and pull with the right elbow because of the pain, people begin to move their arm more stiffly which begins to stress the next joint up. (PX1; p.24, 25). He testified this was based on his experience. (PX1; p.25). He testified that Dr. White diagnosed an impingement syndrome with a probable rotator cuff tear. (PX1; p.26). He testified that this diagnosis was something that could be seen in individuals who do forcefully exert their arm through the shoulder by reaching out and pulling towards them, doing things at or above shoulder height, which was something Petitioner described. (PX1; p.26).

Dr. Coe testified that it was his opinion to a reasonable degree of medical certainty that Petitioner's continued work activities as office manager and coordinator caused a breakdown in her right shoulder. (PX1; p.26). He further testified that the right shoulder surgery Petitioner had was to a reasonable degree of medical certainty causally related to the repetitive activities that Petitioner described to him. (PX1; p.27).

Dr. Coe testified that Petitioner developed the same problem in her left elbow as she had in her right elbow, which was lateral epicondylitis and that to a reasonable degree of medical certainty, continued work activities and trying to protect the right arm caused the condition in the left elbow. (PX1; p.30, 31, 34, 35). He further testified that there is a causal relationship between Petitioner's work activities with Respondent and the development of right lateral epicondylitis, left lateral epicondylitis and her right shoulder condition. (PX1; p.36).

Dr. Coe testified that he had not seen a typed job description or any other representation of Petitioner's workplace. (PX1; p.39). He testified that he relied on what Petitioner told him. (PX1; p.40). He testified that he relied on Petitioner's use of the term "overuse" which is subjective, and he had no way of measuring it. (PX1; p.40).

Dr. Coe testified that Petitioner told him that she had Type 2 diabetes for years. (PX1; p.42). Dr. Coe testified that as seen on MRI, Petitioner certainly had pre-existent degenerative arthritis in her right shoulder at the AC joint which was one of the places that Dr. White did surgery on. (PX1; p.44).

Dr. Coe testified that in some literature, repetitive meant "more often than not during the workday . . . around two-thirds of the workday." (PX1; p.47). Dr. Coe agreed that the literature states that the key to epicondylitis is the forceful and repetitive nature of a trauma. (PX1; p.55). He testified that he did review in Petitioner's medical records repeated references to the fact that she sat at her desk all day, and he testified that that was recognized as an office sedentary seated position. (PX1; p.56). Dr. Coe testified that he did not have information about the frequency in which Petitioner filed or number of times she actually moved larger files versus little files. (PX1; p.59).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issues C & D: *Accident and Date of Accident*

The Arbitrator concludes the Petitioner did not sustain any injuries arising out of and in the course of her employment with Respondent on August 19, 2010, January 14, 2011, October

17, 2011, and August 23, 2012. Petitioner has claimed her injuries were caused by repetitive activities at work and that there was no one specific accident or injury. Whether a person's work activities are sufficiently repetitive must be decided on a case-by-case basis on the particular facts in each case. In _Edward Hines Precision Components vs. Industrial Commission_, 356 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (2d Dist. 2005), the claimant's job as a tractor/trailer driver was not deemed to be repetitive in nature. He stated that he drove an 18-wheel, flatbed truck with a manual transmission an average of 200 miles a day. He shifted gears with his right arm and used his left arm to steer. He delivered trusses that were secured to the flatbed with an average of 10 straps per load. The straps were tightened with either a manual wench or a pry bar. Claimant testified that tightening the strap required application of substantial force so that the load would not shift when the truck was moving. Petitioner's work activities, as described, were not repetitive or forceful in nature, when viewed along with the activities in the _Edward Hines_ case.

In _Williams vs. Industrial Commission_, 244 Ill.App.3d 204, 614 N.E.2d 177, 185 Ill.Dec. 43 (1st Dist. 1993), claimant testified that part of his job required lifting machine parts that weighed anywhere from 30 to 60 or 70 pounds apiece. He would lift such objects about two times a day and he estimated he would spend approximately 30% of his time on each shift lifting objects of this weight range. He would climb on top of a crane for approximately five or six times a day. He would also crawl under certain machinery in order to perform repairs. The crawling would involve lying on his back or stomach and crawling under the machine. He would crawl in such a manner two to three hours per day on a daily or weekly basis. He also used 8, 12, and 16-pound sledgehammers for two to three hours a day on a daily basis and was required to operate a hydraulic air hammer to break up concrete approximately once every six months. He utilized various sizes of weights and tools including pipe wrenches, chain saws, sledgehammers, and box wrenches, etc. Any one of Petitioner's work activities could not compare in forcefulness to any one of the claimant's activities in the _Williams_ case. Any one of Petitioner's activities could not compare in repetitiveness to any one of the claimant's activities in the _Williams_ case. In Williams, the First District Appellate Court held that claimant's job was not repetitive.

Petitioner's case can even be distinguished from _Quaker Oats Co. vs. Industrial Commission_, 414 Ill.326, 111 N.E.2d 351 (1953). In _Quaker Oats_, the claimant was found to have suffered an aggravation or acceleration of a pre-existing condition by the dropping of cans onto his left foot. In this case, Petitioner's work activities were not repetitive as depicted in _Quaker Oats_, as it is evident she had a variety of duties that were interspersed throughout her day. So, the Arbitrator cannot conclude that Petitioner suffered an aggravation or acceleration of any pre-existing conditions.

Issue E: *Notice*

The Arbitrator also finds the Petitioner did not give timely notice of the accidents of August 19, 2010, January 14, 2011, October 17, 2011, and August 23, 2012 to Respondent. Under the Act, a claimant must give notice to an employer as soon as practicable but not later than 45 days after sustaining an accidental injury arising from employment. Although a lack of notice, or a defect or inaccuracy in notice has proven to be a weak defense and would not bar a claim, sometimes a lack of notice, or defect or inaccuracy in notice can be barred if it is prejudicial to an employer. *Health & Hospitals Governing Commission of Cook County vs. Industrial Commission*, 75 Ill.2d 194, 387 N.E.2d 683, 25 Ill.Dec.807 (1979).

In this case, four witnesses testified that they did not know Petitioner was ever injured at work from her work activities. Although Petitioner testified that she provided notice to Patti Murphy, Patti Murphy testified that had she been aware or been told that Petitioner claimed she had been injured at work from work activities, she would have acted on it by contacting Human Resources. Jackie Ladewig testified that had she known, she would have contacted the insurance agent who in turn would have contacted Respondent's workers' compensation carrier. She talked with Petitioner on the phone frequently and never learned that Petitioner was claiming work-related injuries. Jackie testified had she known, she would have assisted Petitioner with the proper forms for workers' compensation. Kathleen Duprey Tagge was Petitioner's supervisor for a time and she was not aware of Petitioner claiming any injury from work activities. Thomas Peer was Petitioner's supervisor for a time and he was not aware of Petitioner claiming any injury from work activities. The evidence supports that Respondent first learned of Petitioner's claims of injury from work activities through the filing of Applications, all which were done on March 19, 2013. Petitioner worked in close proximity with Joanna Guerra for a time, and Ms. Guerra testified that she was not aware of Petitioner's claims of injury from work activities.

Petitioner was in a supervisory position with Respondent and knew of the policy of reporting work accident or injuries. She knew about reporting because she reported an accident that occurred with her in 2008. The type of form is insignificant when Petitioner knew how to report a work accident or injury. All she had to do was tell someone also employed by Respondent, but she failed to do so.

Issue F: *Causal connection*

Petitioner's current condition of ill-being is not causally related to her employment with Respondent based on the rationale set forth for issue (C) above. In addition, the Arbitrator gives more weight to Dr. Nicholson's opinions than Dr. Coe's opinions, because Dr. Coe relied

solely on what Petitioner told him and her definition of "repetitive" work. Both doctors testified that repetitive work is work that is done two-thirds of the time in a work day and involve forceful gripping. Dr. Nicholson described it as assembly line work. Petitioner worked in an office and her job was mostly sedentary. Joanna Guerra testified that she did Petitioner's filing. Petitioner's supervisor, Tom, testified that he did Petitioner's credentialing work for a time after she left, and he did not have any difficulty with pulling files out of a cabinet or putting them back in. Further, none of Petitioner's treating physicians causally related her work duties to any conditions in her elbows or right shoulder, except for Petitioner's medical expert, Dr. Coe, who saw her one time and relied on her description of her work activities. In fact, Petitioner never told any of her treating physicians that any activity at work, such as pulling files out of cabinets or putting them back in, caused pain to her elbows or right shoulder.

The Petitioner's situation is like that present in a recent Illinois Workers' Compensation Commission decision. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017). In *Cook*, the claimant, an office worker much like the Petitioner, argued her bilateral carpal tunnel syndrome was causally connected to her repetitive work for her employer. However, after the Commission reminded the Arbitrator of the proper standard of proof necessary under Illinois case law for repetitive and forceful work claims, the Commission affirmed and adopted the Arbitration Decision denying that claim. *Cook v. Rainbow Book Company*, 17 IWCC 553 (2017).

Issue J: *Medical bills*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of medical bills is moot and the Petitioner's claim for payment of the same is denied.

Issue K: *TTD*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of TTD is moot and the Petitioner's claim for payment of such benefits is denied.

Issue L: *Nature and extent of injury*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of the nature and extent of injury is moot and the Petitioner's claim for payment of such benefits is denied.

Issue N: *Respondent's credit*

Based on the Arbitrator's conclusions of law regarding **Issues C, D, E,** and **F**, above, the issue of Respondent's credit is moot.

Signature of Arbitrator

OCTOBER 18, 2018
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 JEFFERSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIFFANY MOLTON,
Petitioner,

v. NO: 15 WC 42442
16 WC 11409

RED BUD REGIONAL CARE,
Respondent.

20IWCC0103

DECISION AND OPINION ON REMAND

This matter coming before the Commission on an order from the Circuit Court of Randolph County dated September 10, 2019; the Commission being fully apprised in the premises, reverses its prior decision entered on June 13, 2018 and pursuant to the directions of the circuit court, reinstates the decisions of the arbitrator in matters 15 WC 42442 and 16 WC 11409 save the award of prospective temporary total disability benefits.

Procedural History

On June 9, 2017, these matters proceeded to arbitration before Arbitrator Christina Hemenway on the following issues: 1) causal relationship, 2) medical expenses, 3) prospective medical care, and 4) temporary total disability benefits for injuries sustained on December 1, 2015 for the lumbar spine and on March 31, 2016 for the cervical spine and right shoulder. Arbitrator Hemenway issued her decision on October 11, 2017 finding Petitioner proved a causal relationship between her accident of December 1, 2015 and her condition of ill-being in her lumbar spine as well as a causal relationship between her accident of March 31, 2016 and her conditions of ill-being in her cervical spine and right shoulder. The Arbitrator awarded prospective medical as recommended by Dr. Gornet for the cervical and lumbar spine and Dr. Mall for the right shoulder as well as temporary total disability benefits past due and prospectively.

On November 9, 2017, Respondent filed a timely Petition for Review before the Commission. Both parties filed briefs and presented oral arguments before the Commission on April 10, 2018. On June 13, 2018, the Commission entered its decision modifying the decision of the arbitrator by finding Petitioner failed to prove a causal relationship between her accident of

March 31, 2016 and her right shoulder condition of ill-being, and thereby vacating all benefits awarded in relation to Petitioner's right shoulder condition as well as the prospective award of temporary total disability benefits.

On June 28, 2018 Petitioner filed a timely review before the Circuit Court of Randolph County. On September 10, 2019, the circuit court entered its order finding the Commission's Decision to be against the manifest weight of the evidence and remanded the matter to the Commission "with instructions to reinstate the Illinois Workers' Compensation Commission Arbitrator's 19(b) Arbitrator Decision 15 WC 042442 and 16 WC 011409, except the Arbitrator's award of prospective temporary total disability benefits vacated by the Commission in its Decision and Opinion on Review." Circuit Court Order dated September 10, 2019.

On September 13, 2019, October 25, 2019 and November 25, 2019, Petitioner's attorney kindly provided courtesy copies of the circuit court's September 10, 2019 order. On December 3, 2019, the Commission received the official mandate (circuit court order dated September 10, 2019) and the record on appeal from the Circuit Court of Randolph County. Thereafter, the matters were inadvertently reassigned to Arbitrator Gallagher. On December 17, 2019, Petitioner filed her Motion to Enforce Circuit Court Order to be presented before Commissioner Parker on February 21, 2020.

Conclusions of Law

The Commission performed the function to which it is tasked; it weighed the competing evidence and found Petitioner failed to present sufficient evidence to prove causal relationship between her accident of March 31, 2016 and her condition of ill-being as it relates to her right shoulder finding the opinions of Dr. Nogalski more persuasive than those of Dr. Mall. With that said, the Commission is bound to follow the directive of the circuit court. The circuit court found the Commission's decision to be against the manifest weight of the evidence. Pursuant to the instructions of the Court, the Commission adopts the decision of the Arbitrator dated October 11, 2017 which is attached hereto and made a part hereof save for the award of prospective temporary total disability benefits which is vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that, pursuant to the order of the September 10, 2019 Circuit Court of Randolph County, Petitioner's current lumbar spine condition of ill-being is causally related to the December 1, 2015 work accident, and Petitioner's current cervical spine and right shoulder conditions of ill-being are causally related to the March 31, 2016 work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $446.00 per week for a period of 75 weeks, representing December 28, 2015 through March 26, 2016 and April 1, 2016 through June 9, 2017, those being the periods 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 receive credit for benefits previously paid in the amount of $33,704.86.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services totaling $169,130.94, which includes reimbursement to Petitioner in the amount of $41.69, as set forth in Petitioner's Exhibit 15, subject to Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for prospective medical treatment as recommended by Dr. Gornet and Dr. Mall as provided in §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 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: FEB 13 2020

LEC

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

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 Temporary Disability; Permanent Disability	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAN KIMMEL,

Petitioner,

vs. NO: 14 WC 37752

ASM TRANSPORT SERVICES, INC. and
Treasurer as *ex-officio* custodian of INJURED WORKERS'
BENEFIT FUND,

Respondent.

20IWCC0104

DECISION AND OPINION ON REVIEW

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

CONCLUSIONS OF LAW:

I. Causation

In challenging ongoing causal connection, Respondent Injured Workers' Benefit Fund (hereinafter "The Fund") combines elements of causation, maximum medical improvement, and permanent disability and asserts Petitioner's condition stabilized on November 12, 2015. The Fund first posits Petitioner "chose to discontinue treatment on November 13, 2015," and did not resume treatment until February 26, 2018, "at which time he did not seek treatment from a medical doctor, but rather, a chiropractor." The Fund further notes Petitioner "finally saw a medical doctor on May 25, 2018," but did not undergo the recommended MRI "because he felt as if there was nothing that could have been done." Finally, The Fund contends there is no medical evidence to support

Petitioner's testimony that he cannot return to work as a truck driver due to his inability to sit for extended periods; The Fund argues the self-limiting nature of the restriction is demonstrated by Petitioner's ability to drive 45 minutes to the hearing, sit for 53 minutes during the hearing, then drive 45 minutes home thereafter. The Commission disagrees.

The Commission is not persuaded by The Fund's claim Petitioner "chose" to discontinue treatment in November 2015, or that Petitioner, on his own, elected not to pursue the diagnostic workup recommended by Dr. Xia. We observe there is nothing in the record to suggest Petitioner deliberately ceased treatment in November 2015; to the contrary, Petitioner testified he was inpatient at the McAuley Manor rehabilitation facility for a year post-operatively (T. 29) and while there underwent physical therapy. Additionally, the medical records demonstrate that when Petitioner sought additional care in 2018, he related his continuing complaints to the 2014 injury; on June 25, 2018, Dr. Xia memorialized the following history:

> Patient had injury at work 10/21/14. Patient was driving a 18 wheeler and T-boned by another 18 wheeler at 45 mile/hr...[Patient] then had MRI, and that showed significant pathology. Patient was seen by Dr. Iavarone. He was later to Dr. 'shanel' who is a neurosurgeon at central dupage hospital [SIC] and he had fusion for lumbar spine in 2015. He was in nursing home for one year for rehab after surgery. He was better, but then his pain come back. Now he feels pain is as bad as before. PX7.

Further, Petitioner credibly explained Dr. Xia refused to treat him once the doctor learned he was on Medicaid; Petitioner also testified he sought care elsewhere but was repeatedly refused because of his insurance. T. 63. Finally, the Commission notes the fact that a chiropractor managed Petitioner's care is not relevant to causation. Like the Arbitrator, the Commission finds Petitioner's condition of ill-being remains causally related to his work accident.

II. Average Weekly Wage

The Fund argues Petitioner failed to prove his average weekly wage is $1,400, so he is therefore limited to the statutory minimum Temporary Total Disability rate for his date of accident: $220. We disagree.

The Commission is cognizant that Petitioner failed to provide wage documentation. We emphasize, however, claimants can establish earnings through testimony alone, and this is something the Commission routinely sees in Injured Workers' Benefit Fund cases where the employer fails/refuses to participate. While Petitioner testified he earned $1,400 some weeks, he acknowledged this was the maximum he received per week; he further stated $800 was his minimum weekly pay. T. 55. The Commission finds Petitioner's testimony credible.

Given Petitioner's testimony as to his earnings, the Commission finds it is appropriate to calculate the average of that wage range and utilize that figure for the average weekly wage ($1,400 + $800 = $2,200 / 2 = $1,100). The Commission affirms the Arbitrator's finding of an average weekly wage of $1,100.

III. Medical

The Fund argues it is not liable for any treatment expenses incurred at Integrity Medical Group, nor for treatment rendered after November 12, 2015. The basis for The Fund's denial of liability for Integrity Medical Group is that the treatment was rendered by a chiropractor, "not a medical doctor," and there was no referral from a medical doctor to DC Iavarone. The basis of The Fund's denial of post-November 12, 2015 treatment is its argument Petitioner reached maximum medical improvement as of November 12, 2015. The Commission is not persuaded by either argument.

The Commission observes chiropractic care is a valid treatment option under Section 8(a). Moreover, it is irrelevant that a medical doctor did not refer Petitioner to DC Iavarone; DC Iavarone was Petitioner's first choice of physician and his treatment thereafter was within DC Iavarone's chain of referrals: Iavarone → Chunduri → Spine Surgeon (Chennelle). As such, The Fund's challenge to liability for DC Iavarone's bills fails. Moreover, given our finding that Petitioner's condition of ill-being remains causally related to his work accident, The Fund's MMI argument also fails.

Petitioner's Exhibit 7 contains expenses incurred for Petitioner's medical treatment. The Commission finds these charges are related to Petitioner's work injury and are reasonable and necessary as provided in Section 8(a). The Commission specifically orders the State responsible for the Medicaid lien.

IV. Temporary Disability

The Arbitrator found Petitioner entitled to Temporary Total Disability from October 21, 2014 through April 1, 2017; this is the date Petitioner testified he was discharged from McAuley Manor. The Commission views the evidence differently.

For reasons which are unclear, the McAuley Manor records are not in evidence. As such, there is no documentary evidence as to the length of Petitioner's stay. Petitioner testified he was released from McAuley Manor on April 1, 2017. T. 62. The Commission believes Petitioner was in fact discharged on April 1, 2016. We emphasize an April 1, 2016 discharge date is consistent with Petitioner's testimony of being at McAuley Manor for a year following the 2015 surgery. T. 29. We further note a 2015-2016 admission at McAuley Manor is corroborated by Dr. Xia's May 25, 2018 evaluation history: "He was in nursing home for one year for rehab after [2015] surgery." PX7.

The Commission finds Petitioner was temporarily and totally disabled from October 21, 2014 through April 1, 2016, a period of 75 4/7 weeks. The award of Temporary Total Disability benefits from April 2, 2016 through April 1, 2017 is hereby vacated.

V. Permanent Disability

Upon performing the requisite Section 8.1b analysis, the Arbitrator found Petitioner sustained permanent partial disability to the extent of 2% loss of use of the left leg, 2.5% loss of use of the person as a whole for the closed head injury/cervical strain, and 32.5% loss of use of the person as a whole for the lumbar spine injury. On review, The Fund takes issue with two aspects

of the award: 1) the 2.5% loss of use of the person as a whole for the closed head injury/cervical strain, and 2) the 32.5% loss of use of the person as a whole for the lumbar injury.

A. Head/Cervical Spine

In challenging the award of permanent disability for the closed head injury/cervical strain, The Fund highlights that Petitioner did not treat for these injuries after the initial workup at the emergency room, nor did he testify to any ongoing complaints or symptoms related to that injury. The Commission agrees.

The record reflects Petitioner last reported head/neck symptoms at the October 24, 2014 initial evaluation with DC Iavarone. Petitioner complained of mild to moderate constant headaches, dull and achy pain localized in the bilateral occipital areas, moderately severe constant pain bilaterally in neck, and restricted movement with sharp pain migrating to the posterior bilateral upper shoulders and right deltoid area. He rated his headache pain at 4/10, and neck pain at 7/10. PX7. The Commission observes Petitioner testified those complaints resolved within a week thereafter. T. 24. Significantly, when describing his current complaints, Petitioner did not identify any head or neck symptoms.

The Commission finds Petitioner did not sustain any permanent head/brain or cervical spine disability as a result of the work accident. Therefore, the award of 2.5% loss of use of the person as a whole for the closed head injury/cervical strain is hereby vacated.

B. Lumbar Spine

In arguing Petitioner's lumbar spine permanence should be decreased, The Fund argues the award amounts to a loss of trade but Petitioner failed to prove he cannot return to work as a truck driver. The Commission disagrees.

The Commission first observes the lumbar spine award as written is well below the usual and customary loss of trade range. Moreover, the Commission does not find Petitioner's ability to sit for an hour during the hearing or drive for 45 minutes equates to the sitting tolerance required of a long-haul truck driver. We further find it significant that Petitioner credibly testified sitting is not the only bar to him resuming his trucking career; when asked what job duties he can no longer perform because of his back, Petitioner identified, "Cranking up and down the landing gear. Loading or helping unload. General maintenance to the truck." T. 37. Given Petitioner's ongoing complaints as well as Dr. Xia's objective examination findings and recommendation for further workup, the Commission finds the 32.5% loss of use of the person as a whole award is supported by the evidence and it is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed October 11, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $733.33 per week for a period of 75 4/7 weeks, representing October 21, 2014 through April 1, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act. The award of TTD benefits from April 2, 2016 through April 1, 2017 is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and related medical expenses contained in Petitioner's Exhibit 7, pursuant to §8(a), subject to the §8.2 of the Act. The State is responsible for the Medicaid lien.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $660.00 per week for a period of 162.5 weeks, as provided in §8(d)2 of the Act, for the reason the lumbar spine injuries sustained caused the 32.5% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $660.00 per week for a period of 4.3 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 2% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award hereby is entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund. The Respondent-Employer's obligation to reimburse the Injured Workers' Benefit Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: FEB 14 2020

L. Elizabeth Coppoletti

LEC/mck

D: 12/18/19

Stephen Mathis

43

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

KIMMEL, DAN Case# **14WC037752**
Employee/Petitioner

ASM TRANSPORT SERVICES INC AND IWBF
Employer/Respondent

20IWCC0104

On 10/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4282 VITU LAW OFFICES
JOSEPH F VITU JR
30 N LASALLE ST SUITE 1728
CHICAGO, IL 60602

0000 ASM TRANSPORT SERVICES INC
CAROLY C MILTON
18406 STONECREEK DR
HAZEL CREST, IL 60429

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF **WILL**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
CORRECTED

Dan Kimmel
Employee/Petitioner
v.
ASM Transport Services Inc. and IWBF
Employer/Respondent

Case #**14** WC **37752**

20IWCC0104

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/21/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned ***$57,354.00***; the average weekly wage was ***$1,100.00***

On the date of accident, Petitioner was ***46*** years of age, ***single*** with ***no*** dependent children.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**
Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

- The Respondents shall pay directly to the provider, medical expenses for treatment, pursuant to the Illinois Medical Fee Schedule as provided in Sections 8(a) and 8.2 of the Act. The expenses are detailed in attached paragraph (J) of this decision and included in Petitioner's Exhibits.
- The Respondents shall pay Petitioner temporary total disability benefits of **$733.33/week**, for **127-5/7** weeks, commencing **10/22/14 through 4/1/2017**, pursuant to §8(b) of the Act.
- Respondent shall pay Petitioner permanent partial disability benefits of **$660**/week for **179.3** weeks, because the injuries sustained caused 3**2-1/2% loss of use of man as a whole for the lumbar region, 2-1/2% loss of man as a whole for the closed head injury and cervical spine; and 2% loss of use of the left leg,** as provided in Section **8(d)2** and **8(e)** of the Act.
- Respondent-Employer is due a credit in the amount of **$0.00** under section 8(j) of the act.
- The Illinois State Treasurer, ex-officio custodian of the Injured Worker's Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Worker's Benefit Fund has the right to recover the benefits paid due and owing Petitioner pursuant to Sections 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the injured worker's benefit fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Worker's Benefit Fund.

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

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

Signature of Arbitrator

10/8/18
Date

OCT 11 2018

FINDINGS OF FACT:

Petitioner testified he was employed by ASM Transport Services, Inc. ("ASM") in Hazel Crest, Illinois, as truck driver. He was hired in the spring of 2012 by Carolyn Milton, who was one of the co-owners of ASM. The other owner of ASM was Aaron Milton, who was Carolyn's son. ASM was a company that delivered freight to various places all over the country. As a truck driver, Petitioner drove a semi-trailer truck, hauling various items all over the country. There was no formal hiring process and Petitioner did not receive any special training from ASM. Petitioner testified that he was the sole employee of ASM, and that ASM operated out of the home of Carolyn and Aaron in Hazel Crest, Illinois.

Petitioner testified that ASM provided the semi-trailer truck, carried the vehicle insurance and registration for the vehicle, and paid for all repairs required for the truck. Petitioner reported to Carolyn for an assignment. Petitioner testified that he was paid eighty (80) to ninety (90) cents a mile, and traveled approximately five (5) thousand miles per week. He testified that he was paid between $800.00 and $1,400.00 per week. He would inform Carolyn of his mileage on a weekly basis either over the phone or in-person. When he was in town he was required to drop off log books and pre-trip inspection reports at ASM's headquarters which was a converted room in the home in which the Miltons lived at 18406 Stonecreek Drive, Hazel Crest IL 60429-1672. If Petitioner was on the road, ASM would wire him his weekly pay. If he was in town, Petitioner would pick up a check from Carolyn or Aaron at their Hazel Crest home. Petitioner testified that when he was paid with checks, he would go to the local currency exchange and cash the check. He did not have a bank account. Petitioner testified that he never received W-2s or 1099s while working for ASM, despite requesting them. Petitioner testified that he did not file tax returns with the Internal Revenue Service.

Petitioner testified that on October 21, 2014, he was driving the semi-truck during an assignment with ASM when his truck collided with another truck in Joliet, Illinois. Petitioner testified that he was making a right-hand turn, traveling northbound at a T- intersection when another truck came in front and hit his truck. The other truck was traveling eastbound. He did not recall the name of the streets or intersection in which the accident happened. Petitioner testified that the police were notified, and a police report was completed, but no citations were given. He testified that when the accident occurred, he was wearing a seatbelt, and he violently bounced around within the seatbelt. There was "minor to major" damage to the bumper, grill, and fender of the semi-truck. The truck was no longer drivable after the accident. After the accident, Petitioner was transported to Presence St. Joseph Medical Center via ambulance. Petitioner testified that he called Carolyn Milton at the scene and informed her of the collision.

The Joliet EMS report indicates that emergency personnel was dispatched to 333 N. Madison, Joliet, Illinois at 3:33 p.m. to a motor vehicle accident. Petitioner informed EMS personnel that he was turning right when he was struck by another semi-truck that was driving past him. Petitioner complained of pain to left knee, and slight headache. EMS personnel noted swelling to Petitioner's left knee, and a bump on his right forehead. (Petitioner's Group Exhibit 7, Sec. 1)

The records of Presence St. Joseph Emergency Room reflect that Petitioner was driving an 18-wheeler semi-truck when he was sideswiped by another semi-truck. Petitioner reported that he was pulling away from a stop when he was struck by an automobile on the driver's side at an estimated 40 miles per hour. According to the records, Petitioner complained of mild pain to the head, neck, and left knee. Petitioner was unsure as to whether he lost consciousness, but did not remember hitting his head. Nevertheless, he complained of pain at the occipital region and stated that he believed he had several seconds of memory loss. He underwent an x-ray of the cervical spine which was normal. An x-ray of his left knee revealed mild prepatellar soft tissue swelling

on the left knee without any definite radiographic evidence of acute fracture or dislocation. Petitioner was diagnosed with a closed head injury and left knee sprain. Upon discharge, he was given prescriptions for medications, referred to an orthopedist and instructed to return to the ER if his symptoms worsened. Petitioner was also excused from work for the remainder of the week. (Petitioner's Group Exhibit 7, Sec. 2)

Petitioner testified that as a long-haul truck driver, he lived in the truck. As the truck was "totaled" he checked into a motel. Petitioner provided that while convalescing at the motel, his pain levels increased. On October 24, 2014, he reported to Gregory Iavarone, D.C. Petitioner reported mild to moderate constant headaches, and dully, achy pain in the right occipital area and left occipital area. He additionally reported moderately severe constant pain in the neck area. Petitioner had restricted movement with sharp pain to posterior right upper shoulder, posterior left upper shoulder, and right deltoid area. He had constant moderately severe pain on right area of lumbar spine. Petitioner reported mild to moderate constant pain in left knee, and throbbing sharp pain in left medial knee and left kneecap with weakness. Dr. Iavarone diagnosed sprain/strain injuries to the neck, thoracic and lumbar. Also diagnosed were headaches and MLI left knee. Dr. Iavarone opined that "it is my professional opinion that the patient's signs and symptoms are consistent with that of the history of the motor vehicle accident on 10/21/14 as described." A conservative treatment plan was devised and Petitioner was ordered off work for two weeks. (Petitioner's Group Exhibit 7, Sec. 3)

On October 31, 2014, Dr. Iavarone noted Petitioner reported worsening symptoms. As a result, Petitioner was referred to Dr. Krisha Chunduri at Advanced Spine & Pain Specialists. (Petitioner's Group Exhibit 7, Sec. 3) Petitioner reported to Dr. Chunduri that same day. He complained of aching, throbbing, sharp pain in the neck and lower back on the right side. He was diagnosed with cervicalgia/cervical strain and lumbar strain. The doctor recommended conservative management with continuation of therapy and the addition of high-dose NSAID's and muscle relaxants. Dr. Chunduri felt that "…based upon a reasonable degree of medical certainty that the above diagnoses and symptoms are causally related to the motor vehicle accident and that current treatments and recommendations are medically necessary." (Petitioner's Group Exhibit 7, Sec. 4)

Pursuant to Dr. Iavarone recommendation, Petitioner underwent an MRI of the lumbar spine on November 10, 2014, which revealed: (1) L4-L5 left central herniation; (2) L5-S1 central herniation; and (3) Spondylosis deformans L1-L2, and L2-L3. (Petitioner's Group Exhibit 7, Sec. 5)

Petitioner followed up with Dr. Chunduri on November 14, 2014. Petitioner reported that the neck pain had resolved, but he continued to have low back pain. Dr. Chunduri noted that the MRI revealed two herniations at L4-L5 and L5-S1. He was diagnosed with a lumbar disc herniation and cervicalgia. He was administered a Medrol Dosepack and ordered to continue in therapy with Dr. Iavarone. (Petitioner's Group Exhibit 7, Sec. 4)

On November 19, 2014, Dr. Iavarone noted that Petitioner's pain continued and which was worse in the lumbar spine than the cervical spine. Petitioner also reported that his left knee was much improved. Dr. Iavarone released Petitioner to return to work with a limitation of five (5) hours only. (Petitioner's Group Exhibit 7, Sec. 3) Petitioner testified that the restriction was not accommodated.

By November 21, 2014, the pain at the cervical spine was 'much improved' but the pain in the lumbar spine continued. Dr. Iavarone released Petitioner to return to work with a limitation of ten (10) hours with no lifting. On November 24, 2014, the records reflect there were no overall changes in his low back pain. He continued to have difficulty bending at the waist and sleeping. Petitioner's restrictions were continued. By December 12, 2014, Petitioner reported that his low back pain was much worse with difficulty sitting and raising from a seated or lying position. (Petitioner's Group Exhibit 7, Sec. 3)

Petitioner next saw Dr. Chunduri on December 12, 2014. Petitioner reported that his low back pain radiated down his right leg, and he had difficulty bending forward because of the severe pain. Dr. Chunduri

assessed 1.) lumbar disk herniation with radiculitis and 2.) cervicalgia and cervical strain. The doctor recommended an epidural steroid injection and opined that the diagnoses are related to the work accident and that the treatments and recommendations are medically necessary. (Petitioner's Group Exhibit 7, Sec. 4).

On December 17, 2014, Petitioner underwent a right L4-L5 transforaminal epidural steroid injection under fluoroscopic guidance with Dr. Chunduri. (Petitioner's Group Exhibit 7, Sec. 6)

Petitioner returned to Dr. Iavarone on December 21, 2014. Petitioner reported his pain was much worse and he had bilateral pain going into the feet since the injection. By January 2, 2015, Petitioner reported his low back pain continued to be worse and he had on occasion bilateral numbness in feet. On January 12, 2015, it is noted that Petitioner was referred to a neurosurgeon, Dr. Salhi by Dr. Chunduri. (Petitioner's Group Exhibit 7, Sec. 3)

Petitioner followed with Dr. Chunduri on February 6, 2015 with continued complaints of severe low back pain with right leg numbness and tingling as well as neck pain. Dr. Chunduri noted Petitioner continued with significant symptoms which had not improved with conservative care. The doctor continued to recommend a surgical evaluation. (Petitioner's Group Exhibit 7, Sec. 4)

Petitioner next saw Dr. Chunduri on February 20, 2015, and reported that he had not yet seen the surgeon. Petitioner informed the doctor that because of this accident he had been living homeless in a tent, and the cold weather is aggravating the symptoms. Petitioner followed up with Dr. Chunduri on March 20, 2015 with continuing reports of severe pain. (Petitioner's Group Exhibit 7, Sec. 4)

Although the record is unclear as to when the relationship began, Petitioner began treating with Dr. Andrew Chenelle at Northwestern Central DuPage Hospital. On July 10, 2015, Dr. Chenelle performed surgery consisting of 1.) L4 total laminectomy, medial facetectomy and foraminotomy for correction of central and lateral recess stenosis; 2.) L5 total laminectomy, medial facetectomy and foraminotomy for correction of central and lateral recess stenosis; 3.) pedicle screw fixation across 1 single interspace, L4-5 bilaterally; 4.) lateral mass arthrodesis L4-5, Formagraft BMP sponge and autologous harvested spinous process and laminar fragments, L4-5. The records from Northwestern Central DuPage Hospital indicate Petitioner remained in-patient through July 16, 2015 when he was discharged to "…subacute rehab" with a diagnosis of lumbar spinal stenosis s/p L4-5 laminectomy and fusion. Because of Petitioner's homeless situation, an attempt was made to get Petitioner admitted into a subacute facility. According to the records submitted, Petitioner was ultimately approved to have his care transferred to Presence McCauley Nursing and Rehabilitation in Aurora. (Petitioner's Group Exhibit 7, Sec. 8, CM Rounds Note dated 7/16/15)

Post surgery, Petitioner returned to Dr. Chenelle periodically for x-rays and follow-up care on August 13, 2015, September 16, 2015 and November 12, 2015. X-rays of the lumbar spine taken on August 13, 2015 demonstrated stable post fusion changes at L4-5. A third x-ray of the lumbar spine taken on November 12, 2015 was read to demonstrate status post L4-L5 posterior fusion without adverse features. (Petitioner's Group Exhibit 7, Sec. 8)

Petitioner testified that he was housed and received therapy at Presence McCauley for approximately one (1) year, indicating he was discharged in April of 2017. Petitioner provided that during that period his back improved "somewhat" indicating his back pain decreased to levels as low as '4/10', but never less. (The Arbitrator notes that the records and bills of McCauley Manor were not introduced at trial.)

Petitioner testified that following his release from McCauley Manor Care, his back pain gradually increased. By February 26, 2018, he returned to Dr. Iavarone's office complaining of lower back pain with bilateral lower extremity symptoms. He resumed therapy with pain levels assed at 7-8/10. On March 5, 2018,

Dr. Iavarone noted that all of Petitioner's activities of daily living were compromised. On March 7, 2018, Dr. Iavarone referred Petitioner to pain management. (Petitioner's Group Exhibit 7, Sec. 3)

On May 25, 2018, Petitioner was seen for an initial appointment by Tian Xia, D.O. of Integrated Pain Management of Lombard. Dr. Xia's records noted Petitioner had an injury at work 10/21/14 when the 18-wheeler Petitioner was driving was T-boned by another 18-wheeler at 45 mph. The records go on to recount Petitioner's medical history through surgery and his time at McCauley for "one year for rehab after surgery." Petitioner reported that he was better, but then the pain came back. Now he feels pain is as bad as it was before. Petitioner reported pain from low back with radiation to both legs/feet. Also reported was that pain caused weakness in both legs and the pain was burning/sharp/tingling in nature. The pain was worse in his right leg. After performing an examination, Dr. Xia diagnosed Petitioner with radiculopathy, lumbar region and postlaminectomy syndrome. The doctor prescribed an MRI, and an EMG. Also prescribed was Cyclobenzeprine and Neurontin. Petitioner was to return to the doctor after the MRI. (Petitioner's Group Exhibit 7, Sec. 10) Petitioner testified that he did not follow with Dr. Xia as the doctor did not accept Medicaid.

Petitioner continued to treat with Dr. Iavarone. On June 8, 2018, the doctor wrote, "[B]ased on today's exam the patient has not demonstrated much improvement, we are having difficulty finding him a pain management consult due to finance issues." The last time Petitioner saw Dr. Ivarone prior to trial was June 25, 2018. At that time, Petitioner continued to complain of low back pain with radiation to both lower extremities.

Petitioner testified that he stopped seeking treatment because he was told there is nothing else that could be done. He has not gone back to work for Respondent and has been unemployed since the accident. He testified that he is not able to work in his prior role as truck driver as he is unable to sit for extended periods of time. Petitioner testified that the highest grade he completed was high school. He did not attend college or trade school. He testified that he is unable to use a computer. Petitioner testified that when he informed Respondent that he was unable to drive the truck and that he was only able to do office work, he was told that there was no job for him. He attempted to obtain another job by walking around and asking people if they were hiring, and reading the classified section of the newspaper.

Petitioner testified that he was not paid by Respondent-Employer for the time he was off work. He did not have group health insurance at the time of the accident. Since the accident, he obtained Medicaid. The Central Dupage Hospital bills, totaling $196,400.26, were paid by Medicaid. (Petitioner's Group Exhibit 7, Sec. 8) The remainder of the bills, totaling $50,818.81, remain unpaid. Several of Petitioner's medications were placed through the Injured Worker's Pharmacy which asserts a lien on any award in this matter. (Petitioner's Group Exhibit 7, Sec. 11)

Petitioner testified that he had no back pain prior to the subject accident and was generally in good health, working full time and fulfilling all the duties of his job without restriction or discomfort.

Petitioner testified that he continues to experience severe back pain on a daily basis. He takes over-the-counter medication in an attempt to control pain levels. He has lost his profession as a truck driver. Activities such as hunting, walking, and fishing are difficult. Petitioner felt that he could not drive a truck anymore indicating his "back can't handle it." Petitioner cited truck related activities would be difficult, i.e., the cranking, loading and unloading, maintenance and sitting for long periods of time. Petitioner also related that his sleep patterns are severely and adversely affected by his back pain.

With respect to A.) Was Respondent-Employer ASM Transport operating under and subject to the Illinois Workers' Compensation Act or Occupational Diseases Act, the Arbitrator finds the following:

Petitioner testified that he began working for Respondent-Employer, ASM Transport, as a truck driver in 2012. He further testified that the Respondent-Employer was a business engaged in the freight business in Hazel Crest Illinois. ASM was a company that delivered freight to various places all over the country. As a truck driver, Petitioner drove a semi-trailer truck, hauling various items countrywide. Based upon the unrebutted testimony and other credible evidence, as well as the automatic coverage provisions of Section 3 of the Act, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that on October 21, 2013, Respondent-Employer was operating under and subject to the Illinois Workers' Compensation Act.

With respect to B.) Was there was an Employee-Employer relationship, the Arbitrator finds the follows:

This Arbitrator finds an employee-employer relationship existed between Petitioner and ASM Transport. The law in Illinois provides no specific litmus test for determining whether an employer-employee relationship exists. Rather, such a relationship, if one exists, must be inferred from the conduct of the parties. While, the right to control work is often the primary factor in determining an employment relationship, there are multiple factors to consider in assessing the nature of the relationship between the parties. *Roberson v. Indus. Comm'n,* 225 Ill. 2d 159, 175 (2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with the needed instrumentalities; and (7) whether the employer's general business encompasses the person's work. *Id.*

Petitioner's unrebutted testimony established that he was employed by ASM Transport. Petitioner was hired by Carolyn Milton in 2012 and was paid by cash or check weekly. ASM provided the semi-trailer truck, carried the vehicle insurance and registration for the vehicle, and paid for all repairs required for the truck. All of the tools needed to make repairs on the truck were provided by ASM. Petitioner was the sole employee of ASM. As a truck driver who delivered freight to their destinations, Petitioner's work encompassed ASM's general business as a freight distribution company.

Based upon the unrebutted testimony and other credible evidence, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that on October 21, 2014, an Employee-Employer relationship existed between Petitioner and Respondent-Employer ASM Transport.

With respect to C.) Did an accident occur that arose out of and in the course of Petitioner's employment with the Respondent, the Arbitrator finds the following:

Petitioner testified that on October 21, 2014, he was driving the semi-truck on an assignment for ASM when his truck collided with another truck in Joliet, Illinois. Petitioner was making a right-hand turn, traveling northbound at a T- intersection when another truck came in front and clipped his truck. The other truck was traveling eastbound. The police were notified, and a police report was completed. He testified that when the accident occurred, he was wearing a seatbelt, and he violently bounced around within the seatbelt. There was "minor to major" damage to the bumper, grill, and fender of the semi-truck. The truck was no longer drivable after the accident. After the accident, Petitioner was transported to Presence St. Joseph Medical Center via ambulance. The Joliet EMS report indicates that emergency personnel was dispatched to 333 N. Madison, Joliet, Illinois at 3:33 p.m. to a motor vehicle accident. Petitioner informed EMS personnel that he was turning right when he was struck by another semi that was driving past him. Petitioner complained of pain to left knee, and slight headache. EMS personnel noted swelling to Petitioner's left knee, and a bump on his right forehead. Petitioner was seen in the Presence St. Joseph Emergency Room. The records reflect the fact that Petitioner was driving an 18-wheeler semi-truck when he was sideswiped by another semi-truck.

Based upon the unrebutted testimony and other credible evidence, the Arbitrator finds that Petitioner has established by a preponderance of the credible evidence that on October 21, 2014, he sustained an accidental injury which arose out of in the course of his employment by Respondent-Employer.

With respect to D.) What was the date of the accident, the Arbitrator finds the following:

See the findings in paragraph "C" above.

Based upon the unrebutted testimony of Petitioner and the medical records from the emergency room, the Arbitrator further finds that Petitioner has established by a preponderance of the evidence that the date of accident was October 21, 2014.

With respect to E.) Was timely notice of the accident given to the Respondent, the Arbitrator finds the following:

The unrebutted testimony of Petitioner established that Respondent-Employer had timely notice of Petitioner's accident. Petitioner testified that he informed Carolyn Milton of same on the day of accident. Petitioner's Exhibit 6 was admitted into evidence, which is a letter from Carolyn Milton to Petitioner's attorney, Joseph Vitu. The letter dated November 11, 2014, indicates that ASM Transport is aware that Petitioner was injured. It states that ASM wishes to provide compensation to Petitioner, but more information is needed.

Based upon the unrebutted testimony and credible evidence, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that he provided Respondent-Employer with timely notice of the accident as defined by the Act.

With respect to F.) Is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The unrebutted testimony of Petitioner established that prior to the date of accident Petitioner never had any problems with his knee, cervical or lumbar spine. Petitioner's medical records and bills were admitted into evidence as Petitioner's Group Exhibit 7. The Arbitrator finds the care and treatment contained therein was reasonable and necessary for the injuries sustained in the incident of October 21, 2014 and that Petitioner was reasonably referred for care from one provider to another as his medical needs evolved. This finding is made in light of numerous opinions contained therein by several licensed medical providers that connects Petitioner's condition of ill-being and the subject work accident. Further, there is no evidence of any intervening accidents or conditions to refute the same.

The Arbitrator notes that on July 10, 2015, Dr. Chenelle performed surgery consisting of 1.) L4 total laminectomy, medial facetectomy and foraminotomy for correction of central and lateral recess stenosis; 2.) L5 total laminectomy, medial facetectomy and foraminotomy for correction of central and lateral recess stenosis; 3.) pedicle screw fixation across 1 single interspace, L4-5 bilterally; 4.) lateral mass arthrodesis L4-5, Formagraft BMP sponge and autologous harvested spinous process and laminar fragments, L4-5. Petitioner remained in-patient through July 16, 2015 when he was discharged to "...subacute rehab" with a diagnosis of lumbar spinal stenosis s/p L4-5 laminectomy and fusion. Because of Petitioner's homeless situation, an attempt was made to get Petitioner admitted into a subacute facility. Petitioner was ultimately approved to have his care transferred to Presence McCauley Nursing and Rehabilitation in Aurora.

Petitioner testified that he was housed and received therapy at Presence McCauley for approximately one (1) year, indicating he was discharged in April of 2017. Petitioner provided that during that period his back improved "somewhat" indicating his back pain decreased to levels as low as '4/10', but never less. (The

Arbitrator notes that the records and bills of McCauley Manor were not introduced at trial.) Petitioner testified that following his release from McCauley Manor Care, his back pain gradually increased. By February 26, 2018, he returned to Dr. Iavarone's office complaining of lower back pain with bilateral lower extremity symptoms. He resumed therapy with pain levels assed at 7-8/10. On March 5, 2018, Dr. Iavarone noted that all of Petitioner's activities of daily living were compromised. On March 7, 2018, Dr. Iavarone referred Petitioner to pain management.

On May 25, 2018, Petitioner was seen for an initial appointment by Tian Xia, D.O. of Integrated Pain Management of Lombard. Dr. Xia's recorded the accident history and the records recount Petitioner's medical history through surgery and his time at McCauley for "one year for rehab after surgery." Petitioner reported that he was better, but then the pain came back. He relayed that his pain was as bad as it was before. Petitioner reported pain from low back with radiation to both legs/feet. Dr. Xia diagnosed radiculopathy, lumbar region and postlaminectomy syndrome. The doctor prescribed an MRI, and an EMG. Also prescribed was Cyclobenzeprine and Neurontin. Petitioner was to return to the doctor after the MRI; however, he did not do so as Dr. Xia did not accept Medicaid.

Petitioner continued to treat with Dr. Iavarone. On June 8, 2018, the doctor wrote, "[B]ased on today's exam the patient has not demonstrated much improvement, we are having difficulty finding him a pain management consult due to finance issues." The last time Petitioner saw Dr. Iavarone prior to trial was June 25, 2018. At that time, Petitioner continued to complain of low back pain with radiation to both lower extremities.

The records in evidence coupled with the testimony of Petitioner indicate that prior to the accident of October 21, 2014, he was able-bodied and employed full time by ASM in the capacity of a truck driver. Petitioner had no prior complaints of back pain prior to the subject accident and the records reflect that the complaints of pain and his subsequent diagnosis of pain in his back and his complaints of head pain, cervical discomfort and knee pain were consistent with having occurred during the subject collision of October 21, 2014. Further, the records of his doctors all record the mechanism of injury as the trucking accident of October 21, 2014. Further, the records of several of his medical providers – including Dr. Iavarone - specifically state that based upon a reasonable degree of medical certainty the foregoing injuries were caused by the subject trucking accident of October 21, 2014. As his complaints and treatment followed in a reasonable course, the Arbitrator finds Petitioner's current condition of ill-being is related to the subject accident of October 21, 2014.

With respect to G.) What were the Petitioner's earning, the Arbitrator finds the following:

Petitioner alleges that his earnings from Respondent-Employer were $1,400 per week, or $72,800.00 per year. (Arbitrator's Exhibit "Arb Ex" 1). Petitioner testified that he was paid by cash or check from the Respondent-Employer between $800 and $1,400 per week. He was paid weekly, per mile driven at eighty to ninety cents per mile. Petitioner testified that he travelled approximately 5,000 per week. Although Petitioner presented no evidence of check stubs, receipts, travel logs, or employment contract, the Arbitrator notes Petitioner's credibly testified that he attempted/requested a W-2 from Respondent. Respondent went out of business and refused to provide Petitioner with a W-2. Respondent ASM's refusal to provide a W-2 shall not serve to reduce Petitioner's average weekly wage. Relying in part on Petitioner's testimony that he was paid a maximum of $1,400, and a minimum of $800, the Arbitrator finds that Petitioner's average weekly wage was $1,100 per week.

With respect to H.) What was the Petitioner's age at the time of the accident and I.) What was the Petitioner's marital status at the time of the accident, the Arbitrator finds the following:

The unrebutted testimony of Petitioner as well as the emergency room records, established that Petitioner's date of birth is October 24, 1967, making him 46 years of age on the date of accident. Based upon the unrebutted testimony and other credible evidence the Arbitrator finds that Petitioner was 46 years old on the date of accident. The unrebutted testimony of Petitioner also established that he was single and had no children under the age of 18 on the date of injury. Based upon the unrebutted testimony and other credible evidence, the Arbitrator finds that Petitioner was not married and had no children on the date of injury.

With respect to J.) Were the medical services that were provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Contained in Petitioner's Group Exhibit 7, are the following medical bills associated with Petitioner's medical treatment: City of Joliet EMS $1,145.00; Presence St. Joseph Medical Center $6,834.49; Gregory Ivarone $20,175.06; Advanced Spine & Pain $3,114.00; American Diagnostic $1,700.00; Grand Avenue Surgical Center $13,389.00; Windy City Anesthesia $1,350.00; Northwestern Medicine Central DuPage $196,400.26; Integrated Pain Management $220.00; and Injured Workers Pharmacy $890.76.

Having found that Petitioner's conditions of ill-being were related to the accident herein, the Arbitrator awards the above referenced medical bills under Section 8(a) of the Act and pursuant to the Illinois Fee Schedule. Respondent has paid no medical bills to date.

With respect to K.) What temporary benefits (TTD) are in dispute, the Arbitrator finds he following:

Petitioner alleges he is entitled to TTD benefits from October 21, 2014 to present (Arb. Ex 1). Petitioner testified that he was not paid by Respondent-Employer for the time he was off work. When Petitioner told ASM that he was unable to drive the truck and that he was only able to do office work, he was told that there was no job for him. Petitioner testified that he attempted to obtain another job by walking around and asking people if they were hiring, and reading the classified section of the newspaper.

As noted above, Petitioner underwent surgery on July 10, 2015. Petitioner remained in-patient through July 16, 2015 when he was discharged to "...subacute rehab" with a diagnosis of lumbar spinal stenosis s/p L4-5 laminectomy and fusion. Because of Petitioner's homeless situation, an attempt was made to get Petitioner admitted into a subacute facility. Petitioner was ultimately approved to have his care transferred to Presence McCauley Nursing and Rehabilitation in Aurora.

Post surgery, Petitioner returned to Dr. Chenelle periodically for x-rays and follow-up care on August 13, 2015, September 16, 2015 and November 12, 2015. A x-ray of the lumbar spine taken on November 12, 2015 was read to demonstrate status post L4-L5 posterior fusion without adverse features. This is the last documentation regarding care with Dr. Chenelle. There is no reference to Petitioner's work capabilities.

Petitioner testified that he was housed and received therapy at Presence McCauley for approximately one (1) year, indicating he was discharged in April of 2017. None of the records and bills of McCauley Manor were not introduced at trial. Following his release from McCauley Manor Care, Petitioner returned to Dr. Iavarone on February 26, 2018 complaining of lower back pain with bilateral lower extremity symptoms. He resumed therapy with pain levels assed at 7-8/10. By March 7, 2018, Dr. Iavarone referred Petitioner to pain management. On May 25, 2018, Petitioner was seen for an initial appointment by Tian Xia, D.O. of Integrated Pain Management of Lombard. Dr. Xia diagnosed radiculopathy, lumbar region and postlaminectomy syndrome. The doctor prescribed an MRI, and an EMG. Petitioner was to return to the doctor after the MRI; however, he did not do so as Dr. Xia did not accept Medicaid. Thereafter, Petitioner continued to treat with Dr. Iavarone. On June 8, 2018, the doctor wrote, "[B]ased on today's exam the patient has not demonstrated much

improvement, we are having difficulty finding him a pain management consult due to finance issues." The last time Petitioner saw Dr. Iavarone prior to trial was June 25, 2018. At that time, Petitioner continued to complain of low back pain with radiation to both lower extremities. Neither Dr. Iavarone nor Dr. Xia referenced a work status.

Based on all the above, the Arbitrator finds that Petitioner is entitled to temporary total disability from the date of accident through April 1, 2017, the date Petitioner testified that he was released from McCauley Manor Care. The Arbitrator recognizes that Petitioner failed to introduce records from McCauley Manor Care; however, the Arbitrator finds Petitioner's testimony credible that he was released in April 2017.

With respect to L.) What is the nature and extent of the Petitioner's injury, the Arbitrator finds the follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

With regard to Section 8.1(b)(i) of the Act, the 8.1(a), the Arbitrator finds neither party presented an AMA Impairment Rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(ii) of the Act, the occupation of the injured employee, the Arbitrator finds Petitioner was employed as a long-haul truck driver for Respondent. Petitioner was diagnosed with a knee strain, closed head injury, and two herniations at L4-L5 and L5-S1. He subsequently underwent an L4-L5 laminectomy with Dr. Chenelle and is no longer able to be employed in his profession Therefore, the Arbitrator gives substantial weight to this factor.

With regard to Section 8.1(b)(iii) of the Act, the age of the injured employee at the time of the injury, the Arbitrator finds Petitioner was 46 years old at the time of the accident. As Petitioner is a younger individual, he will live with disability for an extended period. As such, the Arbitrator gives greater weight to this factor.

With regard to Section 8.1(b)(iv) of the Act, the employee's future earning capacity, the Arbitrator finds that no evidence was submitted regarding Petitioner's future earning capacity. As such, the Arbitrator gives no weight to this factor.

With regard to Section 8.1(b)(v) of the Act, evidence of disability corroborated by the treating medical records. The Arbitrator notes that Petitioner sustained injuries that resulted in diagnoses of a knee strain, closed head injury, cervical strain and two herniations at L4-L5 and L5-S1. He subsequently underwent an L4-L5 laminectomy. On May 25, 2018, Petitioner was seen by Dr. Xia. Petitioner reported pain from low back with radiation to both legs/feet. Pain causes weakness in both legs. Pain is burning/sharp/tingling in nature. An examination revealed range of motion reflection and extension were both restricted to 10 degrees. Patient couldn't walk on toes or heels. Lumbar facet loading was positive on both sides. Straight leg raise was positive. Dr. Xia diagnosed Petitioner with radiculopathy, lumbar region and postlaminectomy syndrome. He was recommended to follow-up with Dr. Xia, get an MRI and an EMG and prescribed Cyclobenzeprine and Neurontin. Once Dr. Xia came to learn Petitioner only had Medicaid, he refused to continue to see him. Having been denied a follow-up appointment, Petitioner returned to Dr. Iavarone who continued to treat him. On June 8, 2018, the doctor noted that Petitioner had not demonstrated much improvement, we are having difficulty finding him a pain management consult due to finance issues. Petitioner last saw Dr. Iavarone on June 25, 2018. Petitioner continued in pain. At trial, Petitioner testified that due to this pain, he has difficulty with activities of daily living. He takes over-the-counter pain medication for pain ever since, with little relief. His sleep is negatively impacted.

Based on all the above, the Arbitrator finds that as a result of the accident herein, Petitioner sustained 2% loss of use of the left knee; 2-1/2% loss of man as a whole for the closed head injury and cervical strain; and 32-1/2% loss of man as a whole for the lumbar region under Sections 8(e) and 8(d)2 of the Act.

With respect to O.) Was adequate and proper notice of hearing given to the Respondent-Employer and Is Respondent Injured Workers' Benefit Fund liable for payment to Petitioner, the Arbitrator finds the following:

On the hearing date, no one from ASM Transport, Inc. was present, and the hearing proceeded *ex parte* against Respondent-Employer. Petitioner introduced into evidence correspondence from Petitioner's attorney's office sent via certified mail to Respondent-Employer's addresses including the addresses filed with the Secretary of State registered agent for ASM Transport Services, Inc. ((Petitioner's Exhibits 2,3,4, and 5)

Based on the above, the Arbitrator finds that Petitioner has established by more than a preponderance of the evidence that Respondent-Employer ASM Transport Services, Inc. had adequate and timely notice of the hearing.

This matter was heard on August 10, 2018. It proceeded *ex parte* against Respondent-Employer ASM Transport Services, Inc. The Injured Workers' Benefit Fund was represented by the Attorney General's office by Assistant Attorney General Danielle Curtiss. A review of the Illinois Workers' Compensation Commission records by Roguens Loriston failed to reveal any workers' compensation insurance coverage for Respondent-Employer ASM Transport Services, Inc. on October 21, 2014. ((Petitioner's Exhibit 1)

Based on the above, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that the Injured Workers' Benefit Fund of Section 4(d) of the Illinois Workers' Compensation Act applies and that the Injured Workers' Benefit Fund has been properly named as a Respondent in this matter.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL BEZANIS,

Petitioner,

vs. NO: 15 WC 11754

STATE OF ILLINOIS, DEPARTMENT OF HUMAN SERVICES,

Respondent.

20IWCC0105

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 accident date, notice, average weekly wage, causation, medical, temporary disability, permanent disability, and penalties and 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 June 11, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $205.26 per week for a period of 16 weeks, representing February 4, 2015 through May 26, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses related to treatment for Petitioner's right elbow injury, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $205.26 per week for a period of 31.625 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused a 12.5% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties under Sections 19(l) and 19(k) and Section 16 fees is denied.

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.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: FEB 14 2020

LEC/mck

O: 2/5/2020

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L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEZANIS, PAUL Case# **15WC011754**
Employee/Petitioner

ST OF IL DEPT OF HUMAN SERVICES
Employer/Respondent

20IWCC0105

On 6/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4016 RUBIN MACHADO & ROSENBLUM LTD
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CHICAGO, IL 60606

5002 ASSISTANT ATTORNEY GENERAL
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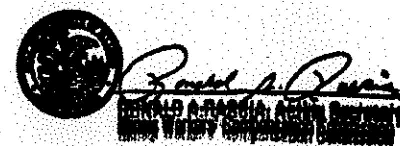
CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

JUN 11 2018



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

Paul Bezanis
Employee/Petitioner
v.
State of Illinois, Department of Human Services
Employer/Respondent

Case # 15 WC 011754

20IWCC0105

An *Application for Adjustment 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 **2/13/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/21/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the 48 weeks preceding the injury, Petitioner earned **$9,852.77**; the average weekly wage was **$205.26**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **1** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services. **(See attached)**

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $205.26 per week for 16 weeks, commencing 2/4/2015 through 5/26/2015, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services related to treatment for Petitioner's right elbow injury, as provided in Sections 8(a) and 8.2 of the Act and as explained below.

Respondent shall pay Petitioner permanent partial disability benefits of $205.26 per week for 31.625 weeks, because the injuries sustained caused the 12-1/2% loss of the Petitioner's right arm, as provided in Section 8(e) of the Act.

Respondent shall pay to Petitioner penalties of $0, as provided in Section 16 of the Act; $0, as provided in Section 19(k) of the Act; and $0, as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 11/21/2014 through 2/13/2018, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

June 11, 2018
Date

JUN 1 1 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a caretaker/assistant ("Personal Assistant") for Petitioner's son, Nikolas, age 29. Nikolas is severely disabled (quadriplegic, TBI, obesity (600 #) and he requires constant care.

Petitioner also had a business, Bezanis Quality Construction and Landscaping ("Bezanis QCL"). Respondent was aware of Petitioner's business at the time of the accident. Petitioner's tax forms for the years 2012, 2013 and 2014 reveal that Petitioner claimed business income from Bezanis QCL on his 1040 tax form and filed a Schedule C for Bezanis QCL, showing no wages were paid by it. (PX 5) There was no testimony regarding any wages paid to Petitioner by Bezanis QCL.

Petitioner testified that he injured his right upper extremity on November 21, 2014, while working as a caretaker for Nikolas. Nikolas fell forward while being transferred from his bed to his electric wheelchair, causing Petitioner to feel immediate pain in his right shoulder, elbow and down into his hands. "Everything just ripped out." "I was just all pain, numb, tingling." Petitioner continued his caretaker work that day, but did not do any more transfers. Petitioner did not seek immediate medical attention. He iced his arm and took Tylenol and Aleve.

According to Petitioner's time sheets, he continued to work as a Personal Assistant through December 19, 2014. (RX 2)

After the injury, Petitioner first sought medical care with his PCP, Dr. Georgios Karanastasis, on November 25, 2014. Dr Karanastasis ("Dr. K") testified via Evidence Deposition at Petitioner's request. (PX 9) Dr. K had seen Petitioner on November 4, 2014 for the first time. Petitioner was seen for hypertension, diabetes, congestive heart failure, non-compliance with physicians' recommendations, diffuse osteoarthritis, CAD, dyslipidemia, chronic liver disease, cellulitis and other maladies on November 4. The chart note identifies this visit as "follow up", but no earlier chart notes are included in the submitted medical records. At the November 4, 2014 visit, ">>glove UE and LE neuropathy" was noted and a referral to Neurology for EMG/NCV study was made. The chart of November 25, 2014 reveals that the patient was seen for follow up and "Pt has other health concerns for provider." Dr. K testified that the other health concerns involved right elbow pain that Petitioner developed attempting to move his son on November 21, 2014. (PX1, PX 9) Dr. K wrote a letter to Petitioner's attorney regarding the November 25, 2014 visit and chart note describing a history of an injury to Petitioner's right elbow lifting his son. Dr. K gave Petitioner a referral to Dr. Primus for an orthopedic consult, per his letter and Dr. Primus thereafter provided treatment to Petitioner's right elbow and right shoulder. (PX 3) Neither Dr. K's records nor his deposition testimony mention any right shoulder injury as a result of the lifting incident. (PX 1, PX 9) Dr. K did not provide any testimony supporting causal connection. (PX 9) Petitioner's testimony was

that he saw Dr. K on November 25, 2014 for his shoulder, elbow and other medical problems and x-rays were ordered. Dr. K's chart of November 25, 2014 reveals a referral to radiology for a right elbow x-ray, "dx: R elbow pain r/o OA vs. elbow strain." (PX 1)

The right elbow x-ray of December 1, 2014 was said to be unremarkable. The clinical history was: "right posterior elbow pain for one week. No known trauma." Dr. K ordered a right elbow MRI that was performed on December 13, 2014. The clinical history was right elbow pain and osteoarthritis. The elbow MRI showed mild osteoarthritic changes, partial tear in the common extensor, partial tear in the extensor carpi radialis longus muscle, subtle edema versus partial tear in the brachialis tendon, soft tissue edema on the radial and posterior aspect and mild elbow effusion. (PX 2)

On December 15, 2014, Dr. Gregory Primus' medical office, Chicago Sports Orthopedics completed a phone intake form for Petitioner. It indicates that he was referred by "Insurance," and that his insurance company was Union Health Service. "Patient has disc or elbow MRI of shoulder(?) needed." It is indicated that there may be workers' comp coverage: "to obtain re: fall." UHS approved the visit via an External Consultation Request. The next day, Petitioner completed a New Patient Face Sheet, and completed a Medical History Information sheet which lists an injury "transfer quadriplegic to chair from bed," and lists an injury date of November 25, 2014. The injuries were said to be to the right shoulder, elbow and hand. "Severe pain, can't use, atrophy." Dr. Primus' chart note from December 16, 2014 states that the patient is seen for consultation of right elbow pain. "The date of injury was November 25, 2014." The precipitating event seems to be lifting and extreme flexion. Patient is a caregiver and was moving son from bed to chair and felt a strain in elbow in shoulder. The assessment was elbow pain; tennis elbow; shoulder pain with muscle atrophy and paralysis. Dr. Primus ordered an EMG and physical therapy. (PX 2)

On December 20, 2014, Petitioner underwent an MRI of the right shoulder which showed focal partial tear in the articular surface of the distal supraspinatus tendon, partial tear in the substance of proximal part of the subscapularis tendon, and mild degenerative changes of the acromioclavicular joint. The clinical history noted "status post work related injury by lifting a client (patient is a caregiver) on November 25, 2014." On December 23, 2014, Petitioner underwent an EMG/NCV which showed polyneuropathy in diabetes, and disturbance of skin sensation. The results state, "the findings are nonspecific for etiology but would be consistent with the clinical suspicion of a diabetic neuropathy." In the History of Present Illness section, the doctor records Petitioner's history of a diabetic coma, bilateral foot numbness, right finger numbness, congestive heart failure, peripheral vascular disease, stents, and that "he has old history of right shoulder and elbow tendon injuries." The physical exam shows that the patient gives way on the right deltoid from old shoulder issues. (PX 2)

Petitioner returned to Dr. Primus on December 28, 2014 and the date of injury of November 25, 2014 was charted. Treatment options were discussed. Petitioner was attending physical therapy and not seeing improvement. No physical therapy records were entered into evidence. Petitioner returned to Dr. Primus on January 16, 2015 and Dr. Primus recommended right ulnar nerve transposition at the elbow, right shoulder arthroscopic rotator cuff repair, right shoulder arthroscopic acromioclavicular joint arthroplasty with distal clavicle excision, and arthroscopic shoulder debridement with labral debridement, synovectomy, subacromial decompression with bursectomy and acromioplasty. Petitioner underwent these procedures on February 2, 2015. Petitioner returned to Dr. Primus on February 10, where he recommended physical therapy. (PX 2, PX 4)

Throughout his treatment with Dr. Primus, Petitioner continued to treat with Dr. Karanastasis for other medical concerns. On April 8, 2015, Dr. Karanastasis recorded Petitioner's severe pain in his right upper extremity, said he is unable to use heavy machinery, and unable to return to work. (PX 1) On April 28 2015, Dr. Primus

completed a Work Status page that says Petitioner should be off-work for 4 weeks, and a note in the Rehab section that seems to say he "must begin" PT. (PX 2) On April 28, 2015, Petitioner had his last visit with Dr. Primus who recorded, "he has not attended any physical therapy states his insurance was dropped…." (PX 2) On April 28 and 29, 2015, Dr. Primus made two more requests for authorization for PT, but it's not clear whether or where the requests were sent. (PX 2) On July 21, 2015, Petitioner's final visit with Dr. Karanastasis, the doctor recorded "RUE abduct up to 90 degree and above that has to support it, also sensation decreased in post arm/forearm and weak grip with pain in R shoulder w/radiation in RUE." Dr. K did not provide an off work slip. (PX 1)

Regarding his non-attendance at physical therapy, Petitioner testified first that the state rescinded his referral, and then United Healthcare rescinded his referral, and then he wasn't sure who rescinded his referral. In any event, Petitioner had a rotator cuff repair and physical therapy was not afforded him. He has had a bad recovery regarding the shoulder surgery, as would be expected.

Petitioner testified that he reported his injury to Ranisah Brown, Miss Gardner, and one other male whose name Petitioner could not remember "around November 24th." He said Ms. Brown was at his house when he told her. Petitioner completed and signed an Employee's Notice of Injury form on May 1, 2015, in which he says he gave notice to Ranisah Brown "approx. 12.26.14." Under "Name of Agency," Petitioner wrote "Illinicare/Ranisah Brown." This form also shows a date of accident of 11/21/14, and a last day worked as 12/19/14. (RX 1)

Petitioner submitteded an email into evidence from roulalapaul@yahoo.com to RanBrown@centene.com. (PX 6) The email is dated December 29, 2014. The email begins "Hello Ranisah," and describes the accident at issue, gives a date of accident of November 21, 2014, and says "I sent you a text on December 26, 2014 for you to call me so I would make you and Illinicare aware of what happen (sic) to Paul, in addition informing you that Nikolas has been in the hospital since Sunday December 21, 2014." (PX 6)

Petitioner testified that Ms. Brown works for the Department of Human Services. When asked if it's possible that Ms. Brown is an employee of Illini Healthcare, and not the State of Illinois, Petitioner said, "I don't know." He also said he did not know Ms. Brown's position. He said he had never heard of a company called Centene.

Respondent submitted no rebuttal evidence regarding this testimony.

Petitioner testified that the bills from Dr. Primus and from South Suburban Hospital have not been paid. The bill from Dr. Primus is $21,160.10. The bill from Advocate South Suburban Hospital is 35,391.00. (PX 3, PX 4)

Petitioner testified that he has difficulty gripping stuff. His arm is atrophied and he has pain. It is hard to get dressed. It is hard to button his pants. He has difficulty putting socks on. He does not perform work for Bezanis QCL. He subcontracts jobs now. He can't hold tools. He does not climb ladders. He does not do physical work. He takes Tylenol and Aleve for pain complaints.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth 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)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

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

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on November 21, 2014. The Arbitrator relies on Petitioner's testimony, the Time sheet records and the records and testimony of Dr. Karanastasis in making this finding. Petitioner's misidentifying the accident date to Dr. Primus and the no trauma histories to the radiologists are considered, but do not lead the Arbitrator to deny the claim based upon no accident or that the accident occurred on 11/25/2014 (the day that Petitioner first sought treatment from Dr. K for "other health concerns").

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

Petitioner gave timely notice of the accident. The Arbitrator bases this finding on Petitioner's unrebutted testimony on this issue, RX 1 (Tristar WC Notice of Injury) and PX 6 (emails regarding accident).

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

Petitioner's current condition of ill-being regarding his right upper extremity is, in part, causally related to the injury.

Petitioner's right elbow condition (right cubital tunnel syndrome with ulnar nerve compressive neuropathy, status post right ulnar nerve transposition at the elbow) is causally related to the injury. The Arbitrator believes that this finding is supported by Petitioner's testimony and Dr. K's testimony that Petitioner reported a November 21, 2014 right elbow injury lifting his son when Petitioner saw Dr. K on November 25, 2014. It is

further noted that Dr. Primus' December 16, 2014 chart first states that the patient is first seen for consultation regarding right elbow pain.

The Arbitrator finds that Petitioner's condition of ill-being regarding his right shoulder is not causally related to the injury. First, it does appear to the Arbitrator that Petitioner did not complain regarding his right shoulder to Dr. K when he presented on November 25, 2014. If he had done so, Dr.K would have remembered it, as he did Petitioner's history of injury regarding the right elbow. A work-up regarding the shoulder would have been initiated had Petitioner complained regarding his shoulder to Dr. K.

"It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Commission, 2 Ill.2d 540, 602 (1954) Here the history given to the initial medical provider is of an injury to the right elbow. The lack of a history of an injury to the shoulder persuades the Arbitrator that no shoulder injury occurred.

In the absence of a competent and persuasive medical opinion regarding Petitioner's shoulder condition, the Arbitrator will not endorse causation regarding same in this case.

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

Petitioner attempts to claim income from his business, Bezanis QCL, as a part of his Average Weekly Wage. Earnings from a business are not included in the AWW. Mansfield v. Illinois Workers' Comp. Comm'n, 2013 IL App (2d) 120909WC, ¶¶ 39-45, Paoletti v. Industrial Comm'n, 279 Ill.App.3d 988, 996 (1996)

Respondent's wage audit reveals that Petitioner earned $9,852.77 in the 48 weeks preceding the accident. The Average Weekly Wage is $205.26.

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

Petitioner submitted bills from Dr. Primus ($21,160.10) (PX 3) and Advocate South Suburban Hospital ($35,391.00) (PX 4).

First, the Dr. Primus bill includes two "No Show" charges (DOS: 4/3/2015 and 5/26/2015, $25.00 each). These are not awarded.

Second, the bills for both providers contain charges for Petitioner's unrelated right shoulder condition. The right shoulder treatment charges are not awarded, based upon the Arbitrator's finding above regarding causation.

The submitted medical expenses from Dr. Primus and Advocate South Suburban Hospital are awarded to the extent that they are related to treatment for Petitioner's right elbow condition and pursuant to §§8(a) and 8.2 of the Act.

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

The Record does not support Petitioner's claim for TTD from 11/22/2014 through the date of trial (2/13/2018). First, Petitioner did not seek medical care for his injuries until November 25, 2014. Dr. K did not excuse Petitioner from work at that time. Indeed, Petitioner's time sheets show that his last day of work was December 19, 2014. A claimant is not entitled to TTD when he is working and receiving wages.

It does not appear that Dr. Primus took Petitioner off work until after the surgery date of February 4, 2015. The last visit with Dr. Primus was on April 28, 2015. At that time, Petitioner was taken off work for 4 weeks. Thus, the Arbitrator finds that Petitioner is entitled to TTD benefits from February 4, 2015 through May 26, 2015, a period of 16 weeks.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes that Petitioner was employed as a Personal Assistant at the time of the injury. The Record does not support the conclusion that Petitioner cannot return to work as a personal assistant due to the condition of his right elbow. This factor is given moderate weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the injury. This factor is given some weight in determining PPD, as the residuals of the elbow injury and Petitioner's age may affect his ability to perform some physical work activities and ADL's.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that no evidence was submitted regarding Petitioner's future earning capacity, as affected by the condition of his elbow. Other than as considered regarding section (iii) and section (v) of §8.1b(b), this factor is given no weight in determining PPD.

With regard to subsection (v) of §8.1b(b), the Arbitrator notes that Dr. Primus' chart note of April 28, 2015 does document residuals regarding Petitioner's right elbow, post injury and post-surgery, along with the recommendation for therapy. This factor is given the most weight in determining PPD.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that as a result of the injuries sustained, Petitioner sustained permanent partial disability to the extent of 12-1/2%% loss of use of his right arm, pursuant to §8(e) of the Act.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the evidence adduced, the Arbitrator declines to award penalties and attorney's fees in this case. The Arbitrator has considered the arguments of counsel in PX 10 and RX 6 and 7.

Causation regarding Petitioner's right shoulder condition was in dispute and Petitioner was not successful in his endeavor to establish same. Petitioner claims TTD (and, assumabley, penalties and fees associated with same) for a time period when he was not medically authorized off work and was in fact still working and collecting wages.

On this Record, penalties and fees are not warranted.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH REYNDERS,

Petitioner,

vs. NO: 12 WC 30274

WALMART,

Respondent.

20IWCC0106

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 18, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 246 4/7 weeks, representing July 16, 2012 through April 6, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given a credit of $38,663.42 for TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses reflected in Petitioner's exhibits 66-72, as provided in §8(a) and subject to §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 30% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $62,000.00. 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.

Stephen Mathis

D. Douglas McCarthy

DISSENT

I respectfully dissent. I afford greater weight to the opinions of Dr. Mather over those of Dr. Harvey. As such, I find Petitioner reached maximum medical improvement as of April 8, 2015, and therefore, I would vacate the medical bills and temporary total disability benefits awarded after such date.

On August 28, 2013, Dr. Harvey performed lumbar surgery consisting of a discectomy and fusion at the L4-L5 level. PX1, p. 22-23. Due to Petitioner's continued complaints of pain, a CT scan was performed on December 31, 2014, which Dr. Harvey interpreted as evidencing a fusion. PX1, p. 30. Dr. Mather, who evaluated Petitioner on November 3, 2014, initially recommended the CT scan to evaluate Petitioner's fusion. RX1, p. 35. Dr. Mather reviewed the CT scan and found Petitioner's fusion to be solid. RX1, p. 41. Dr. Harvey testified he agreed with Dr. Mather's interpretation of the CT scan. PX1, p. 29.

Moreover, during his evaluation of Petitioner on November 3, 2014, Dr. Mather noted several positive Waddell findings. RX1, p. 52. The video surveillance (RX7 & RX8) depicting Petitioner engaged in various physical activities without any signs of discomfort substantiates Dr. Mather's findings. As such, I would afford greater weight to Dr. Mather's opinions. Therefore, I dissent.

DATED: FEB 14 2020

L. Elizabeth Coppoletti

LEC/mck

O: 12/18/19

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYNDERS, DEBORAH
Employee/Petitioner

Case# **12WC030274**

WALMART
Employer/Respondent

20IWCC0106

On 1/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3269 SPIROS LAW PC
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STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

- [ ] 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

Deborah Reynders
Employee/Petitioner

Case # 12 WC 030274

v.

Consolidated cases: ______

Walmart
Employer/Respondent

20IWCC0106

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **New Lenox**, on **12/11/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [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. X Other: Admissibility of RX9

FINDINGS

On **July 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 $**17,418.44**; the average weekly wage was $**334.97**.

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

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

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

Respondent shall be given a credit of $**38,663.42** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**38, 663.42**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 246-4/7 weeks, commencing 7/16/12 through 4/6/17, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**38,663.42** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**38,663.42**.

Respondent shall pay Petitioner the reasonable and necessary medical services reflected in Petitioner's exhibits 66-72, as provided in Section 8 and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 150 weeks, because the injuries sustained caused the 30% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Carolyn M. Doherty

Signature of Arbitrator

1/17/18

Date

JAN 18 2018

FINDINGS OF FACT

The parties stipulated that Petitioner was injured on July 3, 2012 in the course of her duties as an overnight stocker for Respondent and that Petitioner gave timely notice of her accident. Petitioner testified on that date at approximately 2:30AM, something in her back popped while she was unloading a pallet of sugar. She testified that she had trouble standing up immediately after the accident and that she did not complete her shift.

Petitioner testified that she continued to have problems with her back during the days that followed her injury and that she sought medical attention from her general practitioner, Dr. Milik. Medical records admitted into evidence reveal that Petitioner first sought treatment from Dr. Milik on July 13, 2012. Dr. Milik's records also reveal that he ordered an X-ray of the lumbar spine, prescribed medications and prescribed physical therapy. After Petitioner's condition failed to improve with conservative measures, Dr. Milik ordered an MRI of the lumbar spine that was performed on August 20, 2012 and referred petitioner to Dr. Harvey, a neurosurgeon.

Petitioner began treating with Dr. Harvey on September 18, 2012. Dr. Harvey testified via evidence deposition that he reviewed the images from the August 20, 2012 MRI study and that they revealed disk bulging and disk degeneration at L4-5, with some nerve root impingement. Dr. Harvey furthermore testified that he diagnosed lumbar strain, lumbar radiculopathy and lumbar stenosis, all of which were related to Petitioner's work injury. Dr. Harvey prescribed pain medications and referred Petitioner to Dr. Hasan for injections.

Petitioner returned on Dr. Harvey on November 6, 2012 after having undergone a transforaminal steroid injection that targeted the left L4 and left L5 neural foramen. Petitioner reported that the injection made her pain worse and prompted a trip to the emergency room. Concerned that Petitioner may be suffering from either an infection following the injection or a worsened disk herniation, Dr. Harvey ordered a new lumbar X-Ray and a new MRI with contrast that was undertaken on November 9, 2012. Dr. Harvey read the new MRI study as revealing a left foraminal disk herniation at L4-L5 that had not been visualized on her previous low resolution open MRI. He added disk herniation to his diagnosis of Petitioner's work-related lumbar spine condition and recommended a discectomy and fusion surgery. That procedure was eventually performed by Dr. Harvey on August 28, 2013, after approval by Respondent's worker's compensation carrier. Among Dr. Harvey's surgical findings was a "small to moderate-sized partially extruded disk herniation on the left side at L4-5.

Petitioner continued to treat with Dr. Harvey post-operatively, reporting about a 75 percent improvement in terms of her pain as well as the ability to twist, turn, and to walk longer distances as of December 3, 2013. She had attended physical therapy up until this point, but the same had to be placed on hold due to her need to undergo surgical repair of a large abdominal hernia, unrelated to her claimed injury.

On March 6, 2014, Petitioner returned to Dr. Harvey, after having undergone the hernia surgery, reporting "deep aching to sharp low back pain that radiates posteriorly down the right leg stopping at the knee as well as traveling up between the shoulder blades. At that visit, Petitioner reported having sustained a slip and fall injury on December 23, 2013 that had aggravated her symptoms. Dr. Harvey refilled Petitioner's Norco prescription and advised Petitioner to resume physical therapy because "she was still recovering from her spine fusion surgery." Dr. Harvey eventually diagnosed "post-laminectomy syndrome" on April 8, 2014 and referred Petitioner back to Dr. Hasan to consider further pain management therapies.

On May 13, 2014, Petitioner reported to Dr. Hasan with a chief complaint of bilateral lower back pain with radiation into the bilateral lower extremities. Dr. Hasan ordered an MRI study that was completed on May 29, 2014 that revealed L4-L5 surgical changes, no spinal or neuroforaminal stenosis, relatively unchanged mild degenerative spondylosis L3-L4 and no acute osseous pathology. Dr. Hasan's diagnosis was: 1.low back pain; 2. lumbar post-laminectomy syndrome; 3. sciatica and; 4. lumbar spondylosis. Dr. Hasan performed two diagnostic median branch blocks of the lumbar facet joints on June 23, 2014 and July 21, 2014 as well as a radiofrequency median branch neurotomy on August 12, 2014. The medical records admitted into evidence reveal that any relief Petitioner experienced from these procedures was transitory. Dr. Hasan discussed the possibility of Petitioner undergoing a spinal cord stimulator trial procedure at her October 7, 2014 and October 14, 2014 visits with him.

On November 3, 2014, Petitioner attended a Section 12 exam at Respondent's direction with Dr. Stephen Mather. After reviewing Petitioner's medical records and conducting his own examination of the Petitioner, Dr. Mather opined that Petitioner had an aggravation of her lumbar stenosis as a result of her July 3, 2012 accident and that she underwent a technically excellent surgery by Dr. Harvey that "was indicated" and that her spinal stenosis was relieved by the surgery. However, Dr. Mather also opined that Petitioner was possibly suffering from a nonunion due to her pre-operative and post-operative smoking habit. He therefore recommended that Petitioner undergo a CT scan to determine whether or not the fusion was solid.

On December 31, 2014, Petitioner underwent a CT scan that was interpreted by the radiologist as showing "no bony fusion across the intervertebral disc space." Dr. Harvey testified that he interpreted the same CT scan as revealing "at least a bony bridge across L5-S1," but that the fusion was not robust. PX 1, p. 25. Dr. Harvey testified that he disagreed with the radiologist and opined that Petitioner had at least some evidence of a fusion. P. 26. However, he testified that he recommended an external bone growth stimulator to treat the suspected pseudoarthrosis in deference to the radiologist's opinion. P. 27. He further testified that he commonly recommends bone growth stimulators to patients who continue to smoke as did Petitioner. P. 27. The bone growth stimulator was never approved by Respondent's worker's compensation carrier.

On April 8, 2015, Dr. Mather issued an addendum report indicating that he had reviewed the December 2014 CT scan and that in his opinion, the fusion was solid. Dr. Mather further opined that Petitioner suffered from psychogenic pain and functional overlay. He furthermore determined that Petitioner had reached maximum medical improvement, required no further medical intervention and could return to work without restrictions. Dr. Mather testified that he did not feel that a spinal cord stimulator was appropriate treatment because "Petitioner appears to be very emotional . . . [a]nd you really have to have a very stable emotional person at baseline in order to get a get a spinal cord stimulator."

On April 8, 2015, Dr. Mather also issued a separate AMA impairment rating report that was not provided to Petitioner until the day of trial. The report and Dr. Mather's testimony concerning the same was admitted into evidence over Petitioner's objection at trial. Dr. Mather testified that Petitioner's condition merited a whole person impairment rating of 5%.

Respondent terminated TTD and ceased paying medical expenses on April 27, 2015 based on Dr. Mather's opinions. At trial, Respondent stipulated to causal connection through April 27, 2015 and also stipulated that Petitioner was entitled to TTD and medical expenses through that date. At trial, Respondent only disputed Petitioner's entitlement to TTD and the reasonableness and necessity of medical treatment after April 27, 2015.

Petitioner continued to treat with both Dr. Harvey and Dr. Hasan after her benefits were discontinued with complaints of low back pain that radiated down both legs. Dr. Hasan's records reveal that he continued to treat Petitioner's condition with medications and that Petitioner remained off of work throughout his care. A repeat CT scan was ordered by Dr. Harvey on April 14 and performed on June 15, 2015 that was read by a different radiologist as lacking bony fusion. Dr. Harvey testified that thereafter he continued to seek approval for a bone growth stimulator, aquatic therapy and eventually, a spinal cord stimulator trial for Petitioner, all of which had been denied by Respondent. Dr. Harvey furthermore testified that he continued to hold Petitioner off work as of his May 6, 2015 visit with Petitioner and that his opinion as to her work status had not changed as of the March 6, 2016 evidence deposition. Though he admitted on cross-examination that he hoped Petitioner would be capable of performing sedentary work, he also testified on re-direct that he had never released Petitioner to any form of light duty work since there was question as to whether she had a solid fusion and because she had not gone through work hardening.

On April 5, 2016, Dr. Harvey ordered a repeat MRI to evaluate the levels adjacent to Petitioner's fusion which he read as showing only mild spondylitic changes. Finding that Petitioner required no neurosurgical intervention, Dr. Harvey referred Petitioner back to Dr. Hasan on April 28, 2016 for the option of a spinal cord stimulator trial.

On May 4, 2016, Petitioner was re-evaluated by Dr. Hasan at which time the spinal cord stimulator trial was once again considered. After obtaining clearance from a psychiatrist and her primary care physician, Petitioner ultimately underwent that procedure on September 19, 2016. Petitioner returned to Dr. Harvey on November 15, 2016 reporting "great benefit during the trial" and wanting to discuss permanent placement. Dr. Harvey performed a thoracic laminectomy for the insertion of a spinal cord stimulator on December 28, 2016 at Riverside Medical Center without complication. He subsequently prescribed physical therapy and a functional capacity evaluation. Upon reviewing a valid functional capacity evaluation placing her at the medium level and discussing Petitioner's job duties with her, Dr. Harvey released Petitioner from his care on April 6, 2017 with permanent restrictions consisting of no lifting over 40 pounds, limited bending and twisting, and the allowance of frequent breaks as needed.

Dr. Harvey testified via evidence deposition dated March 4, 2016. PX 1. The Arbitrator notes the testimony was given prior to Petitioner's receipt of the trial spinal cord stimulator in September 2016. The Arbitrator again notes that the dispute at trial concerns the care and treatment Petitioner received after April 27 2015. ARB EX 1.

With regard to Petitioner's treatment after April 2015, Dr. Harvey testified that he believed Petitioner continued to have valid pain symptoms and post laminectomy syndrome subsequent to December 2014 including at the time she was examined by Dr. Mather. Dr. Harvey testified that Petitioner never exhibited non-organic findings or exhibit positive Waddell's signs. P. 30. He concluded the cause of Petitioner's continued back pain was multi-factorial with the most common cause being scarring or adjacent level disease. P. 31. He reviewed a second CT scan from June 15, 2015 which the radiologists again interpreted as showing no fusion. Thereafter, Dr. Harvey continued to recommend different treatment forms in deference to the radiologist readings but all treatment was denied. P. 33. At the time of deposition in March 2016, he continued to recommend Petitioner for the trial stimulator. P. 34. He also continued his recommendation that Petitioner stay off work at the time. P. 35. Petitioner had not yet reached MMI in his opinion. Lastly, he testified that Petitioner's continued current condition of ill-being was multi-factorial and causally related to her accident.

Dr. Mather testified via evidence deposition on October 20, 2016. RX 1. This testimony was given after the trial stimulator in September 2016. At the time of the Section 12 exam in November 2014, Dr. Mather

assessed Petitioner with status post L4-5 minimally invasive fusion with a potential for non union due to continued smoking and that it was possible her pain was psychogenic or the result of functional overlap. P. 35. He recommended the CT scan performed in December 2014 and agreed with Dr. Harvey that it showed some fusion. He disagreed with the radiologist reading of no bony fusion. P. 41. He testified that "...since the fusion is solid, it would be inappropriate to order a bone stimulator." P. 43. In his opinion, Petitioner had not "real reason" to have continued complaints as of April 2015 based on his reading of the December 2014 CT scan and the lack of objective support for Petitioner's continued complaints. P. 44,78-80. He characterized Petitioner as "emotional." P. 36. He disagreed with the need for a spinal cord stimulator as well indicating that Petitioner's fusion was solid without screw loosening. He placed Petitioner at MMI based on the CT scan as of April 2015 and without need for further treatment. P. 47. Lastly, he testified that his MMI opinion would not change if Petitioner received the spinal cord stimulator that proved to relieve some of Petitioner's pain. P. 76.

Petitioner testified that she had been employed by Respondent as an overnight stocker for approximately five years prior to her work accident in 2012 and that her job duties required the ability to bend, twist and to lift items in excess of forty pounds. Petitioner testified that she has not worked since her date of accident and that she currently receives Social Security Disability income. She also testified that that she voluntarily resigned her employment with Respondent on March 8, 2013 in order to obtain funds from her 401(k). Petitioner testified that she continued to receive TTD benefits after she resigned from Respondent through April 2015. Mr. Joe Phillips testified on behalf of Respondent. Mr. Phillips is the current store manager at the Bourbonais Illinois Wal-Mart. Mr. Phillips testified that he has been employed with Wal- Mart for several years in management and that he is very familiar with the light duty work available to injured workers. Mr. Phillips testified that Wal-Mart can and does accommodate any restriction for an injured employee. Mr. Phillips testified that even sedentary work can be accommodated for the injured employee if the employee requests such a position. Mr. Phillips testified that he know the petitioner as he was the Assistant Store Manager when she was injured. Mr. Phillips testified that Ms. Reynders never sought employment with him after petitioner resigned her employment in March 2013.

Petitioner testified that she had no prior problems or symptoms in her back prior to her work accident and that she has continued to suffer from various degrees of symptoms ever since. She testified that the spinal cord stimulator has reduced the stabbing pain and the pain that otherwise shoots down her legs. She also testified that she turns the stimulator on at night and that the same allows her to sleep. She testified that she continues to take Cymbalta and Tramadol for symptomatic relief, but that she takes less medication than she did prior to undergoing the implant and no longer takes Norco. She testified that certain activities increase her pain, such as sitting without something to lean against or walking long distances. She also testified that she no longer participates in many activities she used to enjoy with her grandchildren and that she no longer walks her dogs.

The Arbitrator has reviewed Respondent Exhibits 7 and 8 which are surveillance video of petitioner engaged in various activities in October and November 2016 well after the stimulator trial in September 2015. Petitioner does not appear to be in any discomfort in the videos reviewed and appears to be actively engaged in running errands and performing various cleaning activities outside of her home. She is also seen lifting shopping bags and bending actively at the waist.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

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

The undisputed evidence presented at trial reveals that Petitioner was asymptomatic with regard to her low back prior to her work accident of July 3, 2012 and that she has consistently treated for her injury since the accident through April 6, 2017. Both Petitioner's treating neurosurgeon, Dr. Harvey, and Respondent's Section 12 examiner, Dr. Mather, agree that Petitioner's need for the fusion surgery was caused by the July 3, 2012 accident. Their opinions, however, differ in relation to the care rendered after April 8, 2015, the date Dr. Mather issued his addendum report declaring that Petitioner's fusion was solid, that Petitioner had reached maximum medical improvement, and that Petitioner required no further medical care as detailed above.

Dr. Harvey testified in his evidence deposition that though he "basically" agreed with Dr. Mather's interpretation of Petitioner's CT scan and that Petitioner had a "decent fusion", he was still willing to defer to the opinions held by each of the two radiologists who interpreted Petitioner's CT scans as demonstrating pseudoarthrosis and to attempt to treat Petitioner's condition with an external bone growth stimulator. However, the bone growth stimulator was never approved by Respondent's worker's compensation program. Dr. Harvey further testified that even if Petitioner's fusion was solid, that there were other possible anatomical explanations condition, scar tissue formation, and/or adjacent level disease. He also testified that he believed that Petitioner's ongoing complaints after the surgery were real and that in his opinion, Petitioner never showed signs of malingering or non-organic back pain. Thus, Dr. Harvey eventually referred Petitioner to Dr. Hasan for consideration of a spinal cord stimulator trial and eventually performed a permanent spinal cord stimulator implant procedure that appears to have successfully treated and lessened some of Petitioner's symptoms as evidenced by the video of October and November 2016.

The Arbitrator finds that there is no question that Petitioner sustained a low back injury as a result of the work accident that necessitated the one level fusion surgery. Again, Respondent is only contesting the reasonableness and necessity of the treatment performed after April 27, 2015, including the permanent spinal cord stimulator implant. Based upon the opinions held by Petitioner's treating physicians, Dr. Harvey and Dr. Hasan, as well as the psychiatric screening ordered by Dr. Hasan, and the Petitioner's credible testimony and progression of symptoms as documented in the medical records, the Arbitrator finds that treatment rendered to Petitioner after April 27, 2015 was reasonable and that the need for the same was caused by the work accident of July 3, 2012. In so finding the Arbitrator places greater weight on the opinions held by Dr. Harvey that on those held by Dr. Mather. The Arbitrator further notes the improvement in Petitioner's condition subsequent to the treatment she received after April 2015 in finding that treatment reasonable and necessary.

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

Respondent's dispute with regard to medical expenses incurred after April 27, 2015 was based solely on liability. ARB EX 1. Based on the Arbitrator's findings on the issue of causal connection stated above, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expense incurred after April 27, 2015 and those reflected in Petitioner's exhibits 66-72 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

K. What temporary benefits are in dispute?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a total period of 246-4/7 weeks commencing July 16, 2012 the date Petitioner saw Dr. Milik and was placed on light duty. Respondent stipulated to the TTD period commencing July 16, 2012 through April 27, 2015. ARB EX 1.

Based on the Arbitrator's findings on the issue of causal connection subsequent to April 27, 2015, and on the medical records and testimony of Dr. Harvey and records of Dr. Hasan, the Arbitrator further finds that Petitioner is entitled to TTD for the additional period of April 28, 2015 through the date of her release on April 6, 2017, with permanent work restrictions. Respondent shall receive credit for amounts paid.

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

In considering the permanent disability in this matter, the Arbitrator shall base the determination on the following factors pursuant to Section 8.1b(b) of the Act: (1) 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 are explained below.

The Arbitrator initially notes that though Respondent offered Dr. Mather's April 8, 2015 impairment rating was admitted into evidence over Petitioner's objection, the same is given no weight by the Arbitrator because it was performed before the Petitioner reached maximum medical improvement. Section 8.1b(a) requires the rating physician to use the 6th Edition of the AMA's "Guides to the Evaluation of Permanent Impairment" (hereinafter "the Guides") in determining the level of impairment. The Guides clearly require the patient to have reached maximum medical improvement before a physician can conduct an impairment rating. Based on the Arbitrator's finding that Petitioner had not reached maximal medical improvement as of April 8, 2015, the Arbitrator finds that Dr. Mather's impairment rating does not comply with Section 8.1b(a) of the Act and gives it no weight. Thus, the remaining enumerated factors were considered as follows:

The Arbitrator finds that Petitioner was 57 years of age at the time of the accident. As stated above, the Petitioner sustained a disc herniation and radiculopathy that was treated unsuccessfully by a one-level fusion and ultimately resulted in a diagnosis of failed back syndrome which necessitated a permanent spinal cord stimulator implant. The Arbitrator notes Petitioner's continued complaints of pain in her back and legs and that these complaints interfere with Petitioner's activities of daily living, including her ability to walk her dogs and to play with her grandchildren. The Arbitrator further notes Petitioner's testimony that she continues to use the spinal cord stimulator and to take prescription pain medicine at present in order to relieve her symptoms. The Arbitrator further notes the videos depicting Petitioner's ability to ambulate freely and without pain after the stimulator trial. The Arbitrator assigns these factors some weight.

With regard to Petitioner's occupation and her future earning capacity, the Arbitrator finds that the permanent restrictions placed on Petitioner by Dr. Harvey would, at the very least, partially incapacitate her from returning to her former occupation as an overnight stocker. However, there was no additional evidence offered at trial that would indicate that Petitioner's earning capacity has diminished as a result of her permanent work restrictions. The Arbitrator gives these factors little weight.

Based on the foregoing and on the record as a whole, the Arbitrator finds that Petitioner sustained 30% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

O. Admissibility of RX9

Petitioner asserts that the impairment rating provided by Respondent's Section 12 examiner, Dr. Mather, on April 8, 2015 should not have been admitted into evidence based on the Respondent's failure to disclose the April 8, 2015 report in accordance with the requirements of Section 12. In admitting the report into evidence, the Arbitrator notes that Petitioner was afforded the opportunity to cross examine Dr. Mather on the report (without waiver of the objection) and that the report was admitted at trial over objection with the note that it would be given the weight it merited among the other relevant factors. For the reasons noted above, the Arbitrator gave the report no weight.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENISE MCMULLEN,

Petitioner,

vs. NO: 14 WC 14793

CITY OF CHICAGO,

Respondent.

20IWCC0107

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's award of 6.75% person-as-a-whole and finds that Petitioner is entitled to 3.5% person-as-a-whole. The Commission adopts the Arbitrator's analysis of Section 8.1(b) and the weight assigned to each subsection. The Commission, however, finds that the evidence supports a reduction in the permanency award due to the nature of the injury. The Petitioner was diagnosed with a lumbar sprain following her injury. The MRI revealed multiple levels of degenerative disc disease most pronounced at L2-L3. She underwent two epidural steroid injections, physical therapy, and was returned to work full-duty and without restrictions. The Commission finds that 3.5% person-as-a-whole is proper and more in line with the evidence in the record. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 29, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $964.28 per week for a period of 28-6/7 weeks (January 21, 2014 through August 10, 2014), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 17.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 3.5% loss of use of the person-as-a-whole.

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

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

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

DATED: FEB 14 2020

DDM/tdm
d: 2/5/20
052

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McMULLEN, DENISE
Employee/Petitioner

Case# **14WC014793**

CITY OF CHICAGO
Employer/Respondent

20IWCC0107

On 1/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2675 COVEN LAW GROUP
MATTHEW T SMART
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

0010 CITY OF CHICAGO DEPT OF LAW
DONALD CHITTICK
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Denise McMullen
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **14** WC **14793**

Consolidated cases: **N/A**

20IWCC0107

An *Application for Adjustment 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 **11/29/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/4/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**75,213.75**; the average weekly wage was $**1,446.42**.

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 $**28,929.60** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**28,929.60**.

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

ORDER

Respondent shall pay Petitioner $**721.66**/week for **33.75** weeks since Petitioner, as a result of the accident of **1/4/14** sustained a **6.75%** loss of use of her person as a whole, pursuant to Section 8(d)2 of the Act.

Respondent shall pay Petitioner $**964.28**/week from **1/21/14** through **8/10/14**, which represents a period of **28-6/7** weeks, because she was temporarily totally disabled during this time, pursuant to Section 8(b) of the Act.

Pursuant to *Messamore v. Indus. Comm'n*, 302 Ill. App.3d 351, 358-59 (4th Dist. 1999), Respondent may apply a TTD overpayment to the PPD award.

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

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

Signature of Arbitrator

1-28-2019
Date

JAN 2 9 2019

Denise McMullen v. City of Chicago

14 WC 14793

Findings of Fact

On 1/4/14, Petitioner was employed by Respondent as an Assistant Division Superintendent for the Department of Streets and Sanitation. She testified that such job can be light or heavy. On 1/4/14, Petitioner was 59 years of age and had been employed by Respondent since 1986.

Petitioner testified that prior to 1/4/14, her back was okay. In about 1985 or 1986, Petitioner continued, she hurt her back when the truck she was driving hit a pothole. At that time, she took Ibuprofen for the pain but did not undergo surgery.

On 1/4/14, Petitioner was at work, was sitting at her desk, and was assigning work to different drivers when she dropped her pen. Petitioner bent over to retrieve the pen. However, the floor was wet the snow that had been tracked in. Then the chair on which she was sitting slipped out from under her, and she held on so that she would not fall. At that time, she experienced achiness in her lower back.

Petitioner testified that she reported the injury to her supervisor but did not seek medical attention that day because it was a Saturday and MercyWorks was closed. Furthermore, Petitioner testified, they were in the middle of a snow operation at that time.

On 1/20/14, over two weeks after this incident, Petitioner presented to Dr. Homer Diadula at MercyWorks for initial treatment (Px1). On 1/20/14, Dr. Diadula diagnosed Petitioner with a lower back strain, prescribed medication, recommended a course of physical therapy, and took her off work.

On 2/3/14, Petitioner testified, she was in pain; her low back pain radiated down her leg.

On 2/6/14, Petitioner consulted with Dr. Mark Nolden of Northshore University Health System. He noted that Petitioner had a "low back pain episode" approximately 20 years prior (Px2). At that time, Petitioner's chief complaint was low back pain radiating to the bilateral buttocks and posterior thighs. Dr. Nolden concurred with Dr. Diadula's recommendation for physical therapy. On 3/18/14, Petitioner returned to Dr. Nolden, who recommended Petitioner undergo an MRI of the lumbar spine.

On 3/20/14, Petitioner underwent an MRI of the lumbar spine. The radiologist's impression of the MR images is as follows: "Multiple level degenerative disc disease most pronounced at L2-L3. Facet degenerative changes particularly at L4-L5 and to a lesser extent at L3-L4 with lateral narrowing at L4-L5 particularly on the left." (Px1)

On 4/9/14, Petitioner returned to Dr. Nolden, who reviewed Petitioner's imaging. He stated that, overall, her MRI does not look too bad. He found the images reveal mild disk desiccation from L2 to the sacrum with good disk space height preservation at all levels. He found significant facet arthopathy at L4-L5 resulting in only mild spinal stenosis at this level. Dr. Nolden recommended she receive an epidural steroid injection and released her to return to work with no lifting greater than 25 pounds. (Px2).

On 6/13/14, Petitioner received an L4-L5 epidural steroid injection administered by Dr. Matthew Co. of Northshore University Health System (Px2). Petitioner testified that the pain got somewhat better after the injection.

On 7/16/14, Petitioner presented to Dr. Gregory Primus of the Chicago Center for Sports Medicine and Orthopedic Surgery for a Section 12 examination. (Rx1). Following his examination of Petitioner and review of her medical records, Dr. Primus issued a report in which he found Petitioner had reached maximum medical improvement (MMI) and was capable of returning to work full duty with no restrictions.

On 8/8/14, Petitioner followed up with Dr. Co. At that time, she reported a 50% improvement in her symptoms. Dr. Co ordered a second epidural injection and prescribed medication. With regard to Petitioner's work status, Dr. Co wrote: "She was given a letter today stating she may return to work with full duty without restrictions (sic) as she requested today." (Px2)

On 8/11/14, Petitioner did return to work her usual and customary position, full duty with no restrictions.

On 1/23/15, following her return to work, Petitioner received a second epidural steroid injection from Dr. Co (Px2).

Petitioner testified that at Athletico, she underwent a course of physical therapy as well as a course of work conditioning.

Petitioner testified that, presently, she has pain every day. However, she gets around it. If she ties her shoes or sits too long, her back pain flares up.

Petitioner testified that, upon returning to work, she resumed earning the same or higher wages as she had prior to her 1/4/14 injury. Petitioner testified that she continued to work full time, full duty until she retired in 3/15. Petitioner testified that the pain was increasing, and she decided to retire. On cross-examination Petitioner testified that no doctor told her that she could not work. Since she received the second injection, she has not sought more treatment for her lower back. After retiring in 2015, Petitioner testified, she did not seek medical care because she lost her health insurance. So, she managed her pain with over-the-counter medication. Petitioner further testified that she was eligible to receive her pension at the time of her retirement.

Conclusions of Law

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

The parties agree that on 1/4/14, Petitioner sustained an accident that arose out of and in the course of her employment by Respondent. When the chair slipped out from under her, Petitioner did not fall to the floor, but held on. Doctors Diadula, Nolden, and Co concur that Petitioner's condition stemmed from her January 4, 2014 accident.

However, in a report dated 8/4/14, Dr. Primus opined that as a result of the accident, Petitioner sustained a temporary exacerbation of her pre-existing lumbar disk disease and arthrosis. Dr. Primus found that the restrictions at that time were related to her pre-existing disease.

The Arbitrator finds the mechanism of injury to be a plausible source of an aggravation of disc desiccation with arthropathy and stenosis in the lumbar spine. By a preponderance of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being - - aggravation of disc desiccation with arthropathy and stenosis in the lumbar spine - - is causally related to the accident of 1/4/14.

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

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

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

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

With regard to subsection (i) of §8.1b(b), the reported level of impairment pursuant to subsection (a), the Arbitrator notes that neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. The Arbitrator finds that an impairment rating is not necessary based on the Appellate Court's holding in *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016). The court held that an AMA Impairment Rating is not required for the Arbitrator to award permanent partial disability benefits. *Id.* Accordingly, the Arbitrator will not consider this factor as it relates to the nature and extent of the injury.

With regard to subsection (ii) of §8.1b(b), the occupation of the injured employee, the Arbitrator notes that on 1/4/14, Petitioner was employed by Respondent as an Assistant Division Superintendent. She testified that this job could be light or heavy but did not elaborate on her work duties. On 1/4/14, Petitioner was sitting at a desk handing out work assignments just before she bent over to pick up her pen. Yet, when Petitioner was given a 25-pound lifting restriction, Respondent did not accommodate such restriction but paid TTD. Later, Doctors Nolden, Co and Primus authorized her to return to full-duty work with no restrictions. Subsequently, Petitioner did return to work full duty as an Assistant Division Superintendent. The Arbitrator finds that these facts weigh in favor of slightly decreased permanence. The Arbitrator places moderate weight on this factor.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 59 years old. As such, the Arbitrator considers her to be an older worker. The Arbitrator gives moderate weight to this factor. He finds that Petitioner's age weighs in favor of decreased permanence as she has fewer years of productivity remaining.

With regard to subsection (iv) of §8.1b(b), the employee's future earning capacity, the Arbitrator notes that Petitioner's future earning capacity was unaffected by her 1/4/14 accident because she returned to full-duty work with no restrictions following the releases from Doctors Nolden, Co and Primus. Petitioner testified that, upon returning to work, she earned the same or higher wages as she had prior to her 1/4/14 accident. Petitioner testified that the pain was increasing, and she decided to retire. On cross-examination Petitioner testified that no doctor told her that she could not work at the time she retired. There is no evidence that any doctor imposed work restrictions on her at the time she retired. Since she received the second injection, she has not sought more treatment for her lower back. Therefore, the Arbitrator concludes that Petitioner chose to retire. The Arbitrator finds that these facts weigh in favor of slightly decreased permanence. The Arbitrator places moderate weight on this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on 1/4/14, Petitioner sustained an aggravation of a pre-existing condition that consisted of disc desiccation with arthropathy and stenosis of the lumbar spine. She received care from the Dr. Diadula and the MercyWorks staff, Dr. Nolden, Dr. Co, and the staff at Athletico Physical Therapy. MR images of the lumbar spine were interpreted as follows: "Multiple level degenerative disc disease most pronounced at L2-L3. Facet degenerative changes particularly at L4-L5 and to a lesser extent at L3-L4 with lateral narrowing at L4-L5 particularly on the left." Dr. Nolden thought that the MRI did not look too bad and found that she had mild disk desiccation from L2 to the sacrum, good disk height at all levels, and significant facet arthropathy at L4-L5 that resulted in only mild spinal stenosis at this level. Petitioner underwent extensive physical therapy and received two epidural steroid injections for her accidental injury.

These facts weigh in favor of increased permanence. The Arbitrator gives moderate weight to this factor.

Determination of permanent partial disability ("PPD") is not simply a calculation but is an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator finds that as a result of the 1/4/14 accident, Petitioner has sustained a permanent loss of use of her person as a whole to the extent of 6.75%, pursuant to Section 8(d)2 of the Act.

Brian T. Cronin
Arbitrator

1-28-2019
Date

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF KANKAKEE)	☐ 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

Barry Osterhoff,
Petitioner,

vs. No. 14 WC 26319

Village of Bradley,
Respondent.

20IWCC0108

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, notice, causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Corrected Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On page 2 of the Corrected Arbitration Decision, the Arbitrator ordered Respondent to, "pay all reasonable and necessary medical services related to the treatment of Petitioner's left hand from June 17, 2014 through May 10, 2014, as provided in Section 8(a) and Section 8.2 of the Act." However, on page 8 of the Attachment to Arbitration Decision, the Arbitrator found, "that Respondent shall pay for all of the Petitioner's related medical treatment from the date of accident to May 10, 2016, the last time he followed up with Dr. Muhammad…"

20 I W C C 0 1 0 8

The Commission finds that the order on page 2 of the Corrected Arbitration Decision contained a clerical error regarding the date through which Respondent is to pay medical. The Arbitrator's finding on page 8 of the Attachment to Arbitration Decision makes clear that the Arbitrator meant to order Respondent to pay Petitioner's medical expenses through May 10, 2016; not through May 10, 2014. The Commission agrees that Respondent shall pay Petitioner's medical expenses from the date of accident through May 10, 2016. Accordingly, the Commission modifies the dates for which Respondent is ordered to pay Petitioner's medical, to: June 17, 2014 through May 10, 2016.

Also, the Commission notes that the Arbitrator, in his decision, omitted assigning a weight to subparagraph *(v)* of Section 8.1b(b), "Evidence of disability corroborated by the treating records." It is clear, however, that the Arbitrator did consider evidence of disability corroborated by the treating medical records. The Arbitrator stated, on page 9 of the Attachment to the Arbitrator Decision, the evidence he considered regarding subparagraph (v): that Petitioner testified credibly of having ongoing left hand symptoms, especially in the colder months; that his ongoing complaints were corroborated by the treating medical records, and that his complaints were also corroborated by the reports of the Section 12 examiners.

The Commission concurs with the Arbitrator's findings relative to subsection *(v)* of Section 8.1b(b), and accordingly, assigns moderate weight to this factor. With regard to factors (i) through (iv), the Commission affirms and adopts the Arbitrator's findings, determinations and weights assigned to them, and affirms and adopts the Arbitrator's finding that Petitioner's injuries caused a 15% loss of the left hand as provided in Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed on March 19, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's Corrected Decision finding that Respondent pay all reasonable and necessary medical services related to the treatment of Petitioner's left hand from June 17, 2014 through May 10, 2014, is vacated. Respondent shall pay all reasonable and necessary medical services related to the treatment of Petitioner's left hand from June 17, 2014 through May 10, 2016, as provided in Section 8(a) and Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that moderate weight is assigned to subsection *(v)* of Section 8.1b(b) of the Act. The Commission affirms and adopts the Arbitrator's findings, determinations and weights which the Arbitrator assigned to subparagraphs *(i)* through *(iv)* of Section 8.1b(b) of the Act, and the Commission affirms and adopts the Section 8(e) award of 15% loss of use of the left hand.

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

20IWCC0108

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: FEB 14 2020

o-12/19/19
mp/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

OSTERHOFF, BARRY
Employee/Petitioner

Case# **14WC026319**

VILLAGE OF BRADLEY
Employer/Respondent

20IWCC0108

On 3/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% 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:

3269 SPIROS LAW PC
SANDRA K LOEB
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

0507 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
CORRECTED

Case # **14** WC **026319**

Barry Osterhoff,
Employee/Petitioner
v.

Village of Bradley
Employer/Respondent

20 I W C C 0 1 0 8

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Kankakee, Illinois**, on **1/19/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 17, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$56,103.32**; the average weekly wage was $**1078.91**.

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 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 $**6730.07** under Section 8(j) of the Act.

ORDER

Respondent shall pay all reasonable and necessary medical services related to the treatment of Petitioner's left hand from June 17, 2014 through May 10, 2014, as provided in Section 8(a) and Section 8.2of the Act.

Respondent shall be given a credit of $6,730.07 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 $719.27/week for 9-6/7 weeks, commencing 12/10/15 through 2/16/16, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $647.35/week for 28.5 weeks because the injuries sustained cause 15% loss of the left hand as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

2/27/18
Date

MAR 1 9 2018

FINDINGS OF FACTS:

Petitioner, a 60 year old maintenance worker, alleges he sustained an accidental injury to his left hand due to repetitive work activities that arose out of and in the course of his employment with Respondent and manifested itself on June 17, 2014. Prior to hearing, Petitioner's attorney filed an Amended Application for Adjustment of Claim, amending the date of accident from February 17, 2014 to June 17, 2014. (Arb.2)

Petitioner testified that he worked for Respondent for approximately 21.5 years prior to the alleged date of accident in the maintenance/public works department. His employment was fulltime, 8 hours per day and 40 hours per week. A written job description prepared by Respondent was admitted into evidence as Respondent's Exhibit No. 7. Petitioner testified that although he performed most of the varied job duties set forth in Respondent's Exhibit 7, at some point during his employment with Respondent, the vast majority of his time was spent mowing and landscaping parks during the spring and summer months and performing snow-removal and equipment repairs during the winter months.

Petitioner testified that during the spring and summer months, 80% of his workday, or about 6 hours, consisted of mowing grass in the parks spread throughout the Village of Bradley, Illinois. Petitioner testified that the size of the parks he mowed varied, with the largest park being approximately fifteen acres, and the smallest park being about one-quarter of an acre. He further testified that it would take him approximately six hours to mow a single large park, while he could complete mowing some of the smaller parks in approximately one hour. Petitioner further testified that when mowing smaller parks, he would mow numerous parks in the same day.

Petitioner testified that he operated a Farris-Z riding mower and that in doing so, he was constantly "working his hands and wrists" in order to control and maneuver the machine. Petitioner stated that in order to operate the mower, he had to maintain a grip on the handles of the mower at all times and that those handles needed to be pushed forward and back whenever he changed directions or encountered obstacles such as fences, fence poles, and park benches. Petitioner also testified that he regularly encountered such obstacles and that each time he did, it would require him to both to bend his wrists forward and extend them backwards multiple times with pushing and pulling on the mower's handles. Petitioner provided that while it didn't take heavy force to push the handles back and forth, he had to employ "a lot" of back and forth motion in an effort to avoid the above referenced obstacles. Petitioner demonstrated the repetitive wrist flexion and extension that was required while operating the riding mower during his testimony.

Petitioner testified that the remaining 20% of his job duties in the spring and summer months consisted mostly of performing other landscaping duties such as weed whipping. He testified the weed whip weighed about fifteen pounds, and that he would carry it by grabbing the top by the motor with his right hand and the handle down the shaft with his left hand, anywhere from ten minutes to an hour at a time, depending on the size of the park he was trimming. Petitioner explained that while holding the weed whip, he would constantly swing his left hand back and forth following weeds. Petitioner testified that this motion required his left wrist to bend forwards and to extend backwards "a little bit." He also testified that weed whip was heavy and would feel progressively heaver, the longer he operated it.

Petitioner also testified that, when needed, he spent some of this time during the summer months performing other park maintenance duties such as repairing fences, raking, spreading mulch, and repairing playground equipment and park benches utilizing various hand tools.

Petitioner testified that on one occasion, sometime during the Spring or Summer months of 2014, he was required to use a sod cutter to carve out baseball diamonds in the parks. Petitioner testified that he spent two full days using the sod cutter which was a very heavy machine with a steel handle and blade approximately eighteen inches long. Petitioner testified that when operating the sod cutter, he had to grip the steel handle very tightly in order to maintain control of the machine and to prevent it from "getting away" from him. He further testified that when operating the sod cutter, the machine vibrated and jumped such that it was "vibrating [his] whole body." Petitioner testified that though he experienced symptoms of numbness and tingling in his left hand before using the sod cutter machine, his symptoms increased dramatically after the two days of its use.

Petitioner first saw his primary care physician, Dr. Wroblewski for a prescheduled diabetic check-up appointment on June 17, 2014. Dr. Wroblewski's medical record indicates that Petitioner complained of numbness, stinging, and burning sensation in the first three digits on his left hand "for a couple months" and that those symptoms "can interfere with sleep." Dr. Wroblewski's record suggests a past medical history of type II diabetes, hypertension, hyperlipidemia, obesity and peripheral neuropathy, among other conditions. On examination, Petitioner had a positive Tinel's sign on the left and a negative Phalen's sign. His upper extremities were normal with no edema noted. Petitioner was diagnosed with left carpal tunnel syndrome and was referred to Dr. Kermit Muhammad, an orthopedic hand surgeon. (PX 6)

Petitioner was first seen by Dr. Muhammad at OAK Orthopedics on June 24, 2014. At that visit, Petitioner complained of numbness and tingling and pain in his left hand. According to Dr. Muhammad's notes Petitioner reported that his condition was not work related. Dr. Muhammad's examination showed positive Tinel's at the median nerve, and a positive Phelan's test on the left upper extremity. Dr. Muhammad diagnosed Petitioner with carpal tunnel syndrome on the left and recommended an EMG/ nerve conduction study for further evaluation. (PX 7)

On July 8, 2014, Petitioner underwent the prescribed EMG/NCV studies that revealed electrodiagnostic evidence of severe carpal tunnel syndrome on the left, and moderately severe carpal tunnel syndrome on the right. There was also electrodiagnostic evidence of a sensorial peripheral nerve polyneuropathy bilaterally (PX 9) Petitioner was seen by Dr. Muhammad for follow-up on July 11, 2014. At that visit, Dr. Muhammad reviewed the EMG findings and recommended Petitioner undergo a left carpal tunnel release surgery. (PX 10)

Petitioner underwent pre-surgical clearance with his primary care physician, Dr. Wroblewksi, on July 15, 2014. Dr. Wroblewski noted Petitioner had "...left carpal tunnel symptoms for about 8 months, severe for the last 3 months." In addition to noting Petitioner's pain interfered with his sleep, Dr. Wroblewski also noted that Petitioner "...has repetitive wrist movements with work, including different machinery." Dr. Wroblewski assessed Petitioner as medically stable for carpal tunnel release surgery. (PX 11)

Petitioner testified that he notified his employer of his condition on July 17, 2014. On July 21, 2014, Petitioner and his supervisor, James Bessler, completed a "Report of Public Liability Accident" form and an Illinois Form 45. The Form 45 was signed by Mr. Bessler and indicates that Petitioner suffered from left-sided carpal tunnel due to repetitive injury. (PX 5, PX 8)

On September 8, 2014, Petitioner presented to Dr. Craig Phillips for a Section 12 examination. According to Dr. Phillips, Petitioner reported a five month history of symptoms which included burning in the tips of his fingers, and numbness in his thumb, index, and middle fingers. Dr. Phillips noted Petitioner felt his symptoms began insidiously and got progressively worse. Dr. Phillips took a work history from Petitioner, who reported he worked at Village of Bradley Public Works as a laborer for about twenty years, and that his job primarily involved using a lawnmower, a weed whip, hand tools to repair the mower, driving a snowplow, and driving a truck. Dr. Phillips also reviewed the written job description prepared by Respondent that described additional and varied job duties performed by Petitioner at various times throughout his employment. After

performing an examination and reviewing medical documentation, Dr. Phillips diagnosed Petitioner with severe carpal tunnel syndrome, left greater than right, and noted left carpal tunnel release surgery was reasonable and necessary given Petitioner's condition. Dr. Phillips opined in his report that Petitioner's carpal tunnel syndrome was due to his diabetes as well as his narrowed carpal tunnels. Dr. Phillips indicated that he could find nothing in Petitioner's job description or in his verbal description of his job that would put him at high risk for developing carpal tunnel syndrome. (RX 1, Dep. Ex.2)

On October 14, 2014, Petitioner followed up with Dr. Muhammad who indicated in his medical record that Petitioner was previously scheduled for left carpal tunnel release surgery, but was unable to proceed due to insurance approval issues. Dr. Muhammad continued to recommend left carpal tunnel release surgery. (PX12) Petitioner testified that he carried a letter written by his attorney to the October 14th appointment. The October 14, 2014 letter requested Dr. Muhammad take a detailed work history from Petitioner and opine whether or not Petitioner's work activity contributed to or increased his risk of developing carpal tunnel. On November 6, 2014, Dr. Muhammad authored a narrative report. Dr. Muhammad wrote, "An assessment of this case is a pretty straightforward case of carpal tunnel although there is the associated diagnosis of poly neuropathy…In reference to causation of his carpal tunnel, this is always a difficult question to answer as most cases of carpal tunnel are idiopathic although in relation to work and repetitive use these are definitely contributing and exacerbating factors. Because of the type of labor involved, I would feel comfortable in saying that this related to and worsened by his work conditions." (PX 1, Dep. Ex. 2)

Petitioner underwent carpal tunnel release surgery by Dr. Muhammad on December 10, 2014. (PX 13) Petitioner tolerated the procedure well without complication. From December 18, 2014 through February 5, 2015, Petitioner underwent a course of physical therapy at River Valley Physical Therapy and was fitted for a splint at ATI Physical Therapy. As of his February 5, 2015 discharge from therapy, Petitioner had ongoing constant pain in his left volar wrist which was aggravated by movement of the affected body part. Petitioner's diagnoses at discharge were status-post left carpal tunnel release, limited finger range of motion, and numbness. Petitioner was instructed to continue a home exercise program independently. (PX 15, PX 16)

On February 9, 2015, Petitioner saw Dr. Muhammad for what was presumed to be a final follow-up visit. Petitioner reported that he still had pain and swelling, and that his numbness, tingling, and weakness continued to slowly improve. Dr. Muhammad allowed Petitioner to return to full duty work as of February 17, 2015 and instructed him to continue his home exercise program and to follow up as needed. (PX 14) Petitioner testified that he returned to work full duty with Respondent from that date until he retired from his employment in February 2016.

Dr. Muhammad testified via deposition in this matter on May 11, 2015. Dr. Muhammad testified that he took a history from Petitioner concerning his work duties on October 14, 2014 and reviewed the job description documented in Dr. Phillips' IME report. Dr. Muhammad ultimately opined that Petitioner's work duties significantly contributed to his development of his carpal tunnel. (PX 1, pp. 10-13) When questioned regarding certain specific job duties, Dr. Muhammad testified that Petitioner's use of a lawn mower or weed whip can exacerbate carpal tunnel if it involves sitting with the wrist in a flexed position or in a position that aggravates compression of the median nerve. Dr. Muhammad also testified that using a weed whip can exacerbate carpal tunnel due because it is a manual and repetitive activity. (PX 1, pp. 12–13)

During cross-examination, Dr. Muhammad admitted that he did not know exactly what it took to do any of Petitioner's job duties, or the exact hand positions involved. Nevertheless, he provided that if your hands are held in a certain position for a long period of time, that's something that can exacerbate or aggravate carpal tunnel. The doctor added that many of Petitioner's other job duties as they are documented in Respondent's written job description could also contribute to or worsen the condition, if they involve "extremes in extension or extremes in wrist flexion." (PX 1, p.17)

Dr. Muhammad confirmed that when he first saw Petitioner on June 24, 2014, Petitioner did not relate his complaints as work-related. (PX1, p. 21) It was not until his visit on October 14, 2014, that the doctor documented that Petitioner related his symptoms to his work duties. (PX 1, p. 25) Dr. Muhammad confirmed that Petitioner's history of diabetes is a contributing factor to his carpal tunnel syndrome, as well as his obesity and hypertension. (PX 1, p. 32-34) He also testified that activities involving repetitive flexion and extension of the wrist can increase the pressure in the carpal tunnel. (PX1, pp. 37, 40)

Dr. Phillips testified via deposition in this matter on September 8, 2015. According to Dr. Phillips, he reviewed the First Report of Injury, Dr. Muhammad's medical records, EMG studies as well as the written job description prepared by Respondent prior to formulating his opinions. He also took a history taken from Petitioner wherein Petitioner advised Dr. Phillips that his primary job duties included using a lawnmower, a weed whip, hand tools to repair the mower, driving a snow plow and driving a truck. The doctor stated that Petitioner did not have an answer when asked which of the job activities he felt contributed or caused his carpal tunnel syndrome. (RX 1, pp. 10-14)

Dr. Phillips testified that his examination revealed that Petitioner had severe left carpal tunnel syndrome. After his examination, review of the records, and work activities described by Petitioner, Dr. Phillips opined that Petitioner's work activities did not play a role in his developing or exacerbating carpal tunnel syndrome on either of the left or right side. (RX 1, p.18) Dr. Phillips testified that Petitioner's carpal tunnel syndrome most likely related to his underlying diabetes. Dr. Phillips did, however, agree that it would be reasonable for the Petitioner to undergo surgical release of his left carpal tunnel, and that he was not at maximum medical improvement as the time of his September 2014 examination. (RX 1, pp. 19- 21)

On cross-examination, Dr. Phillips testified that current literature suggests that people with prolonged wrist flexion and extension for 60 percent of their work day has shown to increase the risk of causing or exacerbating carpal tunnel syndrome. (RX1, p. 26) The doctor provided that simple griping and squeezing when not in terminal extension or flexion for a significant portion of an eight-hour day would not accelerate carpal tunnel syndrome. He added however, if the wrist was held for prolonged periods in a hyperextended or flexed positon, same can cause carpal tunnel syndrome. (RX 1, p. 27)

Dr. Phillips testified that not all patients with diabetes suffer from carpal tunnel syndrome and that patients with diabetes who engage in occupational activities that involve prolonged wrist flexion and extension are more likely to develop carpal tunnel syndrome than those who do not. (RX1, pp. 27-28) Dr. Phillip admitted that it was possible Petitioner's wrists would be in extension when he drove a lawn mower and that it was also possible that they were in flexion or extension when he operated the weed whip. The doctor admitted he could not state exactly which position Petitioner's wrist were in when operating the mower. He didn't know how long Petitioner held his wrist in any certain position while using the weed whip. He didn't know how long it took to mow a park or how many parks he mowed per day. Nor did he know how often Petitioner operated the weed whip. Dr. Phillips stated that his opinion that these activities did not contribute to Petitioner's carpal tunnel syndrome was based on the assumption that Petitioner was not performing these activities for prolonged time periods and that he engaged in multiple activities during his work day. (RX1, pp. 31-33)

At the request of his attorney, Petitioner was examined by Dr. Gary Kronen on April 19, 2016. Petitioner advised Dr. Kronen that he had experienced numbness and tingling, and a burning sensation in his left hand for "some months prior to" completing the First Report of Injury form and Illinois Form 45 on July 21, 2014. Petitioner also advised Dr. Kronen that his symptoms had worsened during the previous spring season when he was using a sod cutter which had a substantial amount of vibration. During Dr. Kronen's examination, Petitioner confirmed the written job description that was provided to Dr. Phillips regarding his job duties. Dr. Kronen' s opinion was that Petitioner's left hand carpal tunnel syndrome was a work-related condition. He

stated in his report that there was no single activity that Petitioner did on a repetitive basis that caused the condition. However, Dr. Kronen indicated that the overwhelming majority of Petitioner's employment required him to use forceful gripping of the bilateral upper extremities as well as to perform repetitive type activities. He also indicated that he found Petitioner's history of exacerbated symptoms after using the sod cutter to be significant. Dr. Kronen also noted that Petitioner was reporting minimal symptomatic improvement postoperatively and that there was concern of persistent carpal tunnel syndrome. He therefore recommended that Petitioner undergo repeat electrodiagnostic testing to determine whether there was any electrical resolution of Petitioner's carpal tunnel syndrome. Dr. Kronen further stated that depending on the results of that study, Petitioner could require a diagnostic corticosteroid injection and/or a second left carpal tunnel release. (PX 4)

On May 10, 2016, Petitioner returned to Dr. Muhammad with complaints of continued symptoms of burning with numbness in his fingertips on his left hand. Dr. Muhammad reviewed Petitioner's pre-surgical EMG study and noted that this showed severe left carpal tunnel syndrome as well as a sensory peripheral polyneuropathy. Dr. Muhammad indicated in his record that he was confident that Petitioner's carpal tunnel was released and that his residual nerve issues were likely due to his unhealthy nerves. Dr. Muhammad offered Petitioner no further treatment. (PX 17)

Petitioner underwent a second Section 12 examination with Dr. Phillips on December 29, 2016. Dr. Phillips reviewed the updated medical records and the evidence deposition testimony of Dr. Muhammed. He also took additional history from Petitioner concerning his work duties, including his use of the sod cutter during the Spring of 2014. It continued to be Dr. Phillips's opinion that Petitioner's left wrist carpal tunnel was not related to his work activities for Respondent. Dr. Phillips felt that nothing Petitioner did was very repetitive or traumatic or forceful on his wrists. He felt Petitioner's carpal tunnel was so severe that any and all activities would increase his symptoms. Again, he felt Petitioner had significant risk factors for developing carpal tunnel syndrome irrespective of Petitioner's work activities. Dr. Phillips also found Petitioner to be at MMI, and assessed Petitioner with an AMA impairment rating of 4% of the left upper extremity. (RX 2, Dep. Ex. 1)

Dr. Kronen testified via deposition in this matter on May 8, 2017. Dr. Kronen testified that he took his own history from Petitioner, who stated he had numbness and tingling in his hands for a few months prior to July 2014, that his symptoms worsened during the spring of 2014, shortly after using a sod cutter which involved a significant amount of vibratory activity. (PX. 3, pp. 8–9) Dr. Kronen further testified that he took a work history from Petitioner, who reported that he performed a variety of duties for Respondent. (PX. 3, p. 9) Dr. Kronen opined that while he related no one specific work activity as the cause for Petitioner's condition, it was his opinion that the totality of Petitioner's work duties, all of which required repetitive activity, forceful gripping, or use of vibratory tools, caused or contributed to cause Petitioner's left carpal tunnel syndrome. (PX. 3, pp. 28)

Dr. Kronen testified that he performed a physical examination of Petitioner which yielded positive findings, including a positive Tinel's sign, and persistent numbness and tingling. (PX. 3, p. 10) Dr. Kronen testified that he diagnosed Petitioner's condition as persistent left carpal tunnel syndrome, and that his diagnosis was made to a reasonable degree of medical certainty. (PX. 3, pp. 10-11)

Dr. Phillips testified by deposition a second time on June 20, 2017. Dr. Phillips confirmed his earlier testimony that the job duties described by Petitioner were not of a forceful, repetitive, or vibratory nature that would lead to the development of carpal tunnel syndrome. Dr. Phillips also confirmed his prior testimony related Petitioner's comorbidities. (RX 2)

In support of the Arbitrator's decision with regard to whether (C) an accident occurred that arose out of and in the course Petitioner's employment by Respondent; and (F) whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

An employee who suffers a repetitive trauma injury is still required to meet the same standard of proof as an employee who suffers a sudden injury. Durand v. Indus. Comm'n, 224 Ill. 2d 53, 64 (2006). "That means, inter alia, an employee suffering from a repetitive trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person." Id. at 65. This is otherwise known as the "manifestation date." Id. The manifestation date is "the date on which both the fact of the injury and causal relationship of the injury to the claimant's employment would become plainly apparent.'' Peoria County Bellwood Nursing Home v. Industrial Comm'n, 115 Ill.2d 524 (1987).

The Commission has previously found that in any particular case, there could be more than one date on which the injury "manifested itself." These dates could be based one or more of the following, depending on the facts of the case: (1) the date Petitioner first seeks medical attention for the condition; (2) the date Petitioner is first informed by a physician that the condition is work related; (3) the date Petitioner is first unable to work as a result of the condition; (4) the date when the symptoms became more acute at work; (5) the date that Petitioner first noticed the symptoms of the condition.

In this case, Petitioner is alleging an injury to his left hand due to repetitive work activities that arose out of and in the course of his employment and manifested itself on June 17, 2014. It is undisputed that June 17, 2014 is the date Petitioner first sought medical attention for his condition from his primary care physician, Dr. Wroblewski, as well as the first time he was ever diagnosed with carpal tunnel syndrome. Therefore, the Arbitrator finds that June 17, 2014 is the date on which both the fact of the injury and causal relationship of the injury to the claimant's employment would become plainly apparent.

The Arbitrator also finds that Petitioner sustained an accidental injury to his left hand that arose out of and in the course of his employment on that date. Based upon Petitioner's credible testimony concerning his work activities (including the frequency, duration, and manner of performing), as well as the opinions of Dr. Muhammad and Dr. Kronen, the Arbitrator finds Petitioner's work activities, at the very least, aggravated or exacerbated his left-sided carpal tunnel condition, though that condition most likely preexisted his accident date. The Arbitrator further finds that the testimony of Dr. Muhammad and Dr. Kronen is more persuasive than Dr. Phillips. The Arbitrator therefore concludes that that Petitioner's current condition of ill-being is causally related to the Petitioner's job duties with Respondent.

In support of the Arbitrator's decision with regard to (E) whether timely notice of the accident was given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner provided Respondent with timely notice of his repetitive trauma injuries. It is undisputed that Respondent, through its agent James Bessler, completed and signed a Report of Public Liability Accident and an Illinois Form 45 documenting Petitioner's claim of repetitive trauma injury on July 21, 2014, 34 days after the manifestation date of June 17, 2017.

In support of the Arbitrator's decision with regard to (J) whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having found the requisite causal relationship and that no evidence was introduced to dispute the reasonableness and necessity of the medical care rendered to Petitioner, the Arbitrator finds that Respondent shall pay for all of Petitioner's related medical treatment from the date of accident to May 10, 2016, the last time he followed up with Dr. Muhammad, as provided by in Section 8(a) and 8.2 of the Act. Additionally, Respondent shall be given credit of $6, 730.07 for medical benefits that have been paid, and Respondent shall

hold Petitioner harmless from any claims by any providers for which Respondent is receiving this credit, as provided in section 8(j) of the Act.

In support of the Arbitrator's decision with regard to (K) what temporary benefits are in dispute, the Arbitrator finds as follows:

Having found the requisite causal connection, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the time he held off work by Dr. Muhammad from December 10, 2014 to February 16, 2015, for a total of 9 and 6/7 weeks. No evidence contradicting Petitioner's entitlement to temporary total disability during this period was offered at trial.

In support of the Arbitrator's decision with regard to (L) what is the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to the most current edition of the American Medical Associations "Guides to the Evaluation of Permanent 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; (v) evidence of disability corroborated by the treating medical records, (820 ILCS 305/8.1b(b).

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 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 Dr. Phillips determined that Petitioner had a Partial Permanent Impairment of 4% Upper Extremity. The Arbitrator gives some 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 maintenance worker at the time of the accident and that he continued to work full duty in that occupation for approximately one year after he was released from Dr. Muhammad's care in February 2015 before he retired from that position. The Arbitrator gives little weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 60 years old at the time of the accident. Because of the length of time Petitioner will live with his permanent disabilities, the Arbitrator gives little weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner's credible testimony that he retired sooner than he had previously planned due to his injury. The Arbitrator gives some weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner credibly testified that he continues to experience ongoing symptoms in his left hand at present, especially during the colder months. Petitioner's ongoing complaints were corroborated by the medical records and by the reports of the Section 12 examiners.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 15% loss of use of the left hand pursuant to section 8(e) of the Act.

STATE OF ILLINOIS)	☐ Affirm and adopt (with explanation)	☐ 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 Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LIWANDA HENRY,

Petitioner,

20IWCC0109

vs.

NO: 15 WC 1469
15 WC 17028

FORD MOTOR COMPANY,

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 all issues, and being advised of the facts and law, modifies the award of temporary total disability benefits to February 13, 2016 to June 14, 2018. The Commission 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 (1980).

I. FINDINGS OF FACT

A. Accident

Petitioner alleged that she sustained right shoulder and radiating cervical injuries while working the overnight shift from October 10, 2014 to October 11, 2014. The two case numbers are duplicate filings for the same accident that cover the two dates during that overnight shift. As such, the Decision of the Arbitrator set October 10, 2014 as the accident date for Petitioner's injuries.

Petitioner was called to testify twice at the bifurcated hearing held on December 21, 2018 and February 22, 2019. She testified that on October 10, 2014, she was working with rag joints on the IP line. Petitioner explained that she was standing and pumping a rag joint when she felt a large blue bin, which was called a steering column bin, bump into her entire right side from her

neck to her foot. Petitioner gave some conflicting testimony as to whether she saw the impact coming. Petitioner testified that she was five feet tall, whereas the bin was significantly taller at eight feet or more. She described the bin as a large metal cart that held steering columns and was attached to a "tug buggy," which was also called a forklift. Petitioner identified PX 21 as a photograph of a similar bin and RX 3D through RX 3L as photographs of steering column carts.

Petitioner testified that her entire right side went numb immediately after being struck. She then promptly presented to Respondent's medical clinic on the accident date and filled out an accident report, which she identified as PX 2. However, Petitioner testified that PX 2 was not accurate, because she had not referred to a forklift or tug buggy in the report and she had incorrectly referred to the steering column cart as a blue bin. Petitioner further explained that, as she was filling out PX 2, she felt under pressure and a nurse named "Diana" was yelling at her.

Petitioner testified that on October 21, 2014, she provided a handwritten statement that corrected her accident report by clarifying that a steering wheel column cart had been involved. She identified RX 11 as the statement that she gave to Respondent's medical clinic. Petitioner testified that she also wrote other reports attempting to clear up the misunderstandings in the accident report. She testified that she had separately written out what had happened, but she was brushed off when she brought the rewritten report to Respondent's clinic. Petitioner did not have a copy of this revised accident report at the time of the December 21, 2018 hearing.

When Petitioner was recalled on February 22, 2019, her testimony predominantly concerned her initial accident report and subsequent reports. This testimony was often confusing, as it was not always clear what documents or dates were being referenced. Nevertheless, at that time, Petitioner presented a copy of the revised accident report that she had attempted to provide to Respondent's clinic. She testified that it had been rejected by "Nurse Diana." PX 23 was identified as her original note, and PX 22 was identified as its copy. However, after Petitioner's testimony, PX 22 was withdrawn, re-labeled, and admitted as RX 15.

Petitioner testified that she wrote the front page of the note on October 17, 2014 and the back page on October 21, 2014. However, she testified that the back page was empty when she tried to give it to Nurse Diana and contained her own personal notes that she never intended to show anyone. Petitioner thereafter provided confusing testimony regarding when she had drafted and edited the note. Petitioner's attorney clarified that some of what was written on the original note was brought to Nurse Diana on October 17, 2014, but Petitioner had added some other comments after the note was rejected.

Petitioner further testified that she drew the tug buggy and steering column on the note's front page, because it was hard for her to otherwise describe them. She testified that it was only after she had asked questions to her supervisors that she realized it was a steering wheel column cart attached to a tug buggy that had hit her. Petitioner also testified that Nurse Diana told her that the piece of equipment that hit her was called an "Adunis."

Respondent called Mr. Rick Roggetz as a witness. He explained that he had been Respondent's plant injury investigator since March of 2015. Mr. Roggetz testified that he is familiar with the rag joint job that Petitioner was performing on the accident date. Mr. Roggetz

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identified RX 3D to RX 3L as photographs he took in July of 2018 of two steering column carts. He explained that the steering columns went inside these carts, and the carts were moved throughout the plant by buggy. He testified that the carts were also pushed by hand away from where they were stored, but they were never moved by a forklift. He described the carts as two feet wide, four feet long, and six feet tall with wheels.

Mr. Roggetz further identified RX 13 as the investigation report that was completed by the Labor Relations Department for Petitioner's accident. Mr. Roggetz was not employed by Respondent at the time of Petitioner's accident and was not involved in the investigation's reporting, witness statements, or interviews.

B. Medical Treatment

The medical records reflect that shortly after midnight on October 11, 2014, Petitioner presented to Respondent's clinic and reported that a large blue bin had pushed into her right side from her shoulder to her thigh. An ambulance was called for Petitioner. The ambulance record states that Petitioner had been caught in between objects, and it also reported that a forklift had pushed a bin into her and caused injury to her right side.

Upon arrival to the Franciscan St. Margaret Hammond emergency room, an intake technician wrote that Petitioner had been hit on the right side by a large box. Thereafter, at 5:12 a.m., an emergency room nurse noted that Petitioner was on the assembly line when a box hit her right shoulder as it went by. When Petitioner eventually saw the doctor at 6:09 a.m., he indicated that she had been hit by a large steel cart in the right upper back. Right shoulder X-rays revealed no active bony pathology. On physical examination, Petitioner exhibited decreased range of motion and tenderness to palpation in her right shoulder. Petitioner was diagnosed with right scapular and upper back contusions.

Petitioner presented to Respondent's clinic on October 13, 2014 complaining of right posterior arm and shoulder pain. The clinic doctor's assessment included superficial injuries to multiple regions of the right arm and contusions of the right thigh, right shoulder and upper arm, and right upper back. The clinic doctor recommended physical therapy, a muscle relaxant, and Ibuprofen. Petitioner returned the following day and described her accident as occurring when someone hit her with a cart. The assessment at that time was superficial injuries involving multiple regions of the right arm and a right shoulder contusion. She was given Ibuprofen and told to return to work.

Petitioner thereafter began seeing Dr. Muhammad Rafiq on October 20, 2014. On examination, Petitioner had mild tenderness over the right shoulder area, but no focal neurologic deficit. Dr. Rafiq diagnosed her with a right arm and shoulder contusion and instructed her to avoid lifting and pushing heavy objects. Petitioner next presented for physical therapy on October 21, 2014 and informed the physical therapist that a forklift driver had backed into her right side. She complained of pain that traveled from her right shoulder blade to her elbow with occasional right-hand tingling.

Petitioner next presented to orthopedic surgeon Dr. Robert Coats on October 22, 2014

with complaints of radiating right arm pain with tingling. On examination, Petitioner had tenderness to palpation diffusely throughout the right upper extremity and pain with passive and active right shoulder range of motion, as well as with impingement-type maneuvers. Dr. Coats diagnosed her with a right shoulder strain and impingement, administered a right shoulder injection, and prescribed a Medrol Dosepak. He further recommended no use of the right upper extremity.

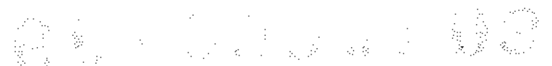
On November 3, 2014, a cervical X-ray revealed mild osteoarthritis at C5-C6 with narrowing of the intervertebral disc space and small formation. When Petitioner returned to Dr. Rafiq on November 10, 2014, she was diagnosed with degenerative joint disease and a right arm contusion. Shortly thereafter, on November 24, 2014, Petitioner told Dr. Coats that in addition to her right shoulder pain, she had numbness and tingling in her right hand and pain radiating into her neck. Dr. Coats ordered an upper extremity MRI, which was obtained on December 4, 2014 and revealed mild degenerative joint disease with a moderate partial tear of the articular surface of the distal supraspinatus tendon.

Petitioner thereafter began treating with Dr. William Payne on February 5, 2015, at which time she complained of continued numbness, tingling, and radiating neck pain. On examination of her right shoulder, Petitioner had abnormal active abduction, passive abduction, forward flexion, and active external rotation. Petitioner was also positive for right shoulder joint pain, tingling, and impingement. Dr. Payne recommended a right subacromial decompression and rotator cuff repair.

On April 15, 2015, Petitioner returned to the emergency room and complained of a right-sided headache and lightheadedness after leaning over on the assembly line to place stickers on a Ford Explorer. She indicated that the pain in the back of her head radiated up over the right side of her scalp and down into her neck. Petitioner was diagnosed with an acute cervical strain and lightheadedness. A few days later, on April 17, 2015, Respondent's clinic doctor was called to find Petitioner sitting in a chair and complaining of dizziness. The clinic doctor believed that Petitioner's dizziness was caused by her medication.

On April 24, 2015, Petitioner underwent the recommended surgery consisting of a right shoulder subacromial decompression acromioplasty, bursectomy, and partial debridement of the labrum and rotator cuff. The postoperative diagnoses included a partial rotator cuff tear, partial labral tear, and subacromial impingement. Petitioner was prescribed Norco and a muscle relaxant for her postoperative pain before renewing physical therapy on June 2, 2015. Shortly thereafter, on June 8, 2015, an EMG yielded normal results with no evidence of cervical radiculopathy or peripheral neuropathy in the upper extremities. Petitioner continued to treat with prescription medication and physical therapy post-operatively.

However, Petitioner had continued complaints of right shoulder pain. Dr. Payne noted tenderness in the right acromion joint, active abduction to 80 degrees, passive abduction to 100 degrees, extension to 50 degrees, and forward flexion to 80 degrees. His assessment was listed as: status-post right subacromial decompression acromioplasty, bursectomy, partial debridement of labrum, and partial debridement of the rotator cuff on April 24, 2015. Dr. Payne's office recommended an additional surgery consisting of a right shoulder manipulation on July 23, 2015.



Petitioner underwent the right shoulder manipulation on September 9, 2015 and began another round of physical therapy on October 7, 2015.

On November 5, 2015, Dr. Payne reported that Petitioner still had pain radiating into her neck with numbness and tingling in her right arm and hand. He diagnosed her with cervical radiculopathy in addition to the partial rotator cuff tear.

Petitioner thereafter presented for a consultation with Dr. Chandrasekhar Sompalli of the Illinois Orthopedic Network on February 1, 2016. She told Dr. Sompalli that there were periods when her physical therapy had not been approved and she now had shoulder stiffness and pain that prevented her from lifting above shoulder-level. Dr. Sompalli opined that Petitioner had adhesive capsulitis as a direct result of her lack of therapy after her shoulder surgery and later manipulation. He recommended aggressive physical therapy, which Petitioner participated in from February 5, 2016 to September 28, 2017.

A few days after her initial physical therapy evaluation, on February 9, 2016, a right shoulder MRI revealed a small subacromial subdeltoid bursal effusion and an anteriorly down sloping acromion. Dr. Sompalli took Petitioner off work on February 13, 2016 and recommended a second right shoulder manipulation with an arthroscopy and debridement on April 9, 2016. Petitioner underwent this third recommended surgery on June 7, 2016 including extensive debridement of the subacromial space and glenohumeral joint, distal clavicle resection, subacromial decompression with partial acromioplasty and release of the coracoacromial ligament, and manipulation.

C. Section 12 Examination and Report – Dr. Welch

On August 22, 2016, Petitioner submitted to an examination at Respondent's request with Dr. Robert Welch who provided a report of the same date. Petitioner informed Dr. Welch that her accident had occurred when another employee backed up a "tub buggy" with a steering column on it and struck her lateral right shoulder. Dr. Welch opined that Petitioner had suffered a right shoulder contusion and developed bursitis and adhesive capsulitis secondary to the shoulder trauma. However, he indicated that he could not mechanically explain her neck symptoms from the blow to her scapula or shoulder area. Nevertheless, Dr. Welch recognized that there was no history of preexisting shoulder or neck problems and her symptoms had all occurred in relation to the accident. For the adhesive capsulitis, Dr. Welch agreed with Dr. Sompalli that Petitioner should reach maximum medical improvement six months after her June 7, 2016 surgery. For her cervical radiculitis, he recommended cervical films with a follow-up MRI. He noted that the cervical radiculopathy symptoms were reported at Petitioner's second treatment visit and were at least chronologically related to her injury.

D. Continued Medical Treatment and Second Section 12 Examination – Dr. Welch

Petitioner continued medical treatment related to the right shoulder, but more focused on the cervical spine and pain management. On October 7, 2016, Petitioner underwent a cervical MRI that showed straightening of the spine, disc dehydration throughout the cervical spine, and diffuse disc protrusions at C5-C6 and C6-C7 with disc material and facet hypertrophy causing

bilateral neural foraminal stenosis encroaching on the left and right exiting nerve roots.

Petitioner thereafter presented to Dr. Krishna Chunduri, a pain management doctor from the Illinois Orthopedic Network, on October 13, 2016. Dr. Chunduri reported that a cart pulling other cars filled with steering wheel columns had hit Petitioner and crushed her between her workstation. He opined that Petitioner's right upper extremity pain, numbness, and tingling from her neck to her fingers was a result of the injury to the right side of her shoulder. An EMG obtained on October 26, 2016 further revealed evidence of right C6 radiculopathy with mild muscle fiber membrane electrical instability, chronic neurogenic changes, and reinnervation. On November 3, 2016, Dr. Chunduri diagnosed Petitioner with C6 radiculopathy per the EMG, recommended an injection, and kept Petitioner off work. Petitioner underwent the right C6 epidural steroid injection on November 10, 2016.

On November 19, 2016, Dr. Sompalli reported that a recent November 15, 2016 right shoulder MRI had revealed no significant abnormalities. Dr. Sompalli continued Petitioner's physical therapy for another eight weeks and indicated that upon its completion, Petitioner would be at maximum medical improvement and released from his care.

However, on December 1, 2016, Dr. Chunduri noted that Petitioner had not received any improvement from her C6 injection and continued to have pain radiating into her palm area, which was in the C7-C8 dermatome. As such, he opined that the appropriate nerve root might have been missed and recommended a C7-C8 injection to evaluate it as the potential pain source. Petitioner underwent the C7-C8 injection on December 8, 2016. When Petitioner returned on December 22, 2016, Dr. Chunduri reported that she had ongoing right upper extremity paresthesias with no significant improvement from the injections. He therefore opined that her pain and paresthesias were likely permanent and due to nerve damage that she may have sustained in the accident. Dr. Chunduri recommended medication management to address Petitioner's symptoms.

On January 23, 2017, Petitioner presented for an initial consultation with Dr. Geoffrey Dixon, a spine surgeon at the Illinois Orthopedic Network. Dr. Dixon indicated that Petitioner had been struck by the steering column of a buggy and had severe right-sided pain. He advised Petitioner to return with her MRI scans for his review and to discuss surgical options.

Petitioner submitted to a second examination at Respondent's request with Dr. Welch who provided a report dated January 30, 2017. Regarding the cervical radiculitis, Dr. Welch noted that Petitioner had complained of numbness and tingling into her right hand since her October 21, 2014 physical therapy visit and denied any prior numbness or tingling. However, he found it difficult to explain based on her mechanism of injury how a direct shoulder blow caused the numbness and tingling. Nevertheless, he opined that the numbness and tingling were at least chronologically associated with the work accident.

Regarding the cervical condition, Dr. Welch further opined that Petitioner had not yet reached maximum medical improvement. Based on her positive EMG findings and right neural foraminal narrowing, he thought Petitioner required a decompression of the C5-C6 and C6-C7 nerve roots. However, regarding her right shoulder condition, Dr. Welch opined that Petitioner

was at maximum medical improvement as of January 7, 2017. **20 I W C C 0 1 0 9**

E. Continued Medical Treatment and Third Section 12 Examination – Dr. Singh

Petitioner thereafter returned to Dr. Dixon with her cervical MRI images on February 6, 2017. Dr. Dixon found that the images showed a large disc protrusion that was eccentric to the right and causing nerve root compression within the lateral recess and foramen. He recommended a C5-C6 anterior cervical discectomy and fusion. On February 25, 2017, Dr. Sompalli then opined that most of Petitioner's pain was radicular from her neck rather than any shoulder abnormality. He told Petitioner that she could return to him if she continued to have shoulder pain after the surgery, but she was to follow up with Dr. Dixon only for now.

On March 20, 2017, Dr. Dixon indicated that he had reviewed Dr. Welch's section 12 report and agreed with his finding of radiculopathy. He further agreed with Dr. Welch's recommendation for a C5-C6 and C6-C7 decompression. Dr. Dixon also noted that Petitioner was at maximum medical improvement for the right shoulder aspect of her injury.

Dr. Dixon provided a narrative statement on May 8, 2017. He reported Petitioner had said that upon being struck by the steering column of a "tub buggy," she was forcibly turned and immediately felt right shoulder pain that extended into her right upper extremity and hand. Dr. Dixon's diagnosis was C5-C6 and C6-C7 herniated discs, causing a C6 radiculopathy that resulted in pain, numbness, tingling, and weakness in Petitioner's right arm. He opined that being struck by an object with sufficient force had caused significant injuries to Petitioner's right shoulder and a rotational-type injury to the cervical spine, which then caused traction on the cervical nerve roots and the brachial plexus, which then caused or exacerbated the effects of the herniated cervical discs. Dr. Dixon opined that the relationship between Petitioner's symptomatology and work accident was biomechanically understandable and plausible.

Petitioner submitted to a third examination at Respondent's request with Dr. Kern Singh who issued a report dated June 19, 2017. As part of his examination, Dr. Singh performed Waddell's testing and marked all five Waddell's signs as positive. He diagnosed Petitioner with a cervical muscular strain but wanted to review her cervical MRI before making a determination as to causation. Nevertheless, Dr. Singh expressed concern that Petitioner's pain complaints were in her entire spine and right upper extremity with no dermatomal distribution.

After reviewing the October 7, 2016 cervical MRI, Dr. Singh provided an addendum report dated July 7, 2017. Dr. Singh found that Petitioner had a normal neurological exam with full motor strength, no sensory or reflex loss, and an essentially normal MRI with multi-positive Waddell's findings and inconsistent behavior. He further opined that Petitioner's EMG was an erroneous false positive that did not correlate with a C6 radiculopathy, because she had no wrist extensor weakness, sensory loss in a C6 distribution, or loss of the brachioradialis reflex. As such, Dr. Singh believed surgical intervention and additional cervical treatment were not warranted. He placed Petitioner at maximum medical improvement for a resolved soft tissue cervical muscular strain.

On December 11, 2017, Dr. Dixon indicated that he disagreed with Dr. Singh's findings

and opinions expressed in his report. He disagreed in terms of the diagnosis, the interpretation of the MRI, and the presence of Waddell's signs. Specifically, Dr. Dixon opined that Petitioner had a herniated C5-C6 disc with associated C6 radiculopathy that directly resulted from her work accident. He interpreted Petitioner's MRI to show multilevel spondylosis with significant C5-C6 disc osteophyte complex eccentric to the right, causing both lateral recess and foraminal stenosis as well as nerve root compression. Dr. Dixon further noted that Petitioner had not exhibited any positive Waddell's findings on his examination.

Dr. Dixon thereafter continued to refill Petitioner's prescriptions and keep her off work as she awaited surgical authorization. Then, on April 23, 2018, he updated her work restrictions to include a three-pound weight limit. Petitioner last saw Dr. Dixon on October 29, 2018. Dr. Dixon noted that she had been working with restrictions as they continued to seek surgical authorization. He continued Petitioner's medications and the three-pound weight restriction.

F. Physicians' Deposition Testimony

Petitioner called Dr. Dixon as a witness and he gave testimony at a deposition on March 26, 2018. Dr. Dixon maintained that Petitioner had suffered a C5-C6 herniated disc with C6 radiculopathy caused by her work injury. He explained that when he prepared his narrative report, he reviewed reports from Respondent, Dr. William Payne, and Dr. Welch. He testified that his opinions had not changed since he authored that narrative report. Dr. Dixon further testified that Petitioner being struck by an object with sufficient force to cause a significant right shoulder injury caused a rotational-type injury to the cervical spine. He explained that this mechanism caused traction on the cervical nerve roots/brachial plexus and caused or exacerbated the effects of the cervical herniated discs.

Dr. Dixon testified that his review of the medical records also led to his opinion that Petitioner had suffered a rotational-type injury. He testified that diagnostic testing supported his conclusion, because Petitioner had herniated cervical discs and a positive EMG. Dr. Dixon testified that Petitioner now required an anterior C5-C6 and C6-C7 discectomy and fusion. He further disagreed with Dr. Singh's conclusions regarding the MRI and EMG results. Dr. Dixon believed it was a positive EMG and no Waddell's signs were present and noted that his exam yielded significantly different results than Dr. Singh's exam.

Respondent called Dr. Welch as a witness and he provided testimony at a deposition on May 11, 2018 regarding his section 12 reports. Dr. Welch identified himself as a board-certified orthopedic surgeon who specializes in the hand and upper extremity. He clarified that he treats shoulders, but not the cervical spine. However, Dr. Welch testified that although cervical treatment is not part of his practice, he commonly diagnoses cervical conditions. He has also read cervical MRIs but did not consider himself to be an expert on them.

Dr. Welch maintained his opinion that Petitioner had a right shoulder contusion that led to bursitis and adhesive capsulitis, which necessitated her surgeries. He explained that adhesive capsulitis could happen after trauma, but there did not have to be a direct shoulder injury. Dr. Welch further testified that at his August 22, 2016 examination, he did not believe that the mechanism of injury was consistent with causing a cervical condition. He also took issue with

Petitioner denying numbness and tingling in her initial emergency room visit. However, he acknowledged that it had at least some temporal relation to Petitioner's injury, admitting that some issues can come on slower and be overshadowed by more pressing conditions.

Regarding his January 30, 2017 examination, Dr. Welch further testified that Petitioner's disc dehydration was seen in aging and more of a degenerative issue. As such, he testified it was more likely a degenerative condition that had gradually progressed and occurred sometime near the shoulder injury. Lastly, Dr. Welch indicated that Petitioner had demonstrated pain avoidance behavior and did not always give maximal effort.

Respondent also called Dr. Singh as a witness and he gave deposition testimony on May 31, 2018. Dr. Singh testified consistent with the opinions contained in his section 12 report. He explained that he had performed his first examination of Petitioner with his assistant present and then his assistant performed a secondary repeat examination with all the same tests. Dr. Singh testified that Petitioner had a normal examination on June 19, 2017 with full strength in her arms and legs, normal reflexes, and normal monofilament testing. He testified that although Petitioner's doctors identified C5-C6 as a potential pain generator, it would not explain why her entire spine or arm were painful. Dr. Singh also expressed concern that Petitioner had subjective complaints without radiographic or physical evidence of nerve root compression.

Lastly, Dr. Singh opined that Petitioner's October 7, 2016 MRI showed no disc herniation and her EMG showed no radiculopathy. Dr. Singh testified that Petitioner's normal nerve root function, strength, sensation, and reflexes were inconsistent with the EMG. Dr. Singh maintained his opinions on cross-examination. Dr. Singh maintained that he performed the first exam of Petitioner with his assistant present and then his assistant thereafter performed a secondary or repeat exam with all the same tests.

G. Additional Information

Petitioner testified that she eventually returned to work on or around June 14, 2018, although she had not yet been released back with no restrictions. She could not recall if she had worked under restrictions prior to that time. Petitioner testified that her return was prompted by a letter Respondent had sent her telling her to come back. She thereafter went on mental health leave on August 17, 2018 and was not working at the time of the hearing.

Petitioner further testified that she had received no pre-accident treatment for her neck, shoulder, arm, or hands. She also had no prior right arm or hand tingling. In the days leading up to the accident, Petitioner presented to Respondent's medical clinic on several occasions with various complaints of finger pain. None of Respondent's pre-accident visits to the clinic concerned her neck or right shoulder.

Regarding her current condition of ill-being, Petitioner testified that she is now always in pain from her mid-head to her neck and down her right arm into her fingertips. She testified that at the hearing, her neck and shoulder were also tingling. Petitioner stated that she wished to proceed with the surgery recommended by Dr. Dixon.

II. CONCLUSIONS OF LAW

A. Accident

Following a careful review of the entire record, the Commission agrees with the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to a compensable work accident that she sustained on October 10, 2014.

Although Petitioner is sometimes a poor historian regarding the exact mechanism of injury and the exact name of the equipment involved in her accident, the evidence overwhelmingly establishes that Petitioner was struck on the right side of her body by a large industrial cart containing heavy parts. The minor variations in the name by which Petitioner referred to the cart do not undermine her testimony overall. With regard to whether the cart struck Petitioner forcefully enough to cause the alleged injury, the Commission notes that the only evidence on the point was provided by Petitioner. The Commission further notes that Petitioner's testimony must be considered in light of her condition at the time of the hearing, which included a non-occupational mental health condition for which she went on mental health leave on August 17, 2018.

Although Petitioner called the equipment by different names, such as cart, tug buggy, bin, or forklift, the record establishes that a large industrial cart significantly impacted Petitioner on the accident date and necessitated an ambulance being called. Moreover, the testimony of Mr. Roggetz confirms the different terminology used, and that the large cart (two feet wide, four feet long, and six feet tall with wheels) was moved throughout the plant by "buggy." Petitioner admitted that she was not sure what to call the equipment or how to accurately describe it. She indicated that she drew the tug buggy and steering column in PX 23, because it was hard for her to otherwise describe them. Regardless of any name discrepancies, the photographs in PX 21 and RX 3D to RX 3L provide the Commission with depictions of the type of large industrial cart that hit Petitioner.

The record further establishes that Petitioner required no pre-accident medical treatment for her right shoulder or cervical spine and suffered from no pre-accident symptoms that prevented her from performing her job. Petitioner immediately expressed right shoulder pain, although she did not initially complain of radiating cervical symptoms while undergoing treatment to address the prominent right shoulder condition. Nevertheless, her cervical and radicular complaints were made timely after the accident and confirmed by an October 26, 2016 EMG, which showed right C6 radiculopathy. Petitioner's October 7, 2016 MRI showed C5-C6 and C6-C7 disc protrusions that caused bilateral foraminal stenosis encroaching on the existing nerve roots. The objective diagnostic testing, along with the treating doctors' clinical examination findings, show that Petitioner sustained both cervical and right shoulder injuries, even though the injury was originally misdiagnosed as only encompassing the right shoulder. It was only after Petitioner was struck by the large cart at work that she developed right shoulder pain and radiating cervical symptoms, which are corroborated by the medical records.

Additionally, three physicians opined regarding the relatedness, if any, of Petitioner's right shoulder condition and her cervical spine condition to the accident at work. The Commission finds the opinions of Dr. Dixon to be persuasive. He opined that Petitioner was struck by an object with sufficient force to cause a significant right shoulder injury causing a rotational-type injury to the cervical spine. He explained that this mechanism caused traction on the cervical nerve roots/brachial plexus and caused or exacerbated the effects of the cervical herniated discs. Of note, Petitioner's October 7, 2016 cervical MRI revealed diffuse disc protrusions at C5-C6 and C6-C7 with disc material and facet hypertrophy causing bilateral neural foraminal stenosis encroaching on the left and right exiting nerve roots.

Respondent's Section 12 examiner, Dr. Welch, conceded that the accident had caused Petitioner's shoulder injury, but waivered on whether it had caused her ongoing cervical injuries. Dr. Welch admitted that he specializes in the hand and upper extremity, not the spine, and his practice does not treat the cervical spine. Nonetheless, Dr. Welch admitted that Petitioner's cervical condition had at least some temporal relation to her injury and that some issues can come on slower and be overshadowed by more pressing conditions. The Commission finds that the opinions of Dr. Dixon regarding Petitioner's right shoulder condition to be persuasive, noting that they are supported by the opinions of Dr. Welch.

Dr. Dixon also opined that Petitioner's cervical spine was caused by a rotational-type injury at the time of her accident. Respondent's Section 12 examiner, Dr. Singh, disagreed maintaining that Petitioner had a normal examination with him, or his assistant, on June 19, 2017. He also expressed concern about Petitioner's subjective complaints without, in his opinion, radiographic or physical evidence of nerve root compression. Dr. Singh believed that Petitioner's October 7, 2016 MRI showed no disc herniation and her EMG showed no radiculopathy. Dr. Singh further testified that had normal nerve root function, strength, sensation, and reflexes were inconsistent with the EMG that he believed showed false positive results. However, Dr. Dixon's causation opinion is supported by objective diagnostic evidence.

Dr. Dixon interpreted Petitioner's MRI to show multilevel spondylosis with significant C5-C6 disc osteophyte complex eccentric to the right, causing both lateral recess and foraminal stenosis as well as nerve root compression. Petitioner's MRI on October 7, 2016 showed diffuse disc protrusions at C5-C6 and C6-C7 with disc material and facet hypertrophy causing bilateral neural foraminal stenosis encroaching on the left and right exiting nerve roots. The radiologist's findings support Dr. Dixon's interpretation regarding the presence of cervical spine pathology that Dr. Singh maintains is not present.

Moreover, Petitioner's EMG confirmed that she suffered from cervical radiculopathy and Petitioner consistently complained of radiating pain, numbness, and tingling from shortly after the accident through the hearing date. Dr. Singh explained that the results constituted a false positive but accepting his opinion would require ignoring the determination of both the EMG physician and Dr. Dixon that the EMG results were, in fact, positive. Dr. Singh also failed to account for Petitioner's lack of pre-accident cervical symptoms with post-accident cervical spine pathology with contemporaneous symptoms.

In consideration of the physicians' opinions, the Commission finds the opinions of Dr.

Dixon to be persuasive in this case. In so concluding, the Commission relies on Dr. Dixon's qualifications and the objective medical evidence supporting Dr. Dixon's opinions regarding the casual connection between Petitioner's cervical spine condition and injury at work. Ultimately, the record establishes that the impact that Petitioner sustained was significant and the chain of events supports Petitioner's claim that it contributed to her post-accident condition. Petitioner's minor variations in her recitation of the mechanism of injury to Dr. Dixon are *de minimus*; Dr. Dixon indicated that his review of diagnostics and objective medical evidence assisted him in forming his opinion that Petitioner had suffered a rotational injury.

As the objective clinical findings and diagnostic testing show that Petitioner sustained right shoulder and cervical injuries for which she had no pre-accident symptoms, the Commission finds that Petitioner has established a causal connection between her current condition of ill-being and the October 10, 2014 accident. The Commission affirms and adopts the Decision of the Arbitrator accordingly.

B. Causal Connection

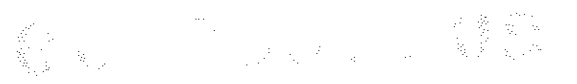
The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. As explained herein, the medical records and opinions of Dr. Dixon establish that Petitioner did sustain a work-related accident that resulted in a current condition of ill-being of her right shoulder and cervical spine. Given this record, the Commission concludes Petitioner's condition of ill-being is causally related to the accident.

C. Temporary Total Disability

Petitioner claims that she is entitled to temporary total disability benefits from February 13, 2016 to June 14, 2018. The medical records reflect that Petitioner was placed off work on February 13, 2016 and thereafter kept off work or on light duty restrictions by her treating doctors. Petitioner was never returned to full duty work after February 13, 2016. Although Respondent entered its timekeeping records as RX 9, no one testified as to how to properly read these documents and it is not clear to the Commission whether the entries in RX 9 show Petitioner's attendance or absence. Thus, the Commission finds that Petitioner is entitled to the claimed temporary total disability benefits and modifies the Decision of the Arbitrator accordingly.

D. Medical Expenses

Petitioner claims Respondent should pay outstanding reasonable and necessary medical expenses as outlined in the medical records that Petitioner submitted at the time of the hearing for her right shoulder and cervical spine injuries pursuant to §8(a), subject to the applicable medical fee schedule in §8.2 of the Act. Petitioner also acknowledges Respondent should be given a credit of $8,592.43 for medical benefits paid by its group medical carrier. Respondent disputed this claim by denying the accident arose out of the course of Petitioner's employment. Petitioner also claims entitlement to prospective medical care in the form of the anterior cervical discectomy and other treatment prescribed by Dr. Dixon.



As explained herein, the Commission finds that Petitioner has established that she sustained a compensable accident as well as a causal connection between her current condition of ill-being and accident at work. The Arbitrator further finds that the treatment rendered to Petitioner is reflective of reasonable and necessary medical treatment to diagnose and treat Petitioner from the effects of her injuries to the right shoulder and cervical spine as opined by Dr. Dixon.

Thus, the Commission awards Petitioner the claimed medical expenses subject to sections 8a and 8.1 and awards Petitioner the prospective medical treatment recommended by Dr. Dixon, Respondent the credit under §8(j) of the Act as stipulated by the parties, and Respondent shall hold Petitioner harmless for any claims for which it receives such credit.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $400.58 per week for 121 and 5/7ths weeks, commencing February 13, 2016 to June 14, 2018, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED that the Decision of the Arbitrator filed May 20, 2019 is otherwise affirmed and adopted.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical expenses for Petitioner's right shoulder and cervical spine injuries from October 10, 2014 to December 21, 2018 as provided in §8(a) and §8.2 of the Act pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED that Respondent is liable for Petitioner's prospective medical care for her related cervical condition in the form of the treatment and surgical procedures recommended by Dr. Dixon.

IT IS FURTHER ORDERED that Respondent shall receive a credit of $16,938.81 for temporary total disability benefits already paid. Respondent shall receive a credit for any and all payments made to or on behalf of Petitioner on account of said accidental injury.

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

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.

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: FEB 18 2020

Barbara N. Flores

Marc Parker

DLS
O- 12/19/19
46

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

20IWCC0109

HENRY, LIWANDA
Employee/Petitioner

Case# **15WC001469**

15WC017028

FORD MOTOR COMPANY
Employer/Respondent

On 5/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.35% 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:

2356 DONALD W FOHRMAN & ASSOC LTD
MONTE BEATY
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

0075 POWER & CRONIN LTD
JORDAN ANN LEJCAR
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

20IWCC0109

20IWCC0109

20IWCC0109

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)

LIWANDA HENRY,
Employee/Petitioner

v.

FORD MOTOR COMPANY,
Employer/Respondent

Case # **15** WC **01469**

Consolidated cases: **15 WC 17028**

An *Application for Adjustment 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 **12/21/18** and **02/22/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

E. [ ] 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, **10/10/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**5,407.87**; the average weekly wage was $**600.87**.

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

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

Respondent shall be given a credit of $**16,938.81** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**15,905.55** for other benefits, for a total credit of $**32,844.36**.

Respondent is entitled to a credit of $**8,592.43** under Section 8(j) of the Act.

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of the medical bills submitted as provided in Sections 8(a) and 8.2 of the Act and as found in this Decision as follows: Illinois Orthopedic Network in the amount of $4,133.70; Premium Healthcare Solutions in the amount of $6,965.00; South Suburban Physical Therapy in the amount of $59,263.95; Cook County Health & Hospital Systems in the amount of $3,805.00; Franciscan St. James Health in the amount of $1,123.00; Metro Anesthesia Consultants in the amount of $7,121.54; QMed Assist in the amount of $27,954.55; and Midwest Specialty Pharmacy in the amount of $10,300.16. All such treatment was reasonably required to diagnose and treat Petitioner for the effects of her injury and these services were causally related to her work injury.

Respondent shall be given a credit of $8,592.43 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $400.58/week for a total period of 71-1/7 weeks, commencing 02/13/2016 through 12/02/16; 03/10/17 through 07/07/17; and 07/21/17 through 10/13/17, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $16,938.81 for TTD benefits previously paid and $15,905.55 for nonoccupational indemnity disability benefits that have been paid, for a total credit of $32,844.36.

Prospective Medical

The Arbitrator adopts the findings of treating physician Dr. Dixon and accordingly awards Petitioner prospective medical care in the form of an anterior cervical discectomy or any future care he so prescribes.

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 Robert M. Harris

May 20, 2019
Date

ICArbDec19(b)

MAY 2 0 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission Petitioner,	)	
v.	)	15 INC 124 19WC20261
Edgar O. Ramirez, Individually & Owner of La Esperanza General Construction. Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents.

Deborah L. Simpson

Commissioner Deborah Simpson

FEB 19 2020

Dated: 2/11/2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

ILLINOIS WORKERS' COMPENSATION COMMISSION,)
Petitioner,)
v.) No. 15 INC 00279
19wc20262
DOMINIK K. LEWANDOWSKI, individually, and as President and Secretary of CONNOISSEUR LOGISTICS, INC.,)
Respondent.)

COMMISSION ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondent.

Deborah L. Simpson
Commissioner
Illinois Workers' Compensation Commission

Dated: Feb 11, 2020

FEB 19 2020

20IWCC0109

STATE OF ILLINOIS	)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LIWANDA HENRY,

Petitioner,

vs. NO: 15 WC 1469
15 WC 17028

FORD MOTOR COMPANY,

Respondent.

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner lacked credibility due to the numerous inconsistencies in her retelling of the alleged work accident.

At the hearing, Petitioner testified that she was standing and pumping a rag joint on the IP line when she felt a large blue bin, which was called a steering column bin, bump into the entire right side of her body from her neck to her foot. Petitioner initially testified that she saw the bin bump into her, but she later testified that she was not facing the bin when she was struck and did not see the impact coming. Petitioner testified that the bin was attached to a "tug buggy" that was also called a forklift; however, she also testified that it was different and smaller than a forklift. Petitioner testified that her entire right side went numb immediately upon being struck.

Petitioner identified PX 2 as the accident report she filled out on the accident date. However, she testified that PX 2 was not an accurate representation of the events that had transpired. She explained that she had inaccurately referred to the object that struck her as a blue bin in the accident report when it was actually called a steering column cart, and she had also failed to refer to a forklift or tug buggy in the accident report. Petitioner conceded that this accident report did not mention any numbness or tingling in her right arm, neck, hand, or fingers.

Petitioner testified that on October 21, 2014, she gave a handwritten statement to Respondent's plant medical clinic indicating that she had made an error in her accident report. She identified RX 11 as the October 21, 2014 note that corrected her initial accident report by stating that the piece of equipment involved in the accident was a steering wheel column cart.

Petitioner testified that she also wrote other reports like she did on October 21, 2014 in an

attempt to clear up other misunderstandings in her accident report. She identified PX 23 as an original copy of a note that she had attempted to turn in to "Nurse Diana" at Respondent's medical clinic and PX 22 as a copy of that note. Following Petitioner's testimony, PX 22 was withdrawn, but subsequently re-labeled and admitted into evidence as RX 15. Petitioner provided conflicting testimony as to what dates these documents were written and when she had edited their content.

Petitioner's testimony and written statements regarding how her alleged accident occurred and the equipment involved greatly conflict with how Petitioner described her accident to various medical providers in her treatment records. Specifically, in the ambulance record from the accident date, Petitioner's accident was listed as being caught in between objects. This version of the accident is similar to the version that Petitioner reported to Dr. Chunduri on October 13, 2016. At that time, Petitioner indicated that she had been at her station when a cart came by pulling other cars filled with steering wheel columns, hit her, and crushed her between it and her station. These versions of the accident, which suggest that Petitioner was caught or crushed between two objects, are inconsistent with Petitioner's testimony and the other treatment records. Petitioner testified that she was not crushed in her accident and denied telling Dr. Chunduri that she had been crushed between her cart and her station.

Petitioner again told a different version of the alleged accident at Franciscan St. Margaret Hammond's emergency room on her accident date. Specifically, Petitioner initially reported that she had been hit by a large box on the right side, causing an injury to her right arm and shoulder. A nurse thereafter noted that Petitioner had been working on the assembly line when one of the tolley boxes hit her right shoulder as it went by. When Petitioner thereafter saw the doctor, he indicated that Petitioner had been hit in the right upper back by a large steel cart. These versions of the accident suggest different mechanisms of injury, specifically getting hit by a box on an assembly line, and different points of impact, specifically the upper back. Petitioner also denied any numbness or tingling at this initial emergency room visit, which further conflicts with Petitioner's testimony that her entire right side went numb immediately upon being struck.

Petitioner later told another variation of the accident to Dr. Dixon. In his May 8, 2017 narrative statement, Dr. Dixon stated that Petitioner had reported that she had been forcibly turned upon being struck by the steering column of a "tub buggy" on the lateral aspect of her right shoulder. At his deposition, Dr. Dixon testified that Petitioner being forcibly turned around was indicative of a rotational injury. Dr. Dixon's causal opinion relied on the premise that Petitioner had suffered such a rotational-type injury. However, at the hearing, Petitioner testified that she was not sure whether she told Dr. Dixon that she was struck so hard that she rotated her body around in a circle, but she did not rotate her body at all when she was struck. Dr. Welch, a §12 examiner, also testified that Petitioner had not indicated that she had twisted or rotated the upper portion of her body upon being struck.

These numerous inconsistencies in Petitioner's retelling of her accident diminish her credibility. Throughout her testimony and treatment records, Petitioner alleged multiple versions of her accident that varied as to how she was struck, where on her body was directly impacted, and what the name of the object was that hit her. She was additionally inconsistent with what she felt upon being struck, as she complained of feeling both completely numb on her right side and pain in varying body parts. Petitioner's accounts greatly varied on what hit her, where it hit her, what

body part was injured, and what she reported. Because Petitioner failed to present one credible account of her alleged accident, she failed to meet her burden of proving that she sustained an accident that arose out of and in the course of her employment on October 10, 2014.

In addition to Petitioner's own conflicting versions of the accident, her history of the accident also conflicted with Marko Sretenovic's signed statement that was included in the accident's investigation report. In the October 15, 2014 statement, Mr. Sretenovic wrote that on the accident date, he was working on Respondent's IP line on the steering column pick job. He explained that as he was grabbing an empty rack and turning it toward his buggy, a woman said that he had struck her arm. At the time, he was moving the rack by hand. Mr. Sretenovic stated that he did not see Petitioner get hit nor felt it in the rack. He explained that he did not believe Petitioner had been hit, because he did not feel any restriction or obstruction as he was moving the rack. Mr. Sretenovic's statement implies that no accident occurred, and if it did occur, he indicated that he was moving the rack by hand, and not by a tug buggy as Petitioner claimed, at the time of impact. This inconsistent witness statement further diminishes Petitioner's credibility.

Dr. Kern Singh's §12 examination also presented another barrier to Petitioner's credibility. Petitioner testified that at the June 19, 2017 examination, Dr. Singh never examined her, and she was instead examined only by his assistant. She alleged that Dr. Singh spent two minutes with her before the examination, but he was not in the room during the examination and did not ask her any questions. Petitioner testified that neither Dr. Singh nor his assistant took a history from her, nor asked her what had happened on the accident date.

However, contrary to Petitioner's testimony, Dr. Singh's §12 report indicated that he had personally performed the examination and spoke to Petitioner about her accident and current symptomology. Dr. Singh also testified at his deposition that he had personally examined Petitioner, although his assistant did thereafter perform a repeat examination with all the same tests. Petitioner's testimony that Dr. Singh failed to have any interaction with her aside from two minutes before the examination where he asked no questions is disproved by Dr. Singh's §12 report and deposition testimony, in which he detailed his physical examination findings and the history of Petitioner's accident.

Dr. Singh's physical examination also included a positive finding of all five Waddell's signs. Dr. Singh expressed concern about Petitioner's pain complaints being in her entire spine and entire right upper extremity with no dermatomal distribution. He opined that Petitioner had a normal neurological exam with full motor strength, no sensory or reflex loss, and an essentially normal MRI with multi-positive Waddell's findings and inconsistent behavior. At his deposition, Dr. Singh further testified that he had tried to evaluate Petitioner's range of motion, but she self-limited and prevented motion non-objectively. Dr. Singh explained that when someone goes from a sitting to standing position, it requires at least 30 degrees of bending forward and backward in the cervical spine. He testified that he observed Petitioner being able to do that, but when formally asked to bend forward or backward, Petitioner did not and said it was too painful. Dr. Singh's positive finding of all five Waddell's signs and Petitioner's unsubstantiated allegations that she was not examined by Dr. Singh further undermines Petitioner's credibility.

Lastly, when evaluating Petitioner's credibility, it must be acknowledged that Petitioner's

testimony on February 22, 2019 regarding PX 22, PX 23, and RX 11 was frequently conflicting as to when each document was drafted and altered. A credible timeline as to the dates and times these documents were written and edited cannot be clearly established due to Petitioner's conflicting testimony.

For the reasons stated above, I respectfully dissent from the Decision of the majority. Petitioner's numerous inconsistencies and different versions of the alleged accident greatly diminish her credibility. As such, I would have found that Petitioner failed to meet her burden of proving through credible evidence that she sustained an accident that arose out of and in the course of her employment on October 10, 2011.

DLS/met
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FEB 1 8 2020

Deborah L. Simpson
Deborah L. Simpson

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

ETHAN BARNETT,

Petitioner,

20IWCC0110

vs.

NO: 10 WC 45765

DIVERSATECH METAL FAB, INC.,

Respondent.

DECISION AND OPINION ON REMAND FROM THE APPELLATE COURT

Procedural history

This matter comes before the Commission on remand from the Appellate Court of Illinois, 4th District. The claim had been initially heard by Arbitrator Nowak. He awarded Petitioner 274&6/7 weeks of temporary total disability ("TTD") benefits, $290,473.56 in medical expenses, and found Petitioner permanently totally disabled ("PTD"). Respondent sought review by the Commission. Respondent preserved the issues of causation, average weekly wage/benefit rate, medical expenses, TTD, and PTD.

On review, the Commission modified the Decision of the Arbitrator. The Commission affirmed the Decision of the Arbitrator on all issues except for the PPD award. The Commission found that Petitioner had not proven he was permanently and totally disabled and reduced the PPD award to 250 weeks, representing loss of 50% of the person-as-a-whole. The Commission found that Petitioner had not proven he was PTD because there was not sufficient medical evidence to establish medical PTD and he had not conducted a legitimate job search.

Petitioner appealed the Decision of the Commission to the Circuit Court. The Circuit Court of McLean County confirmed the Decision of the Commission in its entirety. Petitioner also appealed the Decision of the Circuit Court. The Appellate Court affirmed the Decision of the Circuit Court on all issues except PPD. The Appellate Court found that the Commission's finding that Petitioner had not proven that he was medically permanently totally disabled was not against the manifest weight of the evidence. However, the Appellate Court also found that the Commission erred in basing its denial of PTD under the odd-lot PTD only on Petitioner's failure to conduct a job search and not analyzing the second prong of the odd-lot test.

The Court found that the Commission should determine whether Petitioner "proved he was permanently and totally disabled under an odd-lot theory by demonstrating because of his age, training, education, experience, and condition, there are no available jobs for a person in his circumstance." The Appellate Court remanded the matter to the Commission with directions to consider that argument.

In looking at the Commission decision, the Commission did indicate that it found the opinions of Respondent's voc rehab counselor, Mr. Hammond, who opined that Petitioner was employable, more persuasive than Petitioner's voc rehab counselor, Mr. Gustafson, who opined that he was not. That would certainly suggest that the Commission considered such competing assessments and found that Petitioner's age, training, education, experience, and condition, did not render him PTD based on the odd-lot theory. Nevertheless, the Appellate Court is correct that the Commission did not specify that Petitioner did not sustain his burden of proving he was PTD. Rather, the Commission only specifically noted his complete lack of a job search as determination that the odd-lot theory of PTD did not apply to Petitioner.

Conclusions of Law

The Appellate Court mandated the Commission to consider Petitioner's age, training, education, experience, and condition to determine whether he qualified as PTD under the odd-lot theory. In looking at the criteria the Commission must analyze, Petitioner was 21 years old at the time of his accident. He testified that his highest level of education was the 10th grade, which was not rebutted by Respondent. Petitioner also testified that all his prior work experience involved manual labor, which again was not rebutted by Respondent. Therefore, the record establishes that Petitioner was 21, had only a 10th grade education, and prior work experience involved only manual labor. The more difficult question is what was Petitioner's "condition" and capabilities.

Petitioner had an L4-5 replacement and L5-S1 fusion on February 11, 2013. Later, it was determined that Petitioner had pseudoarthrosis (non-union) at L5-S1. Petitioner was sent to Respondent's Section 12 medical examiner, Dr. Rinella, after his surgery. Dr. Rinella recommended a Functional Capacity Evaluation ("FCE"), which Petitioner eventually had on January 21, 2016, three years after surgery. The FCE report indicated that Petitioner "failed 6/14 Performance Criteria" and exhibited six non-organic signs. However, "the preponderance of

evidence indicates the client participated fully in testing" and exhibited "acceptable effort." He functioned mostly at the medium work level, but only at the sedentary level in endurance. Petitioner was "classified mostly in the medium work demand level, but also demonstrated abilities in the sedentary, light, and heavy levels depending on the activity. He would not be able to perform the required activity for required time frame in the medium demand level (he terminated the test at nearly 4 hours. This is a half day of work)."

The record establishes that the FCE was halted early at Petitioner's request based on subjective complaints of pain and it was not stopped by the therapist due to any objective physiological findings. The record reveals that Petitioner also cut short sessions during his work conditioning program as well.

On his last Section 12 medical examination report dated August 13, 2015, Dr. Rinella noted that aftter his prior examination he recommended an FCE to determine permanent restrictions. He noted that Petitioner apparently refused the FCE (the FCE was performed about six months later). Therefore, Dr. Rinella looked at Petitioner's work conditioning records to determine proper restrictions. He placed a 40-pound lifting/carrying restriction and 80-lb pushing/pulling limit. Petitioner should do such lifting/pushing less than 33% of the workday.

Dr. Eilers, a Section 12 medical examiner hired by Petitioner, opined that he did not really see Petitioner as being employable, certainly not back at heavy labor. "At the very best he may be able to intermittently do sedentary type tasks." He did not believe he could work eight hours a day because of his need to always change positions. Petitioner's deficits were permanent. Dr. Eilers acknowledged that he relied on Petitioner's subjective complaints in arriving at his opinions. He also noted that "Petitioner has had multiple surgeries and surgeries without success. He has some significant chronic pain which is persisting in limitation. He certainly is permanently and totally disabled from his employment." "His probability of returning to work is very limited, and he is probably permanently and totally disabled from competitive employment in light of the surgeries and complications." The Commission notes that Dr. Eilers is the only doctor to opine that Petitioner was PTD; a single doctor's opinion that a claimant is PTD is insufficient in itself to establish PTD. It also relates to the Petitioner's "condition," one of the conditions the Appellate Court ordered the Commission to consider when it remanded the case back to the Commission.

In his prior Section 12 medical examination report, Dr. Eilers noted that he believed Petitioner should "consider the issue of the fusion at L5-S1, the redo of the surgery; however, that is probably not going to have a profound impact on his prognosis. At the very best, it might get him to do some sedentary work, but even that is questionable in light of the pain that he is experiencing." Dr. Eilers also opined that Petitioner's pseudoarthrosis was a pain generator, and that it led to an unstable spine.

Dr. Rinella asserted that while he agreed that Petitioner's pseudoarthrosis was a possible pain generator and the level was less stable than if the fusion were a successful fusion, it was still

more stable than a normal spine. Dr. Rinella also recommended re-fusion at L5-S1, with possible extension of the fusion to L4-5. Petitioner declined to have the surgery recommended by both Dr. Eilers and Dr. Rinella.

The issues here revolve around competing voc rehab counselors. Petitioner's counselor, Mr. Gustafson, opined that Petitioner was not employable, while Respondent's counselor, Mr. Hammond, opined that he was. However, all doctors, as well as the counselors, agree that Petitioner could not return to work in his previous job which required a heavy physical demand level and the counselors agreed that Petitioner's prior employment did not avail him of skills that which were transferable to other employment opportunities. Upon consideration of the FCE and the report of Dr. Eilers, Mr. Gustafson opined that Petitioner's lack of experience makes unrealistic the proposition that an employer would hire him to train in an entry-level clerical job, especially because he would not be able to work an eight-hour day even in a sedentary job.

Mr. Gustafson also noted that Petitioner would not be suitable for an office-job because he had no background other than in manual labor. A prospective employer would look for a candidate with relevant experience or a person right out of high school. To obtain requisite skills to become employable, Petitioner would have to be retrained and he recommended he go to the local community college.

Respondent's Section 12 medical examiner, performed two file reviews of Petitioner's case. After his initial review of Petitioner's records, Mr. Hammond identified jobs that paid between $8.50 to up to $13.00 an hour. "A lot of them in the $9 an hour range." "On average, you're going to do to about $11." He identified telephone/switchboard jobs, assembly-line jobs through temp agencies, spray painting, sterilizing medical equipment, and janitorial jobs that were well within the 40-pound restriction. He also identified some hand-pallet jobs.

After the FCE, Mr. Hammond tried to meet with Petitioner, but was able to arrange no such meeting. Mr. Hammond noted that while the FCE indicated Petitioner was able to perform at the medium physical demand level, the FCE was terminated after 4 hours. Mr. Hammond interpreted the FCE results to place Petitioner closer to a 20-lb occasional/10-lb frequent restriction, with frequent position changes. He thought it was significant that the FCE was terminated at Petitioner's request, and not by the therapist based on his/her objective physiological findings of the participant.

Mr. Hammond reviewed the report of Mr. Gustafson. He noted that Mr. Gustafson believed that Petitioner could not work and/or retain employment because the ½ day FCE showed his endurance problems. Mr. Hammond disagreed with that assessment. He opined that Petitioner had the functional capacity to return to gainful employment and there were jobs available within his restrictions in Petitioner's geographic area. He also found Mr. Gustafson's recommendation for further education/training inconsistent with his conclusion that Petitioner was unemployable.

After his review of the additional information, Mr. Hammond concluded that Petitioner was currently employable "at the sedentary to light minimally." He agreed with Mr. Gustafson's recommendation for education. However, "if you can attend school full time, you can work full time." Mr. Hammond testified that the positions he identified would have allowed change of positions and occasional sitting/standing.

In addition, Mr. Hammond did not believe Petitioner's lack of experience precluded him from an entry-level clerical position. He asserted that employers will train such employees and many of these jobs require no more than a high-school education and he identified data entry positions as good examples of these types of jobs.

The Commission finds Mr. Hammond more persuasive than Mr. Gustafson on whether Petitioner is physically able to be employed. We do so based on Mr. Gustafson's reliance on the opinions of Dr. Eilers, who was mistakenly under the impression that Petitioner had "multiple" surgeries, when he had only one. In addition, Mr. Hammond actually based his assessment of employability on his interpretation of the FCE report which appear to be somewhat more restrictive than the restrictions Dr. Rinella recommended before the FCE. Finally, the Commission agrees with the statement of Mr. Hammond that Mr. Gustafson's conclusions were inconsistent because he opined that Petitioner was permanently disabled from employment, but then recommended he go to Community College to be retained for future employment.

In assessing the factors as mandated by the Appellate Court, the Commission finds that Petitioner's limited education (10th grade) and limited employment experience (manual labor only) are factors which militate against employability. However, the Commission also finds that his extremely young age (21 at the time of the accident) and his "condition" based on the FCE, Dr. Rinella's evaluation, and Mr. Hammond's assessment, are factors which support employability.

In looking at the entire record before us, the Commission finds that Petitioner is not eligible for TPD based on the odd-lot theory of permanent disability because he admittedly made absolutely no effort in looking for any employment, he apparently provided less than full effort in his FCE and work conditioning, that despite the limited effort, the FCE showed that he was able to function at least at the light physical demand level, he did not seek vocational rehabilitation assistance, and finally at his young age Petitioner should be able to be retrained in order to find suitable employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $287.94 per week for a period of 274&6/7 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 the sum of $290,437.58 for medical expenses under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

20IWCC0110

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner to sum of $259.15 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 50% of the person-as-a-whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 19 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
Remand
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STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF ST. CLAIR)	☐ 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

TANA TRICE,

Petitioner,

20IWCC0111

vs.

NO: 06 WC 1646

PARK HAVEN CARE CENTER,

Respondent.

DECISION AND OPINION ON REMAND FROM THE APPELLATE COURT

This matter comes before the Commission on remand from the Appellate Court of Illinois 5th District. The matter had been initially heard by Arbitrator Lee. He awarded Petitioner 255&5/7 weeks of temporary total disability benefits ("TTD"), $175,234.89 in medical expenses, and 100 weeks of permanent partial disability benefits representing loss of 20% of the person-as-a-whole. Both parties sought review by the Commission. Respondent preserved the issues of causation, medical expenses, TTD, and permanent partial disability. Petitioner preserved only the issue of the nature and extent of her permanent disability.

On review, the Commission modified the Decision of the Arbitrator to substantially reduce her benefits. The Commission found that Petitioner suffered a permanent, though minor, aggravation of her pre-existing condition, found that she reached maximum medical improvement as of January 27, 2006, terminated medical and TTD as of that date (22&4/7 weeks of TTD was awarded), and awarded Petitioner permanent partial disability benefits of 37.5 weeks representing loss of 7.5% of the person-as-a-whole.

Petitioner appealed the Decision of the Commission to the Circuit Court of St. Clair County. The Circuit Court reversed the Commission on the issues of temporary total disability and medical and affirmed the other aspects of the Commission decision. It based its reversal on the Commission's alleged "failure to award [temporary total disability and] medical bills from medical providers who treated Plaintiff during the agreed upon time frame for payment of benefits." The Circuit Court justified the reversal on Respondent's representations in the stipulation sheet and remanded the matter back to the Commission.

Petitioner appealed the Decision of the Circuit Court to the Appellate Court, which dismissed the matter for lack of jurisdiction as being interlocutory. It noted that the remand by the Circuit Court required more than a mere calculation by the Commission and therefore, the Decision of the Circuit Court was not an appealable final order. Accordingly, the matter was remanded back to the Commission under the mandate provided by the Circuit Court.

In the stipulation sheet Petitioner claimed 459&2/7 weeks of TTD. Respondent claimed the proper TTD period is "8/23/05-9/19/05, 4/6/06-9/6/07, 1/7/06-4/1/06." The Commission calculates that Respondent stipulated to 90 weeks of TTD. Petitioner also claimed temporary partial disability ("TPD") from September 19, 2005 through January 7, 2006 (15&6/7 weeks). Respondent apparently initially disputed that claim but crossed out its denial and agreed to that period of TPD. As noted above, the Arbitrator awarded 255&5/7 weeks of TTD. He did not appear to award TPD benefits even though he indicated that Petitioner testified that she worked part-time, apparently 20-hour weeks, from September 19, 2005 through January 7, 2006.

In looking at the order of the Circuit Court, the Commission concludes that it is mandated to award TTD through the period as Respondent agreed in the stipulation sheet, 90 weeks. On the issue of TPD, we conclude that the Commission is similarly obliged to award temporary partial disability benefits for a period of 15&6/7 weeks. While Petitioner did not testify as to her earnings while working 20-hour weeks, she testified that she normally worked 40 hours a week, and the parties stipulated to an average weekly wage of $480.00. Based on that stipulation, the Commission presumes that by working 20-hour weeks, Petitioner earned ½ of her normal average weekly wage. Section 8(a) provides that a TPD award shall be 2/3 of the difference in the claimant's average weekly wage and what she actually earned while working part time/light duty. According to our calculations, she presumably earned $240.00 a week for 15&6/7 weeks and the temporary partial disability rate is $160 per week.

Implementing the Circuit Court order regarding the proper medical award is a little more difficult. As noted above, the order specifies that the Commission erred in failing "to award medical bills from the medical providers who treated Plaintiff during the agreed upon time frame for payment of benefits." Technically, that would appear to include only the dates which Respondent's actually agreed to pay benefits, which presumably would include only medical expenses incurred during the actual periods Respondent agreed to pay TTD/TPD benefits. The Commission concludes that attempting to award medical only for the period of "the agreed upon time frame for payment of benefits" would be difficult to administer and could lead to additional litigation. Therefore, the Commission finds it prudent to award medical bills incurred through the last day Petitioner is entitled to receive temporary benefits, September 6, 2007. Petitioner was still in need of treatment through that entire time period.

20IWCC0111

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.00 per week for a period of 90 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 $160.00 per week for 15&6/7 weeks, that being the period of temporary partial incapacity to work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $288.00 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of the use of 7.5% of the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses incurred through September 6, 2007 under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION, that the award of medical expenses incurred after September 6, 2007 is vacated.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, 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 $42,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: FEB 19 2020

Deborah L. Simpson

Deborah L. Simpson

Barbara N. Flores

Marc Parker

Marc Parker

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MALISSA WILLIAMS,

Petitioner,

20IWCC0112

vs. NO: 18 WC 37287

BLOOMINGTON REHAB & HEALTH,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained her burden of proving she suffered a compensable accident, that the accident caused a condition of ill-being of her right hand/wrist, and that she is entitled to corresponding benefits.

I. FINDINGS OF FACT

A. Background, Accident and Initial Medical Treatment

Petitioner testified that on November 4, 2018 she was employed by Respondent as an LPN. Her work schedule was double shifts on Sundays, Mondays, Wednesdays, and Fridays, single shift on Thursdays, and off Tuesdays and every other weekend. Typically, she worked 16-hour days. She earned $24.00 an hour. At about 9 a.m. that day, she was asked to assist a CNA. They were turning a patient in a bed to bathe her. Petitioner was holding the patient with her right hand at the patient's hip while the CNA was getting the sheets. Petitioner testified that the patient pushed back or rolled back and hyperextended her hand. Immediately, Petitioner felt

"like a pop slightly, and little pain" in her wrist. Petitioner testified that she said "ouch" and that her hand bent.

After continuing care for the patient, Petitioner went to the office of Administrator, Janice Kindred, and told her what happened. Ms. Kindred gave Petitioner an incident report to fill out, which Petitioner completed, and Ms. Kindred signed. Then, Petitioner went with Ms. Kindred to the med room and got an ace bandage, which another nurse applied to her hand. Petitioner did not recall whether she and Ms. Kindred had any conversation at the time they filled out the incident report.

Petitioner testified that in the incident she injured her right hand but no other body part. On cross-examination, she was asked about the particular body part identified in the incident report[1]. When asked if she failed to indicate any injury to her arm, Petitioner responded "I guess. I don't remember." After additional questioning regarding the body part that she identified in the report, Petitioner testified that she injured her arm and specified that her wrist is her arm. She did not dispute that the medical records only refer to injury to her hand[2]. Petitioner did not dispute the medical records if they failed to reference her arm, and she did not remember what she told the doctors other than having pain in her hand and arm.

After her injury, Petitioner returned to work and finished her shift at 10:00-10:30 p.m. She testified that she remained bandaged and continued to work despite pain. Petitioner worked the next day as well, using a splint. She testified that she was able to do her job even though her hand was painful. Petitioner did not recall the specific date but testified that "a couple of days" later, thinking it was on the 9th, Respondent sent her to the Illinois Work Institute ("IWIN") for medical attention. Petitioner explained that the initial visit to IWIN was prompted after she went to Ms. Kindred's office and told her that her hand was still hurting and swollen. Ms. Kindred made the appointment for her at IWIN.

The medical records from "Bloomington Rehab & Healthcare-IWIN WC" reflect that Petitioner did present on November 9, 2018 and saw a nurse practitioner, NP-C Steele. Petitioner testified that she reported pain in her hand and around the wrist from the thumb up to her wrist and was still wearing the splint. She also testified that she was not informed about the x-ray results, and she was only given work status slips. The medical records reflect her report that on November 4, 2018 she was rolling a patient over with a CNA. As the patient "rolled back" her right hand was hyperextended back. Petitioner identified the area of pain to extend from her thumb to radius, and worsening pain since the injury. Her pain was 10/10 initially and 10/10 currently. She also reported difficulty with range of motion and gripping. She had no prior medical history. X-rays were negative. Ms. Steele diagnosed wrist sprain, provided a self-

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[1] The incident report referenced by Petitioner and referred to as an accident report by Respondent's counsel was not offered into evidence.

[2] Compare the medical records in PX1 and PX2 reflecting that the radiologists, Dr. Plocher, and nurse practitioner, Ms. Steele, refer to Petitioner's complaints, diagnostic findings, and diagnoses as related to her right wrist, hand, and thumb.

adhesive wrap, recommended over-the-counter medication for pain/swelling, taught Petitioner finger exercises, and released her to work without restrictions.

Petitioner testified that she returned to IWIN three more times. Petitioner explained that her work was not restricted in any way despite work restrictions and that she continued to work with a splint. The medical records reflect that Petitioner presented to IWIN on November 14, 2018. She reported 10/10 pain and was still using her wrist-brace but found it difficult to work. The nurse practitioner, Ms. Steele, noted that Petitioner was sitting with no obvious distress. On examination, Ms. Steele noted a pleasant female in no respiratory distress with appropriate mood and affect without depression, anxiety or agitation. The right hand examination was normal overall with mild pain. Nonetheless, Ms. Steele prescribed Meloxicam/Mobic for inflammation and pain and she further noted that the wrist sprain was not resolving. Ms. Steele referred Petitioner for an orthopedic evaluation because of a concern of scaphoid fracture. She also imposed work restrictions. Petitioner testified that she was referred to McLean County Orthopedics, where she saw Dr. Plocher.

B. Separation from Employment

In the interim, Petitioner's employment with Respondent ended. Petitioner testified that her last day of work was November 14, 2018. That morning, Petitioner testified that she went in to work. After clocking out to go to the doctor and returning to work, Petitioner gave the work status form to her supervisor, Sheila Strola. Petitioner explained that Ms. Kindred was not in and she told Ms. Stola that morning that she needed the next day, the 15th, off. Petitioner then continued working and testified that Ms. Strola told her that afternoon that if she did not come to work tomorrow, she would write her up, so she continued to do her work through a double shift.

Petitioner did not work on November 15, 2018 but returned to work on November 16, 2018. She testified that she came in at about 5:45 a.m. and clocked in and went to get the key and had a conversation with the night nurse. Petitioner then waited for Ms. Kindred to arrive. When Ms. Kindred came in, they went to her office to have a discussion. Petitioner asked Ms. Kindred why she needed to call her (Ms. Kindred). Petitioner then left. She was still in the splint and on restricted duty at that time. Later that day, Petitioner talked[3] to a woman at the corporate office and Petitioner testified that she has not worked for Respondent since. Respondent paid for her medical bills, but she has not been paid for any time off work.

On cross-examination, Petitioner agreed that she was able to work after the accident and at least through November 14, 2018, a day in which she worked double shift. Petitioner testified that she needed the day off on November 15, 2018 to take her fiancé to Chicago for eye surgery. She denied that she quit her job that day.

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[3] Respondent's counsel raised a hearsay objection to Petitioner's testimony regarding whatever the corporate office person said. The objection was sustained.

Ms. Kindred was called by Respondent and testified that she had worked as the Administrator for 13 years. Ms. Kindred agreed that she had a conversation, but testified that it occurred Petitioner on November 14, 2018. Ms. Kindred testified that Petitioner came to her and asked to whom should she provide a resignation? Ms. Kindred responded, to the director of nursing.

Ms. Kindred testified that "[Petitioner] stated that the DON would not give her the day off the next day to go to Chicago and that she was -- wanted to know who she gave her resignation to." Ms. Kindred reiterated that "I told her she should give that to the director of nursing." Thereafter, Ms. Kindred testified that Petitioner "showed up [on an unspecified date] and was asked to leave the building." Ms. Kindred testified that after Petitioner's resignation and, but for the resignation, she would have considered to keep her working.

On cross-examination, Ms. Kindred initially testified that she believed that the director of nursing was present during this conversation, but then she could not remember whether anyone else was in the room. In response to further inquiry whether Petitioner "resign[ed] at that time in this meeting in your room -- in your office[]" Ms. Kindred testified "Yes. Yes, sir, she did." Ms. Kindred went on to testify that Petitioner continued to work until 10:30 at night. When questioned why Petitioner was allowed to finish out her shift, Ms. Kindred testified that "[Petitioner] said after her shift is over today, she resigns effective immediately, so we let her finish out her shift." Ms. Kindred maintained that, although Petitioner had resigned in her office, she allowed Petitioner to work another 12 hours. She testified that she let Petitioner continue to work because "[they] didn't have any reason not to let her finish out her shift." Ms. Kindred testified that it was Petitioner's decision to resign.

C. Continued Medical Treatment

After these conversations, and Petitioner's separation from Respondent's employment, on November 19, 2018 Petitioner presented to Dr. Plocher at McLean County Orthopedics for an initial evaluation of severe right-wrist, sharp, shooting pain on referral from IWIN. She reported a hyperextension injury on November 4, 2018 while helping a patient with his ADLs. She "was using her right hand to support the patient from behind when the patient began to tip backwards[and she] sustained a hyperextension type of injury to her right wrist." Petitioner recalled hearing a pop after which she noted immediate pain and swelling. A T-spica splint provided no relief and Petitioner's pain was "localized to the thumb CMC joint, volar ST joint, and anatomic snuffbox." Dr. Plocher noted that the trapezial ridge fracture shown on x-rays would be treated conservatively with casting. Dr. Plocher was also concerned about a possible scaphoid fracture and ordered an MRI and CT scan for evaluation. Petitioner was restricted from right hand use at work and at home.

The MRI taken on November 21, 2018 showed no fracture but did show sprain of the scapholunate ligament without focal tear or widening of the interval, and osteoarthritis of the scapholunate joint. A CT corroborated the lack of a fracture.

Petitioner returned to Ms. Steele at IWIN on November 29, 2018 reporting a weird, tingling sensation in her whole hand and worsened pain with gripping and lifting. Ms. Steele noted Petitioner's recent repeat x-ray with the impression of a trapezial fracture and suspicion of a scaphoid fracture. She further noted that an MRI showed a scapholunate ligament sprain without focal tear or widening of the interval as well as mild osteoarthritis at the scapholunate joint. The MRI and a CT scan did not show an acute fracture or dislocation. Petitioner had been placed in a cast, which was replaced on November 26, 2018 due to pain. Ms. Steele diagnosed a right wrist sprain that was not resolving, maintained Petitioner's work restrictions, and continued cast care with follow up at McLean County Orthopedics.

On November 29, 2018, Petitioner also saw Dr. Plocher who diagnosed a closed fracture of the metatarsal bone. Petitioner reported little change. Dr. Plocher administered an injection, maintained Petitioner's restrictions of no right hand use, replaced the cast with a splint, and advised her to wear her splint at all times.

On December 20, 2018, Petitioner reported that the injection helped significantly but she still had mild pain in her right hand. She also reported thumb pain. Dr. Plocher believed the thumb pain was the result of her feeling better and using her hand more, as well as fighting against the splint which was a bit undersized and digging in at the base of her thumb. Dr. Plocher eased restrictions to lifting no more than five pounds with Petitioner's right hand and discontinued use of the splint.

On January 17, 2019, Petitioner reported she felt much better and was able to do more. She was having no problems working with the five-pound restriction and vto see how it worked out. Dr. Plocher placed Petitioner at maximum medical improvement and released her from treatment to return as needed. Petitioner agreed that she was released to work at full duty.

D. Additional Information

Petitioner acknowledged that she had prior workers' compensation claims, and did not think she had four, but would accept that if the records so indicated. She agreed that she previously injured her neck, back, and left hand, but she did not previously injure her right hand. Petitioner did not recall whether she injured her shoulder. Petitioner was presented with a "Medical History Questionnaire" dated July 23, 2018 that she signed when seeking employment with Respondent. She testified that she did not fill out the entire document. The responses to all of the questions were answered in the negative, and the sections requesting explanations to any "yes" answers are blank.

In pertinent part, the questionnaire asks whether she: (1) was ever restricted in her activities; (2) had been given a percentage of permanent disability to any part of her body for any reason; (3) had ever received treatment for her back, neck, knees or lower extremities from a physician, chiropractor, therapist or other health care provider; or (4) had an injury that required

her to miss time from work. All responses were checked no. Petitioner was cross-examined on these responses and she testified that she did not mention these prior injuries or prior workers' compensation awards in her application for employment with Respondent. Petitioner also testified that she did not sign all of the "no" responses to the questionnaire. The section in which she was supposed to explain any "yes" answers, is blank.

Petitioner was also asked whether she had ever had a sore neck, knee issues, ankle issues, or any problems with her shoulder. She did not recall any knee issues or shoulder problems. Petitioner acknowledged that she had a prior injury to her neck, and she left that question blank in the questionnaire. She also acknowledged that she was taken off work, had been restricted from work, and had received workers' compensation benefits in one claim. Petitioner also agreed she was in a motor vehicle accident many years ago, but denied she filed suit or received a settlement.

Petitioner also signed a "Health Care Worker Background Check" form indicating she was never convicted[4] of a criminal offense. The form specifically excludes certain offenses and directs the applicant, "do not include convictions that have been expunged, sealed, or adjudicated delinquent[.]" On cross-examination, Petitioner was asked about any prior convictions. She denied prior convictions for any felony or past crime. However, she testified that the form indicated that she should not include anything that was expunged or sealed.

On cross-examination Petitioner was also asked about her representations to a prior employer as well as prospective employers after leaving Respondent's employment. She has been unable to obtain a job since November of 2018. Petitioner acknowledged that she worked for St. Paul's Lutheran Life Community years ago, and that she filed a workers' compensation claim against them and received benefits. When asked if she was employed by Cambridge Nursing Home in October 2012 based on records showing as much, Petitioner responded that she "[p]robably" did. Petitioner did not list that job in her application for employment with Respondent. When asked if she may have had some back issues or prior workers' compensation claims involving her back, and whether she disputed that, Petitioner again responded "[p]robably." When shown the 2012 "Confidential Employee Health Record" from Cambridge, Petitioner guessed that she told them she did not have prior back issues.

With regard to prospective employers, Petitioner denied ever working for Sugar Creek although she interviewed there. She testified that she interviewed at a lot of places. Petitioner

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[4] After the arbitration hearing ended and proofs were closed, Respondent moved to reopen proofs stating that they found a felony conviction that had not been sealed or expunged. Respondent argued that it was not offering the conviction to show the actual conviction but rather to show her untruthful testimony. Petitioner objected citing the 10-year limitation from the date of conviction (2008) to the date of hearing (2019). Petitioner also objected because the conviction could have been presented at the hearing. Finally, Petitioner noted that there was no evidence of the disposition of Petitioner's motion to expunge. The Arbitrator agreed with Petitioner, denied Respondent's Motion to Reopen Proofs, and rejected its proposed exhibit. The Commission notes that no such argument was raised by Respondent on review and is deemed waived.

did not remember whether she reported her prior claims or injuries to prospective employers. She agreed that once she went by the name of Malissa Temple.

II. CONCLUSIONS OF LAW

A. Accident

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. *Dunteman v. Illinois Workers' Compensation Comm'n*, 2016 IL App (4th) 150543WC, ¶ 40. The "in the course of" component refers to the time, place, and circumstances under which the injury occurred. *Id.* The "arising out of" component addresses the causal connection between a work-related injury and the claimant's current condition of ill-being. *Id.* An injury "arises out of" employment if it had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.*

In this case, the Arbitrator found that Petitioner did not meet her burden of proving she sustained a work accident on November 4, 2018. He based that finding on his determination that Petitioner lacked credibility. The Arbitrator noted that the medical records suggest that Petitioner "may" have injured her hand on the alleged accident date, but there were too many inconsistencies in her testimony to believe the rest of her claims.

The Commission agrees with the Arbitrator that Petitioner had serious credibility issues; but disagrees that those credibility issues obviate a finding that Petitioner sustained an injury to the right hand/wrist. To the contrary, the medical records establish that Petitioner sustained a traumatically induced injury—albeit a minor one—resulting in objectively identified right hand/wrist pathology noted by both the nurse practitioner and orthopedist to whom Petitioner was referred by Respondent for treatment.

On the date of the accident, Petitioner went to Ms. Kindred and reported the incident. Ms. Kindred took Petitioner to the med room and got an ace bandage, which another nurse applied to her hand. Respondent's in-house nurse did not testify at the hearing. Petitioner continued to have symptoms for several days and she returned to Ms. Kindred for assistance. Ms. Kindred made an appointment for Petitioner at IWIN. Petitioner then underwent treatment exclusively with medical providers to whom she was referred by Respondent.

Petitioner was first evaluated on November 9, 2018 by a nurse practitioner, Ms. Steele, at IWIN. She reported a mechanism of injury consistent with that described at the hearing: that is, that a patient "rolled back" her right hand which was hyperextended back. The medical records reflect that Petitioner reported pain at 10/10 localized to her hand and around the wrist from the thumb up to her wrist. The nurse practitioner diagnosed a wrist sprain and released Petitioner

back to work without restrictions. However, her medical treatment did not end at this point as directed by Ms. Steele.

Petitioner returned on November 14, 2018 reporting the same level of 10/10 pain and difficulty working. Ms. Steele documented a normal right hand examination but was nonetheless concerned that Petitioner had a scaphoid fracture. Thus, even considering Petitioner's subjectively reported pain to be histrionic, the Commission notes that the nurse practitioner found enough objective medical evidence to prompt additional evaluation and possible treatment by a specialist. Ms. Steele referred Petitioner to McLean County Orthopedics, prescribed inflammation and pain medication, and imposed work restrictions.

When Petitioner presented to Dr. Plocher, an orthopedist, on November 19, 2018, she documented a consistent mechanism of injury that Petitioner "was using her right hand to support the patient from behind when the patient began to tip backwards[and she] sustained a hyperextension type of injury to her right wrist." Dr. Plocher also documented a consistent onset of symptoms including Petitioner's report that she heard a pop after which she noted immediate pain and swelling. Dr. Plocher, the only physician that examined Petitioner regarding her injury, addressed the nurse practitioner's concern about a possible scaphoid fracture and ordered additional tests. A subsequent MRI and CT scan were negative for a scaphoid fracture, but they did reveal a sprain of the scapholunate ligament. More importantly, Dr. Plocher identified and diagnosed a trapezial ridge fracture revealed on x-rays. Dr. Plocher recommended conservative treatment with casting. When Petitioner returned to IWIN to see Ms. Steele, she agreed with Dr. Plocher's plan of care.

On November 29, 2018, Ms. Steele noted Petitioner's recent repeat x-ray with the impression of a trapezial fracture. She diagnosed a right wrist sprain that was not resolving, maintained Petitioner's work restrictions, and recommended that she continue cast care and follow up at McLean County Orthopedics. Petitioner presented to Dr. Plocher that very day who noted Petitioner's report of little change in her condition. He diagnosed a closed fracture of the metatarsal bone. Petitioner received an injection and her cast was replaced with a splint.

At the December 20, 2018 visit, Petitioner reported that the injection helped significantly and reported greatly reduced pain. Dr. Plocher believed the thumb pain was the result of Petitioner using her hand more, and the result of fighting against the splint, which was a bit undersized and digging in at the base of her thumb. Dr. Plocher discontinued splinting. When Petitioner returned on January 17, 2019, she reported much improved pain levels and the ability to do more. Petitioner believed she could work full duty, and Dr. Plocher released her without restrictions and from further medical care.

The Commission accepts Respondent's fervent, and justifiable, dissatisfaction with Petitioner's dishonest representations when she applied for employment. However, the Commission is tasked with evaluating whether Petitioner sustained a compensable injury occurring in the course of and arising out of her employment with Respondent. Ms. Steele and

Dr. Plocher found sufficient objective medical bases on which to diagnose and treat Petitioner's right hand/wrist over months inclusive of casting and an injection.

The claimed injury occurred in the presence of a co-worker and was temporarily remedied by an in-house nurse, neither of which testified. The incident was then reported to Ms. Kindred, but, curiously, no investigation into the allegation was performed or documented in a facility staffed with nurses to whom Petitioner reported. The incident prompted immediate treatment of objectively verified pathology as noted herein. Petitioner's lack of credibility regarding other matters does nothing to change the uncontroverted evidence establishing that the only source of Petitioner's right hand/wrist pathology is a witnessed hyperextension injury that occurred while bathing a patient on November 4, 2018 causing a "pop" and resulting in a fracture.

Ultimately, the evidence does not establish that Petitioner suffered no injury at all; nor does the evidence establish that Petitioner injured herself anywhere other than while bathing a patient. To find as much amounts to speculation that requires the Commission to overlook objective medical evidence. Petitioner's dishonesty in her employment dealings with Respondent or other entities, or the existence of an expunged criminal record for an unknown wrongdoing stemming from conduct over 10 years ago, simply do not establish that Petitioner's objectively verified right hand/wrist pathology after November 4, 2018 stemmed from anything other than a patient who rolled back on her hand. Thus, the Commission finds that Petitioner has established that she sustained a compensable injury that occurred in the course of and arose out of her employment with Respondent on November 4, 2018.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. As explained herein, the medical records establish that Petitioner did sustain a work-related accident on November 4, 2018 that resulted in a current condition of ill-being of her right hand/wrist. Given this record, the Commission concludes Petitioner's condition of ill-being is causally related to the accident.

C. Temporary Total Disability

Petitioner claims that she is entitled to temporary total disability benefits from November 15, 2018 through January 17, 2019. It is undisputed that Petitioner was restricted from full duty work and did not work during that period. No evidence was submitted that Respondent was willing or prepared to accommodate the restrictions as of November 15, 2018. It is also undisputed that Petitioner was released to work without restrictions as of January 17, 2019. However, the parties dispute the circumstances of Petitioner's departure from Respondent's employment. Petitioner claims that she was terminated and Respondent claims that she voluntarily resigned.

Two conversations are central to the circumstances surrounding Petitioner's departure from Respondent's employment, which Respondent contends undermines her credibility. One conversation took place between Petitioner and Ms. Kindred, Respondent's administrator. Another conversation took place between Petitioner and her supervisor, Ms. Strola. Ms. Strola did not testify at the hearing. Moreover, the versions of events described by Petitioner and Ms. Kindred are each denied by the other.

Petitioner testified that she went in to work and told Ms. Strola that she needed the next day off. On cross-examination she testified that it was to take her fiancé to the eye doctor in Chicago. Petitioner maintained that she then clocked in to work on November 16, 2018 and had a conversation with Ms. Kindred after which she left and, later that day, spoke with someone at the corporate office. An objection was raised with regard to hearsay, sustained, and Petitioner did not testify about the discussion had with Ms. Kindred. Respondent maintains that Petitioner, in fact, resigned on November 14, 2018 and relies on the testimony of Ms. Kindred to that effect. She testified that when Petitioner asked her, to whom should she provide her resignation, Ms. Kindred directed Petitioner to the director of nursing and then, nonetheless, accepted Petitioner's resignation and allowed her to finish her double shift.

If Respondent's proposition that Petitioner resigned is true, then the Commission must accept incongruent allegations. The Commission would have to accept that Ms. Kindred gave Petitioner a chain-of-command resignation instruction directing her to the DON, which Petitioner ignored, prompting Ms. Kindred to nonetheless accept the resignation and then allow her to complete a double shift despite an orthopedic referral for a suspected scaphoid fracture and work restrictions. The Commission would also have to accept that Petitioner resigned on November 14, 2018 under these circumstances and then returned to Respondent's facility for no apparent reason on November 16, 2018.

The Commission is not persuaded by Ms. Kindred's testimony on its own. The witnesses that could corroborate Ms. Kindred's testimony or controvert Petitioner's testimony, Ms. Strola and the DON, did not testify at the hearing. Moreover, other documentary evidence that could corroborate Ms. Kindred's version of events (i.e., an accident investigation report, employment records, time records, etc.) all of which would be within Respondent's control were not offered at the hearing.

There is no persuasive evidence in the record that Petitioner voluntarily left Respondent's employment releasing Respondent from liability for temporary total disability benefits. Therefore, the Commission finds that Petitioner has established her entitlement to temporary total disability benefits from November 16, 2018 through January 17, 2019.

D. Permanent Partial Disability

Subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of permanent partial disability benefits to which a

claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2018). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

Regarding the level of impairment contained within a permanent partial disability impairment report, the Commission notes that no impairment rating based on the AMA Guides was submitted. Thus, the Commission gives no weight to this factor.

Regarding the claimant's occupation, the Commission notes that Petitioner was employed as a nurse at the time of her accident and was released back to full duty work by Dr. Plocher. Thus, the Commission gives some weight to this factor.

Regarding Petitioner's age, the Commission notes that Petitioner was 40 years old at the time of the accident indicating a considerable number of working years remaining. Thus, the Commission gives considerable weight to this factor.

Regarding Petitioner's future earning capacity, the record reflects that Petitioner was released to return to full duty work and no evidence was submitted suggesting a loss of earning capacity as a result of the injury. Thus, the Commission gives significant weight to this factor.

Finally, regarding evidence of Petitioner's disability corroborated by the treating medical records, the Commission notes that Petitioner did not testify to any substantial ongoing impairment to her right hand. However, the medical records reflect that Petitioner underwent conservative medical treatment including an injection and casting to correct a fracture followed by a full duty released as of January 17, 2019 when Petitioner noted increased, but not fully restored, physical ability. Thus, the Commission gives additional significant weight to this factor.

Thus, in contemplation of the entire record, the Commission awards Petitioner permanent partial disability benefits representing loss of 5% of the right hand.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has established that she sustained a compensable accident and a causal connection between her condition of ill-being and accident at work.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $897.78 per week for a period of 9 & 1/7th weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner \$808.00 per week for 10.25 weeks because the injuries sustained resulted in the 5% loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of \$16,000.00. 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: FEB 19 2020

Barbara N. Flores

DLS/dw
O-1/9/20
46

Marc Parker

DISSENT

I respectfully dissent from the decision of the majority. I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain her burden of proving a compensable accident and denied compensation.

The Arbitrator denied compensation because he found Petitioner to be completely incredible as a witness. He cited her pattern of deception and that she became "increasingly combative and evasive" when confronted about her deception. In my opinion, the Arbitrator was in the best position to assess Petitioner's veracity and he could properly conclude that her underlying deception put her entire testimony in doubt and that therefore she did not sustain her burden of proving she sustained an accident.

In addition, even accepting the majority decision that Petitioner successfully proved accident, I do not believe the majority award of temporary total disability benefits was proper. While Petitioner's treating doctors did place significant work restrictions on her, no doctor took her off work completely. In addition Respondent's administrator, Janice Kindred, testified that Petitioner voluntarily resigned from her position on November 14, 2018 and that without such

resignation, she would have considered any necessary accommodations that Petitioner might have needed. In light of Petitioner's demonstrated untruthfulness, I believe it was correct for the Arbitrator to determine that Ms. Kindred was a more credible witness than Petitioner. Therefore, in my opinion Petitioner was not entitled to temporary total disability benefits because she voluntarily left Respondent's employment, irrespective of whether she had a compensable accident.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain her burden of proving a compensable accident and denied compensation. Therefore, I respectfully dissent from the decision of the majority.

DLS/dw
O-1/9/20

Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRAD JUDD,

Petitioner,

20IWCC0113

vs.

NO: 10 WC 48067
12 WC 38646
12 WC 38647 (cons)

AMERICAN AIRLINES,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's review of Arbitrator Mason's order denying his petition for reinstatement. The Commission, after considering the record, concurs with the Arbitrator that despite Petitioner's Counsel's efforts, his ability to prosecute these claims was hindered by Petitioner's own actions. The Commission hereby affirms and adopts the Arbitrator's order, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 13, 2018 order denying reinstatement is hereby affirmed.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of reinstatement herein, no bond is set by the Commission.

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

DATED: FEB 19 2020

LEC/mck

O: 2/5/2020

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L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brad Judd,

Petitioner,

vs.

Nos. 10 WC 48067
12 WC 38646-7 (consolidated)

American Airlines,

Respondent.

ORDER DENYING PETITION TO REINSTATE

These previously consolidated claims come before the Arbitrator on Petitioner's Petition to Reinstate. The Arbitrator conducted a hearing on said petition on May 17, 2018, after Respondent raised an objection to reinstatement. Counsel for both parties appeared on said date. Petitioner did not appear. A record was made.

In ruling on the Petition, the Arbitrator has considered the following chronology:

1. Petitioner's oldest claim, 10 WC 48067, dates back almost eight years. In that claim, Petitioner alleges head and left eye injuries of November 1, 2010. In 12 WC 38646, he alleges low back injuries of August 1, 2012. In 12 WC 38647, he alleges chemical burns of April 23, 2012. All three cases have been categorized as "red line" or "must appear" for a number of years.

2. The Arbitrator's notes document multiple requests for continuance of these claims, with the requests dating back to at least 2014. Initially, Petitioner's counsel represented that Petitioner was still under treatment. Later, he indicated the parties were beginning settlement negotiations. In mid-2016, he informed the Arbitrator that Petitioner had moved to Bangkok, Thailand, and was continuing to undergo some form of back-related care there.

3. At the hearing, Petitioner's counsel indicated that, while Petitioner has been difficult to communicate with, and declined to accept an offer he recommended, he wants to continue to represent Petitioner and believes the cases have merit.

4. Petitioner's counsel also argued that Respondent had an opportunity, in the past, to secure a Section 12 examination but instead opted to obtain opinions from Dr. Levin via a records review. Respondent's counsel countered that he determined an examination was needed after the deposition of Dr. Brabek. In the latter part of 2017, counsel for both parties began discussing possible dates for an examination as

well as the issue of Respondent's potential liability for expenses relating to Petitioner's attendance. Petitioner's counsel provided Respondent's counsel with dates in early to mid-February 2018. Respondent scheduled the examination for February 7, 2018 and provided notice to Petitioner's counsel. Approximately three days later, unbeknownst to Petitioner's counsel, Petitioner E-mailed a Respondent representative on December 19, 2017 and indicated he was going to be in Chicago between that date and December 30, 2017, and needed access to his previously assigned work locker at O'Hare Airport so that he could retrieve a laptop and other personal items. After Respondent provided this access to Petitioner, Petitioner returned to Thailand. On January 4, 2018, Petitioner sent an E-mail to both counsel indicating he would not attend the scheduled examination unless Respondent provided him with a round-trip, business class ticket that would afford him a "lie flat" bed during the flight. Petitioner also indicated he would need 48 hours to recover from the flight and expected Respondent to cover a week's worth of lodging, food and transportation expenses. Alternatively, Petitioner suggested that the examination take place in Thailand. He identified several potential examiners there, including a provider who he sees for his claimed back condition. RX 1.

Petitioner failed to attend the February 7, 2018 examination. On February 14, 2018, the Arbitrator dismissed the claims on Respondent's motion. Arb Exh 2. This motion had previously been continued. Petitioner's counsel was present on February 7th and subsequently filed the subject Petition to Reinstate on April 12, 2018.

The parties agree there is no evidence of any current travel-related medical restrictions. At the hearing, Petitioner's counsel indicated he does not expect Respondent to pay Petitioner's airfare but does expect payment of expenses Petitioner will incur while in the Chicago area for purposes of the examination. He also indicated that Petitioner plans to be in Chicago between June 21 and July 1, 2018, and will make himself available for a Section 12 examination during this period.

5. On a petition to reinstate before the Commission, the burden is on the claimant to to allege and prove facts justifying the relief sought. Bromberg v. Industrial Commission, 97 Ill.2d 395, 401 (1983). Whether to grant or deny such a petition rests within the sound discretion of the Commission. Conley v. Industrial Commission, 229 Ill.App.3d 925, 930 (1992).

   In these cases, the petition to reinstate was timely filed and promptly presented. Arb Exh 1. The problem is not with Petitioner's counsel, but Petitioner himself. It is up to "a party" and not just his counsel to exercise due diligence in pursuing his claim. Contreras v. Industrial Commission, 306 Ill.App.3d 1071, 1076 (1999). Petitioner's subterfuge has impaired his attorney's ability to represent him and has caused prejudice to Respondent. Banks v. Industrial Commission, 345 Ill.App.3d

1138 (5th Dist. 2004). His pattern of ignoring his attorney's advice causes the Arbitrator to doubt he would attend a rescheduled Section 12 examination.

The Arbitrator, having considered her notes, the pleadings, the arguments of counsel and relevant case law, denies the Petition to Reinstate.

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

Molly C. Mason
Arbitrator Molly C. Mason

Date: June 13, 2018

JUN 13 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIROSLAW AUDZIEJCZY,
Petitioner,

20IWCC0114

vs. NO: 17WC 30876

ESSENCE PAINTING & RESTORATION,
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 employee/employer relationship, medical, nature and extent, whether Petitioner elected out of the WCA, 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 25, 2019, is hereby affirmed and adopted.

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

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

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

DATED: FEB 19 2020
o020520
DDM/jrc
052

D.Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0114

AUDZIEJCZYK, MIROSLAW Case# **17WC030876**
Employee/Petitioner

ESSENCE PAINTING & RESTORATION INC
Employer/Respondent

On 3/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2234 CHEPOV & SCOTT LLC
NATALIA A OLEJARSKA
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CHICAGO, IL 60656

1295 SMITH AMUNDSEN
LESLIE JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

20IWCC0114

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

Miroslaw Audziejczy
Employee/Petitioner

v.

Essence Painting & Restoration
Employer/Respondent

Case # **17** WC **030876**

Consolidated cases: ______

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

DISPUTED ISSUES

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

FINDINGS

On **October 4, 2017**, 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 ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner's average weekly wage was $**1077.76**.

On the date of accident, Petitioner was **65** 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

Denial of benefits

BECAUSE AN EMPLOYEE-EMPLOYER RELATIONSHIP DID NOT EXIST BETWEEN PETITIONER AND RESPONDENT, 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 25, 2019
Date

MAR 25 2019

Miroslaw Audziejczy v. Essence Painting & Restoration, Inc., No. 17 WC 030876

Preface

The parties proceeded to hearing December 21, 2018, on a Request for Hearing indicating the following disputed issues: whether the relationship of Petitioner and Respondent was one of employee and employer; and whether Respondent is liable for unpaid medical bills totaling $73,906.80. Respondent claims to allege Petitioner excluded himself from the Act yet makes no reference to 820 ILCS 305/2 or any other provision of the Act. The parties neglected to indicate whether the nature and extent of the injury was a disputed issue, thus it is not. Arbitrator's Exhibit 1. The hearing did not proceed as a Section 19(b) Petition. Miroslaw Audziejczyk v. Essence Painting and Restoration, Inc., No. 17 WC 030876 Transcript of Proceeding on Arbitration at 4, 8; Arbitrator's Exhibit 1. Two witnesses testified, Petitioner with the aid of a translator and George Pachuta, the owner of Essence Painting.

Findings of Fact

Miroslaw Audziejczyk (Petitioner), a 65 year old male, testified that on October 4, 2017, he was at a residence, 20 Fox Lane, Winnetka. He is a painter, and had his own company, MA Painting, he established in 2008. Petitioner testified he was working on a ladder by the garage. He said he fell off the ladder eight to nine feet onto asphalt. He later told Buffalo Grove-EMT paramedics he fell seven to eight feet to the ground; landing feet first and then fell backwards. He later told medical providers at Northwest Community Hospital the ladder had slipped. Buffalo Grove EMT-paramedics recorded Petitioner told them he was initially alone and slowly made it to his car, where he called his boss. Petitioner, however, testified he texted George Pachuta, who called him and said the manager of Essence Painting (Respondent) was coming. Petitioner said the manager took him to a medical center. He said he felt pain in his legs, spine, and back. Audziejczyk at 41, 11-12, 21, 32, 43, 44; Petitioner's Exhibit 14; Respondent's Exhibit 3; Petitioner's Exhibit 2 at 262, 40.

Petitioner sought treatment at the Immediate Care Center of Northwest Community Hospital in Buffalo Grove. They decided to transfer him to the emergency room for a higher level of care. The transfer was made by the Buffalo Grove Fire Department, who determined Petitioner was able to communicate effectively speaking English. The EMT-paramedics noted, "Smell of alcohol on breath." Petitioner's Exhibit 2 at 11, 262; Petitioner's Exhibit 1 at 1.

Petitioner testified he was treated at Northwest Community Hospital and admitted for over two weeks. He said he had x-rays and CT scans, was diagnosed with broken bones in both feet and a hernia. He got a Cam boot for his right foot and was referred to Dr. Jessica Knight. Knight performed surgery on his left foot and did a second surgery. When he left the hospital, he

got crutches, a walker, and a wheelchair and pain medications. Petitioner said he had one injection in his left foot and last had a visit March 29, 2018. Audziejczyk at 45-50.

The records of Northwest Community Hospital indicate Petitioner was seen in the emergency room October 4, 2017. He had x-rays indicating: right foot (fractures in the metatarsals); left ankle (comminuted fracture calcaneus with disruption of subtalar joint); left foot (comminuted calcaneus fracture disruption of subtalar joint); pelvis (no fracture); left tibula (calcaneal fracture); chest (no acute abnormality). He had CT scans indicating: chest/abdomen/ pelvis (hernia); spine (no fracture); and brain (unremarkable). A consult note from Dr. Knight indicated Petitioner's right foot would be treated without surgical intervention. The left foot would require surgery once fracture blisters were reduced. She noted Petitioner was concerned with regards to payment for the surgery, as he does not have insurance. Petitioner had surgery October 10, 2017. The procedures were: closed reduction of displaced fracture of left calcaneus sander IV with calcaneal tuber varus deformity and application of external fixation of left foot. Petitioner's postoperative diagnosis was closed displaced fracture of the left calcaneus, sander IV with calcaneal tuber varus deformity. Petitioner's Exhibit 2 at 23-25, 48, 50-52.

Petitioner had the external fixator removed, in a surgical procedure, December 13, 2017. Petitioner's Exhibit 2 at 316.

It is unclear why, but Petitioner began treatment with Dr. Mark Sokolowski on November 10, 2017, prior to completing treatment at Northwest Community Hospital. Petitioner testified he last saw Skolowski September 27, 2018. Petitioner's Exhibit 9 at 1; Audziejczyk at 54.

The records of Dr. Sokolowski indicate Petitioner was a self referral who complained of right shoulder pain, right groin pain, lumbar pain, and bilateral lower extremity pain. At the time of his first visit, Petitioner had undergone surgical intervention (Sokolowski did not indicate or did not know why) and was awaiting removal of a fixator. He noted Petitioner was confined to bed or a wheelchair at home. Sokolowski's note of November 10, 2017, is clearly an amateurish attempt for use in litigation. He writes for the reader, not showing medical treatment to Petitioner, "[Petitioner] understands bilateral lower extremity injuries are often associated with lumbar injuries as well, especially after fall from a height." This is an obvious attempt to connect a lumbar claim. Nowhere does Petitioner give a history of a fall from a height. Despite having had an MRI of the pelvis October 4, 2017, Sokolowski thinks Petitioner should have another. He subsequently suggests numerous diagnostics but finds MRI's cannot be done because Petitioner is claustrophobic. Petitioner, by May 2018, has weaned himself off crutches and a cane, and is in slow and steady improvement on physical therapy, which Sokolowski has Petitioner doing in his office. Sokolowski found Petitioner has a right side inguinal hernia. That was known as far back as October 4, 2017, at Northwest Community Hospital. Sokolowski wanted Petitioner to consider surgery for the hernia. Petitioner testified he did not want surgery. We do not know why, but Sokolowski proceeded to send Petitioner for a Functional Capacity Evaluation. That was done September 15, 2018, at Function First Physical Therapy. Although Sokolowski's notes state the FCE proceed ". . . at an independent facility of [Petitioner's] choosing." Function First notes it as a referral from Sokolowski. Petitioner's Exhibit 9 at 1, 2, 6, 18, 21, 24; Petitioner's Exhibit 2 at 24; Audziejczyk at 53; Petitioner's Exhibit 12.

The Functional Capacity Evaluation concluded Petitioner had demonstrated the ability to perform 58.1% of the physical demands of a painter, and that Petitioner would benefit from four weeks' work hardening and conditioning. There is no evidence he ever had that. Sokolowski noted he reviewed the FCE and found Petitioner incapable of unrestricted duty. He assigned permanent restrictions and lifting limits of 15 pounds, no bending, squatting, or kneeling; limited standing and walking; no stair climbing; and no ladder climbing. Petitioner testified he never went back to work because the restrictions ". . . eliminated my possibility to be there." He did not explore the possibility of light duty. George Pachuta testified he has provided light duty to injured people. A review of the records of Sokolowski, as well as the testimony of Petitioner, indicates that except for a period of physical therapy, Sokolowski provided little, if any, cure or relief to Petitioner. Even the physical therapy was essentially a failure. Petitioner's Exhibit 12; Petitioner's Exhibit 9 at 26, 91; Audziejczyk at 56, 76, 141.

Conclusions of Law

The decision in this case begins and ends with disputed issue **B**, was there an employee-employer relationship between Petitioner and Respondent.

The Illinois Supreme Court has set forth the path to an analysis of this issue in Roberson v. Industrial Commission (P.I&I Motor Express, Inc.), 225 Ill. 2d 159 (2007). The court stated an employment relationship is a prerequisite for an award of benefits under the Act and the question of whether a person is an employee remains one of the most vexatious in the law of compensation. The question is a fact specific inquiry. No rule governs all cases. Factors help to determine when a person is an employee: whether an employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; whether the employer supplies the person with materials and equipment. Also, a consideration is whether the employer's general business encompasses the person's work. No single factor is determinative, and the significance of these factors will change, depending on the work involved. The determination rests on the totality of the circumstances. Id. At 174-175.

Initially, I note Petitioner testified he thought he was an employee of Respondent. However, that is not what he thought two days after his fall. In a progress note made by Angela Lubowicki on October 6, 2017, at Northwest Community Hospital, Petitioner told her he is a subcontractor, not a direct employee of Essence. He said he had his own business named MA Painting, and had workman's comp for his company, MA Painting. Audziejczyk at 33; Petitioner's Exhibit 2 at 67.

Could Respondent control the manner in which Petitioner performed the work? Petitioner testified he did everything related to painting. Pachuta testified Petitioner was a professional who know what he was doing and didn't have to be trained. Petitioner admitted Pachuta was mostly absent from a job site. Pachuta said if you care about your business, you exercise quality control. In this arena, quality control, I think, is generally understood to mean

that services performed meet the requirements of the customer or client. There was surprisingly little testimony on behalf of Petitioner regarding the manner, the way in which the painting was done. Audziejczyk at 33, 24, 22, 135, 136; Petitioner's Exhibit 2 at 67. Because of this, I find this factor weighs against finding an employee-employer relationship.

Could Respondent dictate Petitioner's schedule? Petitioner testified he had to work no less than eight hours a day, and that Respondent gave him the address of his job site. Pachuta testified Petitioner could have declined an assignment at any time, someone else would do the job. He said this would happen and he would use the subcontractors again. He also testified nothing prevented Petitioner from doing other jobs at any time. Because he knows Petitioner, he tried to keep him busy during the slow winter season. Audziejczyk at 20, 22, 134, 137, 128. In view of this, I find this factor weighs against finding an employee-employer relationship.

Did Respondent pay Petitioner hourly? On occasion he did. Pachuta testified subcontractors were paid 60% of a contract after subtraction for materials. The job on which Petitioner was injured was a contract estimate to paint a garage for $2,950.00. There were smaller jobs, here and there, Petitioner was paid hourly. Pachuta said 90% of the jobs were by contract. Petitioner testified he was paid by the hour or per contract. Pachuta testified that because Petitioner was injured and didn't complete the job, he paid him for the time he was there. Audziejczyk at 22, 137, 138, 126, 127, 20, 65, 78, 139; Respondent's Exhibit 5. Because of the split method of payment, this factor cuts slightly both ways for and against finding an employee-employer relationship.

Did Respondent withhold income and social security taxes from Petitioner's compensation? No, he did not. Both Petitioner and Pachuta testified there was no withholding of any taxes. Petitioner was paid by company check to his own company, MA Painting. He received no Form 1099 and no W-2 Form was submitted into evidence. Audziejczyk at 135, 29, 142; Petitioner's Exhibit 21. In view of this, I find this factor weighs against finding an employee-employer relationship.

Could Respondent discharge Petitioner at will? Pachuta was asked on cross examination, "While Mr. Audziejczyk was working for you, did you retain the right to fire him?" He answered, "Well, there's always possibility, you know, that he could have gotten fired, obviously, but you know, I never thought about it." Pachuta thought it would mean he would not give Petitioner another project. Pachuta testified if Petitioner did poor quality work, he would talk to him; if he didn't improve his quality of work on the next project, he would not get another project. Petitioner essentially said the same thing. Audziejczyk at 143-144, 147, 37. Under the circumstances, because Respondent could dismiss Petitioner due to his failure to correct the quality of poor work, I find this factor weighs in favor of an employee-employer relationship.

Did Respondent supply Petitioner with materials and equipment? The only evidence on this factor came from Petitioner, who testified that very small tools like screwdrivers, brushes, the trowel for patching, rollers and pans were supplied by him. Respondent supplied sanders, protective gear along with paint, plastics, tape, and primer. Audziejczyk at 38. This factor cuts

both ways for and against finding an employee-employer relationship, as both groups of equipment and materials are necessary for the job.

I think Respondent's general business, residential painting and restoration, encompasses Petitioner's work as a painter. Audziejczyk at 120, 11-12. I find this factor weighs in favor of an employee-employer relationship.

No single of these factors is determinative. The determination rests on the totality of the circumstances. The circumstances here include the fact that Petitioner had his own company which received payment from Respondent; Petitioner was required to procure and did, his own workers compensation insurance; Respondent had its own employees on a weekly payroll, covered by its workers compensation insurance; and Petitioner was not getting a bonus, paid vacation, or health care benefits. Audziejczyk at 21, 27, 77; Respondent's Exhibit 1; Respondent's Exhibit 2.

I find, as a conclusion of law, based on the factors set forth by the Illinois Supreme Court, and the totality of the circumstances in this case, with these facts, Petitioner was not an employee of Respondent.

I further find that because of the absence of that relationship, Petitioner is not awarded any benefits under the Act. All other issues are moot.

Arbitrator

3/28/19
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carmen Cross,

Petitioner,

vs. NO. 14WC 18850

Illinois Department of Revenue,

Respondent.

20 IWCC0115

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019 is hereby affirmed and adopted.

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

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

DATED: FEB 2 0 2020
SJM/sj
o-2/11/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CROSS, CARMEN
Employee/Petitioner

Case# **14WC018850**
14WC018851

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

20 IWCC0115

On 8/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2847 TAPELLA & EBERSPACHER LLC
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MATTOON, IL 61938

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WARREN A WILKE
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ATTORNEY GENERAL
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CHICAGO, IL 60601-3227

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

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

AUG 1 - 2019

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

STATE OF ILLINOIS)

)SS.

COUNTY OF Sangamon)

20 IWCC0115

☐	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

Carmen Cross
Employee/Petitioner

v.

Illinois Department of Revenue
Employer/Respondent

Case # **14** WC **18850**

Consolidated cases: **14 WC 18851**

An *Application for Adjustment 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 **February 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **September 1, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**37,886.46**; the average weekly wage was $**728.59**.

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

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

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

Respondent shall be given a credit of $**0.00** 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 SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT WITH RESPONDENT ON OR ABOUT SEPTEMBER 1, 2012 AND FURTHER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE HAS ANY CONDITION OF ILL-BEING TO HER BACK, CHEST, SHOULDER, HIPS OR PELVIS CAUSALLY CONNECTED TO HER EMPLOYMENT, 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

August 1, 2019
Date

ICArbDec p. 2

AUG 1 - 2019

20IWCC0115

Statement of Facts

This matter was heard by Arbitrator Douglas McCarthy on February 22, 2019. With written consent of the parties, this matter was reassigned to Arbitrator Stephen Friedman for decision based upon the transcript of testimony taken and exhibits offered in this matter. This case was consolidated with case 14 WC 18851 (DOA: January 30, 2014). A single transcript of the consolidated cases was prepared. The Arbitrator has issued separate decisions for each of the consolidated cases. The Arbitrator has redacted RX 5, RX 6, RX 11 and RX 12 to comply with Supreme Court Rule 138.

Petitioner Carmen Cross (A/K/A Carmen Cross-Safieddine; A/K/A Jimerson) testified that she was hired by Respondent Illinois Department of Revenue in 2006 as an office assistant. She held this title for the entire duration of her employment with Respondent through January 2015. Her job duties were tax preparation and processing. She did document control and processing and deposit. Once mail came in, she picked it up and it came to her desk to be computer entered. She did original data entry for checks and cash payments. As the paperwork came in, they would fill buckets, tubs, banker's boxes of work that had to be shifted from lower levels to higher levels, 8 shelves high. The boxes weighed about 50 pounds. Sometimes larger companies would submit multiple boxes taped together. The highest levels were over her head level. These buckets had cut in handles. You picked it up by the end and jockey it that way. She used both hands to pick it up by the end. She testified that she would then take boxes off the shelves to work on. She would unload them down by hand and use a dolly to move them to her desk. She would then lift them to her desk. When she finished labeling them with numbers, she would take them to the table about 15 to 20 feet away where they were taken to data entry. RX 10 is the job description. Petitioner testified she lifted tubs 30% of her day rather than the listed 15%. She used her computer 50% rather than the listed 20%, and used the scanner 5% rather than the listed 15%.

Petitioner testified that if you were injured, you first informed your supervisor. You would get a form from Human Resources and fill it out and give it to your supervisor to sign and give it back to the workers' comp personnel in HR. Then you get called to the office to proceed with Tristar, the State workers' compensation loss entity. Her supervisor was Beverly.

Petitioner testified that before September 1, 2012, she had upper back problems near her shoulder where it had gotten sprained. She was out of work for this. She testified it was from the job. This was the first heavy lifting job she had other than while in the National Guard from 1984 to 1991. Petitioner's prior medical records confirm a history of a 1987 head injury from an MVA. She continued treatment for headaches and dizziness (RX 11). On December 6, 2007, Petitioner reported lifting bales of paper at work and felt a pop in her right wrist with pain at the distal ulnar level. She was diagnosed with a wrist sprain (RX 11). On April 16, 2010, Petitioner reported chest pain after repetitive lifting at work 3 days before. Dr. Adams diagnosed a chest wall strain (RX 11). On January 12, 2012, Petitioner gave a history to Dr. Hillis that she had low back pain frequently for the last 6 to 8 months with no injury. She was not sure when it started. She denied leg pain, numbness or weakness. X-rays found degenerative changes at the lower levels (RX 11). Petitioner had an evaluation at Memorial Rehabilitation Services at Koke Mills on February 16, 2012 for a diagnosis of lumbago. She reported a long history of low back pain for no specific reason (RX 11).

Petitioner testified that on September 1, 2012, she was taking tubs down from the high level and dropped a tub because it ripped a muscle in her upper left chest area. Petitioner testified that she reported it to Beverly

and then got the form, but by then, Beverly had taken time off from work, so she processed the form with a supervisor named Michael Perry, who had her go to the doctor. She testified this process occurred over several months. During this time, she continued to work, and she had tearing at other parts of her body.

Petitioner prepared an Employee Notice of Injury report on October 10, 2013. She lists the date of injury at May 20, 2013. She claims to have reported to supervisor the same day but not on form. She claims to have pulled her arm, hip and back catching a tub of tax documents which would have struck a co-worker in the head. The form lists a 9/10/2012 injury listed as "See notation" treated by Dr. Hillis as not work related, a 2008 sprained wrist as work related, and a 2/2013 hip and low back injury treated by Dr. Hillis at not work related (RX 5). Dorothy Hutchinson, Division Manager, noted that she was unaware of any incident. Nothing was reported to her and no paperwork was completed (RX 5). Petitioner signed a second employee report of injury on November 13, 2013 claiming an injury to her lower back and left hip on November 12, 2013. She claims she reported it to Beverly Langenfeld verbally. She reported that she was transferring stacked papers, squatting repeatedly. Hip and back were already inflamed from days prior injury from performing alternative work (RX 5).

On November 23, 2012, Petitioner was seen at Express Care of Memorial Medical Center with complaints of hip and pelvic pain from a previous visit. It was noted she had been advised to do physical therapy but did not follow through. Petitioner was not concerned with these complaints at that time but rather her left humerus from lifting heavy boxes at work. X-rays were taken of the left humerus and were normal (PX 1). Petitioner returned on February 22, 2013, complaining of left shoulder pain and low back pain since August 2012. She reported no known injury. She stated she lifts heavy large tubs of paper at work (PX 1). On May 13, 2013, Petitioner was seen for a chief complaint of low back pain since September 2012. It started without injury. She reported lifting heavy boxes at work (PX 1).

On October 7, 2013, Petitioner saw Dr. Sanjeev Joshi at Advocate Medical Group complaining of lower back pain, which radiated to the hips since September last year. Petitioner reported she had experienced pain since the last year when she was lifting heavy boxes at work. She also stated that she was taken to a local hospital and told she had a stress fracture and advised to get therapy. Dr. Joshi's assessment was dizziness, sacroiliitis, and low back pain. He prescribed physical therapy and Mobic (PX 2). On November 13, 2013, Petitioner was seen at the Emergency Department of Memorial Medical Center with chronic low back pain that had been exacerbated two months ago. She stated that she worked for the Department of Revenue and has frequent heavy lifting. Low back x-rays noted slight interval progression of her degenerative changes since January 2012. She was prescribed a Medrol Dosepak and Norco, and advised to follow up with Dr. Joshi (PX 1). Dr. Joshi saw Petitioner on December 2, 2013. Petitioner stated she had not worked since November when she was lifting some boxes and her back went out on her. Dr. Joshi prescribed physical therapy and a Medrol Dose Pak, and returned her to work with a lifting restriction of 10 pounds for the next two weeks On January 10, 2014, Petitioner stated her work needs a statement of her lifting restriction so she can be transferred to a different job. Dr. Joshi restricted her to lifting 20 pounds and released her to be seen as needed (PX 2).

On January 16, 2014, Petitioner presented to the Priority Care facility of HSHS Medical group with ongoing back pain. She said that she did a lot of lifting at work. She denied any injury. The assessment was of low back pain. On February 24, 2014, Petitioner again presented to the Priority Care facility complaining of low back pain. She reported an initial injury 9/13 and reinjury January 17, 2014. Pelvis x-ray noted no bony abnormality with mild hip joint degeneration (PX 3).

20IWCC0115

Petitioner has also claimed an injury on January 30, 2014 to her left wrist while lifting boxes. That injury is the subject of the separate decision in the consolidated claim 14 WC 18851 decided in conjunction with this matter.

On March 17, 2014, Petitioner was seen by Dr. John Watson at Orthopedic Center of Illinois for an initial evaluation of her lumbar spine problem which occurred following a specific injury. She complained of pain in the left hip and low back, which was described as achy, burning, and stabbing. Physical examination noted full range of motion with normal sensation, strength and reflexes. There was normal gait and no atrophy. Dr. Watson diagnosed exacerbation of lumbar degenerative disc disease and spinal stenosis and recommended a conservative approach, featuring core strengthening and lumbar stabilization. He recommended lifting up to 10 pounds with transition back to full duty as soon as possible (PX 4). Petitioner continued to see Dr. Watson and attended therapy. On May 12, 2014, D. Watson noted that Petitioner had been doing physical therapy, and her pain was improving, although she still had occasional numbing into the hip. Her lumbar range of motion was limited. He kept Petitioner on a 10-pound restriction. On June 9, 2014, she was discharged from physical therapy to a program of home exercise with a pool program (PX 4). On June 19, 2014, Dr. Watson released Petitioner to be seen as needed. Petitioner returned to Dr. Watson on November 10, 2014, reporting significant pain when she lifts anything heavy. Dr. Watson stated that she is doing fairly well and has no pain on examination. She is concerned about heavy lifting. He notes she is working with a 20-pound restriction. He advised her he does not do impairment ratings and she should consider seeing an occupational medicine doctor and having a functional capacity examination. He notes that she is at risk of reinjury if she lifts heavy items improperly (PX 4). Dr. Townsend put Petitioner on a permanent lifting restriction due to her back and left wrist on January 15, 2015 (RX 12).

Dr. Joshi testified by evidence deposition taken June 21, 2017 (PX 9). He is board certified in internal medicine and geriatrics. He testified he had reviewed his chart of Petitioner's treatment and one earlier x-ray only. He first saw her October 7, 2013 for lower back pain, pelvic pain and hip pain. He testified to a history of the year before she was lifting heavy boxes and started feeling excruciating pain in her back. She was then taken to a local hospital and told she had a stress fracture and advised therapy. He testified he presumes this is the September 2012 injury. His assessment was sacroiliitis and low back pain. He testified to his care through January 18, 2014 in accordance with his chart. Dr. Joshi testified he did not witness the injury. He saw Petitioner a year later. He testified that historically, she said that after lifting she started having pain. Her x-ray showed moderately severe arthritis which takes years to develop; so it is conceivable that the injury was acute on top of the arthritis which could have triggered some of that back pain which was progressively getting worse, because she continued to do what she was doing. This would have exacerbated her pre-existing arthritic condition over time (PX 9).

Dr. Joshi could not state if this is a single incident or repetitive. He is speculating if it could be a single incident. He testified that if you continue to do repeated actions which stress a joint, over time arthritis can get worse. He could not say that the incident in September 2012 caused a permanent change in her arthritis. He testified that if you add trauma to a situation, the arthritic progression is probably going to accelerate. He does not know if that is the case in the present case. He testified that the boxes weighed about 40 pounds, but he does not know their dimensions. He does not know how often or for how long she had to carry them (PX 9).

Petitioner worked throughout the course of her treatment. She applied for a reasonable accommodation to a job with a lesser lifting requirement on January 27, 2015 (RX 13). She testified she retired on January 30, 2015. Dave Klintworth testified that he is employed by Respondent as a Public Service Administrator. He

receives accident reports and manages employees who are off for work related injuries. He testified that Petitioner retired on January 30, 2015. He was aware she was given permanent restrictions of lifting up to 40 pounds. This required accommodation because her job description was lifting of 50 pounds. He testified that the restrictions were being accommodated. Petitioner's request for reasonable accommodation was still pending at the time she retired. She was on payroll until her retirement.

Petitioner was examined at Respondent's request by Dr. Patrick O'Leary on February 22, 2018 (RX 3). Dr. O'Leary testified by evidence deposition taken September 27, 2018 (RX 4). Dr. O'Leary took a history of an injury in 2013 or 2014 where a box was about to fall on a co-worker and Petitioner had to bear the brunt of the box and it caused her to hurt her back. She also described multiple incidents where she used her body to help lift these boxes. Dr. O'Leary's physical examination noted no objective findings. She had no focal neurological findings. Straight leg raising was negative. He notes mild sacral pain. He reviewed medical records and x-ray reports. He diagnosed underlying degenerative spine disease with lumbar spondylosis and chronic low back pain. He opined that, in the incident with the co-worker, she sustained a temporary exacerbation of her condition. Her ongoing back complaints would be hard to link to that injury. Her low back pain is likely related to everyday wear and tear (RX 3).

Dr. O'Leary testified that he is board certified in orthopedic surgery specializing in the spine. Spondylosis is the medical term for degenerative arthritis. This is an accumulation of age-related disorders. Petitioner may have had a lumbar strain. He did not see any permanent changes that were imparted to her spine as a result of the injuries. His assessment of MMI six months after the injury, depends on the date of injury because Petitioner reported to him that she did not know the exact date the injury occurred. He disagreed with Dr. Joshi's diagnosis of sacroiliitis (RX 4).

Petitioner testified that she has not worked anywhere else since her retirement. She testified she has been seen for medical thereafter at the VA but as not had treatment for this injury. She testified that she continues to feel pain. She has pain carrying laundry up and down the stairs, which can last for a few days. She has to wait for the pain to dissipate before she can start doing other things. Sometimes the pain will keep her from walking. Lifting is a problem because it causes pain in the back. Household chores such as mopping, sweeping, and carrying groceries will cause her back to ache. It has also affected her ability to play with her grandkids, as she cannot play with them like most people do with toddlers.

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. 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. An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of employment unexpectedly and without affirmative act or design of the employee. *International Harvester Co. v. Industrial Comm'n.*, 56 Ill. 2d 84, 89 (Ill. 1973).

Petitioner testified to a specific incident occurring on September 1, 2012 when she was taking tubs down from the high level and dropped a tub because it ripped a muscle in her upper left chest area. This claimed injury is contradicted by virtually every history she provided. Petitioner was seen for a chest muscle strain, but it was in 2010. She reported back pain in January 2012 and gave a history to Dr. Hillis that she had low back pain frequently for the last 6 to 8 months with no injury. She was not sure when it started. Petitioner prepared accident reports on October 10, 2013 and November 13, 2013, over a year later. Neither claims a September 2012 accident, but rather a specific detailed event occurring with a co-worker in 2013. This is the same accident description she gave Dr. O'Leary. On November 23, 2012, Petitioner was not concerned with her low back complaints but rather her left humerus from lifting heavy boxes at work. On February 22, 2013, she complained of left shoulder pain and low back pain since August 2012. She reported no known injury. On May 13, 2013, Petitioner was seen for low back pain since September 2012. It started without injury although she reported lifting heavy boxes at work. On October 7, 2013, Petitioner told Dr. Joshi her lower back pain began in September last year when she was lifting heavy boxes at work. She also stated that she was taken to a local hospital and told she had a stress fracture which is not corroborated by the medical records. On November 13, 2013, Petitioner was seen at the Emergency Department of Memorial Medical Center with chronic low back pain that had been exacerbated two months ago. On December 2, 2013. Petitioner stated she had not worked since November when she was lifting some boxes and her back went out on her. On January 16, 2014, Petitioner presented to the Priority Care facility of HSHS Medical group with ongoing back pain. She said that she did a lot of lifting at work. She denied any injury. On February 24, 2014, Petitioner reported an initial injury 9/13 and reinjury January 17, 2014. On March 17, 2014, Petitioner was seen by Dr. John Watson at Orthopedic Center of Illinois for an initial evaluation of her lumbar spine problem which occurred following a specific injury.

Petitioner alternatively alleged multiple inconsistent specific injuries, none of which are document on or about the claimed date of accident on September 1, 2012 while also specifically denying any specific injury repeatedly in the medical records. Even considering the evidence admitted concerning the heavy nature of her job's lifting requirements, an employee who suffers a gradual injury due to repetitive trauma is eligible for benefits under Workers Compensation Act, but must meet the same standard of proof as a Petitioner alleging a single, definable accident. In the present case, claimant's varied and inconsistent histories of the alleged incident, coupled with the documented prior treatment and pre-existing diagnosis, undermine her claim that she suffered accidental injuries arising out of and in the course of her employment.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on or about September 1, 2012.

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). 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. The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct.

3d Dist. 2014). If the claimant had health problems prior to a work-related injury, he bears the burden of showing that the preexisting condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Nunn v. Industrial Comm'n, 157 Ill. App. 3d 470, 476, 510 N.E.2d 502, 505, 109 Ill. Dec. 634 (1987).* Cases involving aggravation of a preexisting condition, especially repetitive-trauma cases, primarily concern medical and not legal questions. *Id. at 478, 510 N.E.2d at 506.* Petitioner presented the opinions of Dr. Joshi as to causation. Respondent presented the opinions of Dr. O'Leary.

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. 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).

After reviewing the evidence including the testimony, medical records, reports and depositions, the Arbitrator finds the opinions of Dr. O'Leary more persuasive. The Arbitrator notes the Dr. Joshi is an internist rather than an orthopedic surgeon. His opinions are based completely on Petitioner's history to him that her lower back pain began in September last year when she was lifting heavy boxes at work. She also stated that she was taken to a local hospital and told she had a stress fracture. As more fully discussed above in the Arbitrator's finding with respect to Accident, this history is only one of many provided and is not supported by the treating records. Further, Dr. Joshi confirms that Petitioner has a pre-existing degenerative condition in her low back. He admits that much of his opinion is based upon speculation and admits that, although he presents a possible aggravation scenario, that he cannot state that that this occurred in the present case. His opinions, based upon how he qualifies his answers, do not rise to the level of reasonable medical certainty. He admits that he has limited understanding of Petitioner's job duties or how often she must lift boxes. Dr. O'Leary's opinions that Petitioner's back complaints would be hard to link to the injury. Her low back pain is likely related to everyday wear and tear are more persuasive and based upon a more complete understanding of the events.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her condition of ill-being in the lower back, pelvis and hips is causally related to her employment with Respondent.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Section 10 of the Act states that the compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52. Overtime is excluded from the calculation of a claimant's average weekly wage unless the claimant is required to work overtime as a condition of her employment, or the overtime hours are part of the claimant's consistent weekly schedule. *Airborne Express, Inc. v. Illinois Workers' Compensation,* 372 Ill. App. 3d 549; 865 N.E. 2d 979; 2007 Ill. App. LEXIS 244; 310 Ill. Dec 259.

Petitioner provided no testimony or other evidence with respect to her wages. The only evidence admitted was RX 8, Petitioner's wage statement. The Arbitrator notes that Petitioner did not establish that the overtime noted was required and it was sporadic.

Based upon the record as a whole, the Arbitrator finds that Petitioner's average weekly wage was $37,886.46/52 or $728.59 per week.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, 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 Notice, Medical and Nature & Extent are moot.

Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)		
) SS.	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF SANGAMON)	☐ 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

Carmen Cross,

Petitioner,

vs. NO. 14 WC 18851

Illinois Department of Revenue,

Respondent.

20IWCC0116

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019 is hereby affirmed and adopted.

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

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

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

DATED: FEB 20 2020
SJM/sj
o-2/11/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CROSS, CARMEN
Employee/Petitioner

Case# **14WC018851**
14WC018850

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

20IWCC0116

On 8/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2847 TAPELLA & EBERSPACHER LLC
DANIEL C JONES
PO BOX 627
MATTOON, IL 61938

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

AUG 1 - 2019

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

STATE OF ILLINOIS **20 IWCC0116**

)SS.

COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Carmen Cross
Employee/Petitioner

v.

Illinois Department of Revenue
Employer/Respondent

Case # **14** WC **18851**

Consolidated cases: **14 WC 18850**

An *Application for Adjustment 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 **February 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 30, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,296.78**; the average weekly wage was $**736.48**.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $25.00, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $441.89/week for 4.1 weeks, because the injuries sustained caused the 2% loss of the Left Hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

August 1, 2019
Date

AUG 1 - 2019

Statement of Facts

This matter was heard by Arbitrator Douglas McCarthy on February 22, 2019. With written consent of the parties, this matter was reassigned to Arbitrator Stephen Friedman for decision based upon the transcript of testimony taken and exhibits offered in this matter. This case was consolidated with case 14 WC 18850 (DOA: September 1, 2012). A single transcript of the consolidated cases was prepared. The Arbitrator has issued separate decisions for each of the consolidated cases. The Arbitrator has redacted RX 5, RX 6, RX 11 and RX 12 to comply with Supreme Court Rule 138.

Petitioner Carmen Cross (A/K/A Carmen Cross-Safieddine; A/K/A Jimerson) testified that she was hired by Respondent Illinois Department of Revenue in 2006 as an office assistant. She held this title for the entire duration of her employment with Respondent through January 2015. Her job duties were tax preparation and processing. She did document control and processing and deposit. Once mail came in, she picked it up and it came to her desk to be computer entered. She did original data entry for checks and cash payments. As the paperwork came in, they would fill buckets, tubs, banker's boxes of work that had to be shifted from lower levels to higher levels, 8 shelves high. The boxes weighed about 50 pounds. Sometimes larger companies would submit multiple boxes taped together. The highest levels were over her head level. These buckets had cut in handles. You picked it up by the end and jockey it that way. She used both hands to pick it up by the end. She testified that she would then take boxes off the shelves to work on. She would unload them down by hand and use a dolly to move them to her desk. She would then lift them to her desk. When she finished labeling them with numbers, she would take them to the table about 15 to 20 feet away where they were taken to data entry. RX 10 is the job description. Petitioner testified she lifted tubs 30% of her day rather than the listed 15%. She used her computer 50% rather than the listed 20%, and used the scanner 5% rather than the listed 15%.

Petitioner testified that if you were injured, you first informed your supervisor. You would get a form from Human Resources and fill it out and give it to your supervisor to sign and give it back to the workers' comp personnel in HR. Then you get called to the office to proceed with Tristar, the State workers' compensation loss entity. Her supervisor was Beverly.

Petitioner testified that before September 1, 2012, she had upper back problems near her shoulder where it had gotten sprained. She was out of work for this. She testified it was from the job. This was the first heavy lifting job she had other than while in the National Guard from 1984 to 1991. Petitioner's prior medical records confirm a history of a 1987 head injury from an MVA. She continued treatment for headaches and dizziness (RX 11). On December 6, 2007, Petitioner reported lifting bales of paper at work and felt a pop in her right wrist with pain at the distal ulnar level. She was diagnosed with a wrist sprain (RX 11). On April 16, 2010, Petitioner reported chest pain after repetitive lifting at work 3 days before. Dr. Adams diagnosed a chest wall strain (RX 11).

Petitioner testified that on September 1, 2012, she was taking tubs down from the high level and dropped a tub, suffering injuries including her chest, shoulder and lower back. Petitioner's claim for this date of accident and the medical evidence related thereto are the subject of decision in the consolidated case 15 WC 18850 decided in conjunction with this matter.

Petitioner testified that on January 30, 2014, it was tax season and they were trying to catch up. She was lifting a large corporate box and her arm just flopped back and cracked. She felt a pop. There was a lump

sticking out of her left arm at the wrist. She testified she showed it to her supervisor. Petitioner prepared an Employee Report of Injury on February 6, 2014 (RX 6). She reported a left hand, lower thumb and wrist/lower arm injury. She stated she was loading and unloading batches of tax returns. While lifting tubs onto the cart she felt a bone or tendon snap. Her supervisor Betty Langenfeld reported on February 6, 2014 that se had no information and was just told on that date that Petitioner hurt her wrist (RX 6).

Petitioner testified she sought medical attention because she could not lift anything. Petitioner saw Dr. Boddu at Priority Care on February 4, 2014, complaining of a small left wrist bump a few days ago that is tender and hurts with some movements, especially twisting (PX 3). She noted left wrist pain. She stated that she has been moving heavy tubs. X-rays showed a slight soft tissue swelling and no acute bony injury. Petitioner received an orthopedic referral (PX 3).

Petitioner did not keep appointments with Dr. Senica at Orthopedic Center of Illinois scheduled on February 10, 2014 or February 17, 2014. She was seen on March 11, 2014 (PX 4). Petitioner provided a history of lifting some tubs of paper at work when her left wrist went into ulnar deviation and she felt a pop about 4 to 6 weeks ago. She stated she was given a brace by her primary care physician. Physical examination showed some swelling over the 1st dorsal compartment with a small mass or knot that is very tender. She has reasonable range of motion. The impression was left de Quervain's tenosynovitis and a possible ganglion cyst. Dr. Senica injected the 1st dorsal compartment. She prescribed a thumb spica brace and Mobic (PX 4). Petitioner returned for follow up on April 3, 2014. She reported feeling much better after the injection. Physical examination noted no swelling, no significant tenderness. There still may be a very small ganglion cyst. Dr. Senica's impression was resolved left de Quervain's tenosynovitis and a possible ganglion cyst, asymptomatic. Dr. Senica released Petitioner to work without restrictions in regard to the left wrist as of April 7, 2014. She was to return as needed (PX 4).

Petitioner worked throughout the course of her treatment. She testified that she had problems lifting the tubs of documents at work. She applied for a reasonable accommodation to a job with a lesser lifting requirement on January 27, 2015 (RX 13). She testified she retired on January 30, 2015. Dave Klintworth testified that he is employed by Respondent as a Public Service Administrator. He receives accident reports and manages employees who are off for work related injuries. He testified that Petitioner retired on January 30, 2015. He was aware she was given permanent restrictions of lifting up to 40 pounds. This required accommodation because her job description was lifting of 50 pounds. He testified that the restrictions were being accommodated. Petitioner's request for reasonable accommodation was still pending at the time she retired. She was on payroll until her retirement.

Petitioner was examined at Respondent's request by Dr. James Emanuel on May 26, 2016 (RX 1). Dr. Emanuel testified by evidence deposition taken February 21, 2017 (RX 2). Dr. Emanuel recorded a consistent history of the injury. Petitioner noted her treatment, but claimed to have blacked out after the injection. She claims to have been on restrictions which the employer could not accommodate, so she retired. Petitioner claimed she does not use the wrist much now. She really doesn't describe much in the way of symptoms. She is right-handed. Physical examination notes full range of motion with no redness, warmth, erythema, swelling or atrophy. Finkelstein and grind tests are negative. There is no tenderness. There may be some thickening, but it did not appear tender. There is no sign of carpal tunnel. He noted her examination was within normal limits without active de Quervain's tendinitis. X-rays taken were normal. Dr. Emanuel reviewed the treating medical records. Dr. Emanuel opined that Petitioner advanced no subjective complaints and the examination was normal. He diagnosed resolved de Quervain's tendinitis. He found Petitioner was at maximum medical

improvement. No further treatment is necessary. No restrictions are needed. He found the condition was causally connected to the accident described. The treatment rendered was reasonable and necessary (RX 1, RX 2).

Petitioner testified that she has not worked anywhere else since her retirement. She testified she has been seen for medical thereafter at the VA but as not had treatment for this injury. Her wrist has affected lifting, carrying, wrestling around with the grandkids.

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 she 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.

Petitioner's unrebutted testimony is that she injured her left wrist while lifting a large corporate box and felt a pop. This accident description is consistently reported to her supervisor and in all the relevant medical records. The Arbitrator finds that Petitioner's testimony with respect to the January 30, 2014 accident, while exaggerated and dramatic, is credible based upon the corroborating documentation. This activity occurred at a place where the claimant may reasonably perform employment duties, and while a claimant fulfills those duties. Lifting heavy boxes is a risk connected with, or incidental to, her employment.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent on January 30, 2014.

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 182, 457 N.E.2d 1222, 1226, 75 Ill. Dec. 663 (1983). A chain of events suggesting a causal connection may also suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994). Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000). In the present case, causation is supported by both medical testimony and the chain of events.

Petitioner's unrebutted testimony is that she had no prior injuries or problems with her right wrist. Following the accident, she sought treatment within a week with a consistent history of injury. The findings on examination were consistent with the mechanism of injury. Further, Dr. Emanuel provided a specific medical opinion that the condition of ill-being of the left wrist was causally connected to the accident described.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that her condition of ill-being in the left wrist and hand is causally related to the accidental injury sustained on January 30, 2014.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Section 10 of the Act states that the compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52. Overtime is excluded from the calculation of a claimant's average weekly wage unless the claimant is required to work overtime as a condition of her employment, or the overtime hours are part of the claimant's consistent weekly schedule. *Airborne Express, Inc. v. Illinois Workers' Compensation,* 372 Ill. App. 3d 549; 865 N.E. 2d 979; 2007 Ill. App. LEXIS 244; 310 Ill. Dec 259.

Petitioner provided no testimony or other evidence with respect to her wages. The only evidence admitted was RX 9, Petitioner's wage statement. The Arbitrator notes that Petitioner did not establish that the overtime noted was required or consistent.

Based upon the record as a whole, the Arbitrator finds that Petitioner's average weekly wage was $38,296.76/52 or $736.48 per week.

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). The Arbitrator has reviewed Petitioner's treating medical exhibits and finds the treatment by Dr. Boddu on February 4, 2014 and by Dr. Senica on March 11, 2014 and April 3, 2014 reasonable, necessary and causally connected to the accident on January 30, 2014.

Petitioner has admitted medical bills as PX 5-8. The Arbitrator finds no causally related medical visits listed In PX 5-7. PX 8 contains the charges for Dr. Senica of $818.00 for March 11, 2014 and $151.00 for April 3, 2014. These have been paid by Blue Cross/Blue Shield, Respondent's group carrier. The bill notes no balance due for these bills, but does note Petitioner paid $25.00 directly.

Based upon the record as a whole, the Arbitrator finds that Respondent shall reimburse Petitioner $25.00 for out-pocket medical. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. However, the Arbitrator has considered Dr. Emanuel's report and testimony as a factor in the evaluation of Petitioner's permanent partial disability as required by §8.1b(b)(i). The doctor noted that Petitioner advanced no subjective complaints and the examination was normal. He diagnosed resolved de Quervain's tendinitis. He found Petitioner was at maximum medical improvement. No further treatment is necessary. No restrictions are needed. Because of these facts, the Arbitrator therefore gives greater 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 office assistant at the time of the accident and that she was released without restrictions from this left wrist injury and was able to return to work in her prior capacity as a result of said injury. The Arbitrator notes the heavy physical nature of her job and her restrictions as a result of her back condition. The Arbitrator notes that Petitioner sought reasonable accommodation for her physical condition prior to retirement, but her medical restrictions were related to her back. Because of these facts, the Arbitrator therefore gives some weight to this factor

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. She would be considered an older employee. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has retired. She alleges this is the result of her physical conditions, but the Arbitrator notes that her medical restrictions were not related to the left hand. The Arbitrator also notes that she retired before a decision on her request for accommodation. There was no evidence submitted of any job search. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner only was seen three times between February 4, 2014 and April 3, 2014. Dr. Senica's April 3, 2014 physical examination noted no swelling, no significant tenderness. There still may be a very small ganglion cyst. Dr. Senica's impression was resolved left de Quervain's tenosynovitis and a possible ganglion cyst, asymptomatic. Dr. Senica released Petitioner to work without restrictions in regard to the left wrist as of April 7, 2014. Because of these facts, 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% loss of use of left hand pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Harvey n/k/a Kevin Zopp,

Petitioner,

vs. NO. 18WC 11848

Illinois Department of Transportation,

20IWCC0117

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 19, 2019 is hereby affirmed and adopted.

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

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

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

DATED: FEB 20 2020
SJM/sj
o-2/11/2020
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARVEY, KEVIN NKA ZOPP, KEVIN Case# **18WC011848**
Employee/Petitioner

ILLINOIS DEPT OF TRANSPORTATION **20 IWCC0117**
Employer/Respondent

On 8/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1053 JOSEPH L SAMUELSON PC
5111 W MAIN ST
BELLEVILLE, IL 62226

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

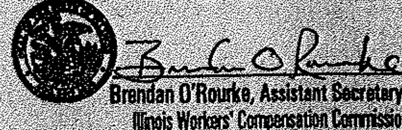
4971 ASSISTANT ATTORNEY GENERAL
WILLIAM PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

AUG 19 2019



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

20IWCC0117

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
NATURE AND EXTENT ONLY

Kevin Harvey nka Kevin Zopp
Employee/Petitioner

Case # **18** WC **11848**

v.

Consolidated cases: **N/A**

Illinois Dept. of Transportation
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **1/15/19**. By stipulation, the parties agree:

On the date of accident, **3/8/18**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**81,033.23**, and the average weekly wage was $**1,558.33**.

At the time of injury, Petitioner was **55** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of $**717.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**717.52**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Respondent shall pay Petitioner permanent partial disability benefits of $790.64/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay all unpaid medical bills pursuant to the Medical Fee Schedule.

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

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

Michael K. Nowak, Arbitrator

8/13/19
Date

ICArbDecN&E p.2

AUG 19 2019

FINDINGS OF FACT

Petitioner is employed by the State of Illinois in its highway maintenance department. His duties include cutting grass, plowing snow, fixing potholes, etc. throughout the highway system. On March 8, 2018 Petitioner was fixing potholes on Interstate 255 near Collinsville, Illinois. As he was lifting concrete debris into his dump truck, he felt intense pain in his left shoulder joint. He was unable to continue working so he immediately reported this accident to his on-site supervisor. (Pet. Ex. #1)

Due to the acute nature of his condition, Petitioner was transported to Memorial Hospital in Belleville, Illinois. There he was treated in the emergency room. X-rays were taken; and Petitioner was placed in a sling and told to seek orthopedic consultation with Dr. Colanese. Petitioner saw Dr. Colanese on March 15, 2018. Dr. Colanese felt Petitioner had suffered a rotator cuff injury. He injected the shoulder joint and ordered physical therapy. (Pet. Ex. #2)

Petitioner continued to see Dr. Colanese on a regular basis. Because his symptomatology did not significantly improve, on May 17, 2018, Dr. Colanese ordered an MRI scan. The MRI revealed a partial thickness tear of the anterior aspect of the supraspinatus tendon with possible biceps tendon involvement. (Pet. Ex. #2) On June 27, 2018, Dr. Colanese discussed the need for surgical intervention, but decided to continue with the regimen of intermittent inflammatory medication and vigorous physical therapy. His records reflect:

> His pain is reasonably controlled, however still with quite a bit of weakness and given his work demands is not satisfied so far. Could potentially consider surgical intervention, would likely need debridement versus repair of the anterior supraspinatus, possible biceps tenodesis, subacromial decompression. He is aware that surgery could potentially make the tear worse, with no guarantee of increased motion or strength. (Pet. Ex. #2)

Petitioner continued with the prescribed conservative regimen through August 20, 2018. At that time, he returned to Dr. Colanese. Dr. Colanese noted:

> He is seen good improvement with therapy, still not as strong or as pain-free as would be ideal. His job does involve a lot of heavy lifting, working continue with light duty for another month or 2, will follow up in 1 month with another clinical recheck. (Pet. Ex. #2)

On September 20, 2018, Dr. Colanese saw Petitioner for the last time. He released Petitioner to return to work and ordered him to follow up as needed. From March 8, 2018 (date of accident) through September 20th, Petitioner had been restricted from performing his regularly assigned work duties. Initially, Respondent paid Petitioner "policy days" (March 9 - 15, 2018). It then paid Petitioner temporary total disability benefits (March 16 - 21, 2018). Thereafter, it provided him light duty employment at his usual and customary rate of pay (March 22 - September 20, 2018). Although released to return to his regular duties, Petitioner has been unable to so return due to a non-occupational spinal condition. Petitioner continues on light duty employment due to this condition. Even in a light duty capacity, Petitioner continues to suffer the long-term effects of his injury.

CONCLUSIONS

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner is employed by Respondent as a member of its highway maintenance program. This requires the performance of heavy manual labor. Petitioner suffered an acute partial thickness tear of the supraspinatus tendon (rotator cuff). This has been treated conservatively. As such, the tear remains and while significantly improved, still causes Petitioner significant symptomatology. Specifically, Petitioner continues to suffer restricted motion (particularly overhead) of the left shoulder joint, intermittent, but persistent, pain throughout the left shoulder which is exacerbated by any lifting or overhead movement, decreased strength of his left arm; and muscle wasting of the left shoulder girdle. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner is currently 56 years of age. He has a life expectancy of 24.8 years. The effects of his injury will continue to hinder him throughout his life. 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's evidence of disability is demonstrated by the medical evidence herein. The nature of his injuries are clearly delineated with the medical records and further corroborated by his credible testimony, 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 7.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Bartz,

Petitioner,

20IWCC0118

vs.

NO. 14WC 22264

Sysco,

Respondent.

DECISION AND OPINION ON REVIEW

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

20IWCC0118

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: FEB 20 2020
SJM/sj
o-2/5/2020
44

Stephen J. Mathis

Douglas D. McCarthy

AUTHORIZATION -SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in Hollywoood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." Id. at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in Hollywood Casino, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

BARTZ, JEREMY
Employee/Petitioner

Case# **14WC022264**

SYSCO
Employer/Respondent

20IWCC0118

On 10/26/2018, 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 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

1120 BRADY CONNOLLY & MASUDA PC
PETER J STAVROPOULOS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS **20IWCC0118**
)SS.
COUNTY OF **COOK**)

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

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

JEREMY BARTZ
Employee/Petitioner

v.

SYSCO
Employer/Respondent

Case # **14** WC **22264**

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 **Chicago**, on **May 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [x] What temporary benefits are in dispute?
[x] 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, **February 28, 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 $**84,806.28**; the average weekly wage was $**1,630.89**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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's right hip condition of ill-being remains causally related to the February 28, 2014 accident.

Respondent shall pay Petitioner temporary partial disability benefits of **$553.93 per week** for **13 weeks**, commencing **December 4, 2016 through March 5, 2017**, and temporary partial disability benefits of **$420.59 per week** for **62-3/7 weeks**, commencing **March 6, 2017 through May 16, 2018**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$27,674.19**, as provided in Section 8(a) of the Act. The Respondent's liability for this award is subject to Section 8.2 (Fee Schedule) of the Act.

Respondent is entitled to credit for any of the awarded medical expenses that have been paid prior to hearing, 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.

The Respondent shall authorize the right total hip arthroplasty surgery that's been prescribed by Dr. Freedberg, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

October 24, 2018
Date

OCT 2 6 2018

STATEMENT OF FACTS

This matter comes before the Arbitrator pursuant to Sections 8(a) and 19(b) of the Act. A prior hearing in this matter was held pursuant to these same Sections and a decision was issued by Arbitrator Thompson-Smith. That decision was made part of the record of evidence as Arbitrator's Exhibit 5.

The Petitioner was working as a delivery driver for Respondent on 2/18/14. On that date, he was making a delivery on what he described as a snowy day. While wheeling a two-wheeled cart loaded with food products down the ramp from his trailer, his left foot slipped out from under him. Petitioner testified that he slid down about twelve inches before he caught himself, twisting his right hip and left leg in the process. He immediately felt a sharp pain in his left hamstring and calf; starting approximately an hour afterwards, he began to notice pain in his right hip as well.

Petitioner underwent a course of treatment, including a right hip MRI, which disclosed extensive labral tearing in the right hip. The treating physician, orthopedic surgeon Dr. Freedberg, opined that Petitioner's condition was causally related to the accident, and recommended surgery. The Respondent's obtained an opinion from Dr. Cherf that disagreed with Dr. Freedberg's. (See Arbx5)

Following the prior Section 19(b)/8(a) hearing, on 2/5/15 the Arbitrator found that Petitioner's right hip condition was causally related to the 2/18/14 accident. The accident was not in dispute. With regard to causation, Arbitrator Thompson-Smith noted that while the Respondent argued that the Petitioner's degenerative hip condition predated the accident based on the opinions of Section 12 examiner Dr. Cherf, there was no evidence indicating Petitioner was symptomatic before the accident. The Arbitrator relied on the opinions of Dr. Freedberg, including that the accident aggravated the preexisting degenerative changes, causing them to become symptomatic, and that the accident likely caused the Petitioner's extensive acetabulum labrum tear "at least in part." Arbitrator Thompson-Smith noted that Dr. Cherf opined that the accident may have aggravated the hip condition, but that any such aggravation was temporary, in part because "one simple slip" on the accident date could not significantly contribute to osteoarthritis. The Arbitrator found that the accident involved significantly more than a "simple slip", as the Petitioner's history of the accident consistently indicated he slid down approximately a foot when he slipped at an incline while holding onto a two-wheeled cart loaded with product as he was descending a ramp from his truck. The Arbitrator also noted that Dr. Cherf did not comment on the labral tear and did not review Petitioner's MRI arthrogram of the hip, and specifically indicated she therefore did not find his testimony convincing. The Arbitrator ultimately relied upon the opinions of Dr. Freedberg in determining that the Petitioner's right hip condition was causally related to the accident and ordered the Respondent to authorize the arthroscopic surgery recommended by the doctor. On Review, the Commission affirmed and adopted the Arbitrator's decision in its entirety. (Arbx5). The Arbitrator notes that the

findings made in the prior decision constitute the "Law of the Case", which are not subject to revision in subsequent proceedings by either an arbitrator or the Commission itself. *Ming Auto Body/Ming of Decatur, Inc. v. Indus. Comm'n*, 387 Ill. App. 3d 244, 254, 899 N.E.2d 365, 376 (2008).

Petitioner underwent arthroscopic right hip surgery with Dr. Freedberg on 3/28/16, involving resection of the acetabular labral tear, removal of a full thickness acetabular articular cartilage defect with microfracture, removal of loose bone ossicles and femoral head osteoplasty. Post-operative diagnoses were a large anterior acetabular labral tear with a bucket handle type, a full-thickness articular cartilage defect of the acetabulum with loose ossicles of bone, and a femoral acetabular impingement. During the procedure, Dr. Freedberg indicated he visualized "a lot of damage inside the hip joint itself", including a large acetabular labral tear, two very large loose fragments of bone in the acetabular labrum, and a denuded full-thickness articular cartilage layer. Dr. Freedberg noted that the exposed bone indicated a poor prognosis, and that Petitioner's right hip "in all probability, will at some point on a premature level go on to a total hip arthroplasty because of the significant amount of not only labral damage, but the articular cartilage loss." (Px1).

Petitioner followed up with Dr. Freedberg following the surgery, and he prescribed physical therapy and off work status. Petitioner attended physical therapy but reported constant pain in his hip between 5/10 and 8/10 on subsequent visits, with some burning pain and/or numbness radiating to his right thigh. On 6/29/16, Dr. Freedberg began to discuss another surgery as a possible treatment option going forward. On 9/8/16, Petitioner reported increased hip pain with certain positions, with popping followed by sharp pain when he would sit and then reposition himself. At this point, Petitioner agreed to proceed with a right hip total arthroplasty. On 10/6/16, Petitioner again reported constant ache in his hip, a slight increase in his pain level, and sharp pain from his hip popping. He remained off work. (Px1).

On 11/3/16, Petitioner underwent a Section 12 examination with Dr. Karlsson at the request of Respondent. Petitioner reported that his right hip symptoms began on the date of accident. He reported having a constant ache in his right hip, with pain and popping anteriorly near the groin, laterally over the greater trochanter and distally, worse when traversing stairs or walking. On examination, Petitioner noted right hip pain at the extremes of motion. Dr. Karlsson noted reduced right hip range of motion on flexion, internal rotation and external rotation. Dr. Karlsson noted that Petitioner had an antalgic gait. Dr. Karlsson opined that Petitioner was suffering from degenerative osteoarthritis, with a preexisting degenerative labral tear and labral cyst. He further opined that Petitioner had suffered no significant right hip injury at work, and that none of Petitioner's conditions of ill-being were causally related to the accident. He opined that the Petitioner's labral tear and cyst were treated appropriately with arthroscopic care and that Petitioner's medical treatment to date had been reasonable and necessary. He also agreed that it was reasonable to proceed with a right hip replacement. He believed that Petitioner was capable of working full duty without restrictions. (Rx2).

Petitioner testified remained off work through 12/3/16, and all TTD was paid. He had been terminated from his position with Respondent on 11/6/14. On 12/4/16, he found work within his restrictions at Competitive Concrete Cutting, a concrete cutting company.

Petitioner returned to Dr. Freedberg on 12/5/16 complaining of hip soreness and constant aching at 5/10, as well as hip popping followed by sharp pain. Dr. Freedberg released Petitioner back to work on restricted duty. Petitioner continued to follow up with Dr. Freedberg, last visiting him on 4/27/17. He reported increased popping and constant pain at 6/10, as well as increased pain with certain movement, pain with sitting too long, and pain with activity. Dr. Freedberg reviewed x-rays, indicating they showed increasing collapse of the joint with irregularity of the femoral head. He reiterated his recommendation that Petitioner proceed with right total hip arthroplasty. (Px1).

As of 4/27/17, Petitioner remained on light duty work restrictions from Dr. Freedberg: no lifting more than 40 pounds; no pushing or pulling more than 40 pounds, limited stooping, kneeling, climbing, and repeat bending. (Px1).

On 5/16/17, Dr. Freedberg testified via evidence deposition. He testified that the Petitioner did not do well following the 3/28/16 arthroscopic procedure, which is why he was recommending total hip replacement. He testified that the Petitioner's full-thickness loss of articular cartilage constitutes end-stage arthritis. After surgery, Petitioner was prescribed therapy and medication, but he wasn't able to regain his function or to be pain free. On 9/8/16, Petitioner complained of worsening with constant pain, and popping with pain in the hip when he would sit and reposition himself and with certain exercises. Therapy wasn't helping, and he complained of worsening back pain. As of Petitioner's 4/27/17 visit, he was reporting constant hip pain at 8 out of 10 with popping and sharp pain when performing certain exercises or repositioning himself in a seated position. (Px2).

Dr. Freedberg testified that he recommended the hip arthroplasty based on Petitioner's pain and dysfunction, including but not limited to his hip giving-way. He opined that arthroplasty provided the best option for improving the Petitioner's quality of life. Dr. Freedberg testified that modern hip replacement hardware is stronger and of better quality, and while he couldn't guarantee it would last for Petitioner's lifetime he believes that it could, and that his patients generally agree that 20 years of relief would be worth the potential that it could fail within 20 years. Dr. Freedberg stated that based on his last exam, he continued to recommend a total hip arthroplasty for Petitioner. (Px2).

Dr. Freedberg reiterated that Petitioner's need for a total hip arthroplasty is causally related to his work accident of 2/18/14. He testified that Petitioner "had no prior existing problems. He had an injury where he not only tore the labrum, but he had a full thickness articular cartilage loss with the production of loose bodies, and that in and of itself changed the ultimate course and prognosis for this patient of his hip. So, despite the conservative measures and the arthroscopic procedure, none of it was successful, and so this would be a subsequent sequelae that one would expect to happen in this particular case. And looking at the medical records and the chronology, everything is consistent with the problem emanating from this accident in question." Dr. Freedberg testified that he disagreed with the opinions in Dr. Karlsson's 11/3/16 report regarding Petitioner's right hip. (Px2).

On cross examination, Dr. Freedberg testified his records are replete with complaints of right hip dysfunction and pain. He testified that Petitioner's "give-way" feeling is generally a reflexive response to feelings of pain in the hip which can be caused by many different issues, such as clicking of the labrum, loose bodies caught in the joint, or stimulation of the subchondral nerve fibers where his lost articular cartilage left exposed bone behind. Dr. Freedberg noted that even though he identified and removed loose bodies within the hip during Petitioner's surgery, this would not preclude the production of additional loose bodies over time. He further testified that Petitioner's pre-surgical loose bodies did not even appear on x-rays, as they were translucent and not radiopaque. (Px2).

On 6/5/17, Dr. Karlsson provided his evidence deposition. He testified that the Petitioner reported moving a load of food on a two-wheeled cart down a ramp on 2/18/14 when his left foot slipped going forward and his right foot went out to the side. He said he fell downward but not all the way down onto the leg, just catching himself before falling, and developed right hip pain about two hours later. Petitioner complained of constant right hip ache, both anteriorly and laterally, with pain and popping, and he had difficulty with walking and stair use. Examination noted some slight loss of range of motion with pain at the extremes of all motions. Dr. Karlsson testified that examination also indicated an antalgic gait, but no loss of strength or atrophy in Petitioner's right leg, which indicated to him that there hadn't been any long-standing disuse of Petitioner's

right leg. He therefore wouldn't expect that Petitioner limped all the time. He testified he also reviewed Petitioner's medical records. (Rx1).

Dr. Karlsson noted that 5/22/14 x-rays showed Petitioner had bilateral degeneration of the hips, with the right (moderate) a little worse than the left (mild to moderate), and that various films from February to June of 2016 showed no significant changes since May 2014 indicating advancement of arthritis. His diagnosis was degenerative osteoarthritis of the right hip. As to the paralabral cyst that had been present on MRI, Dr. Karlsson opined that it would have been caused by a longstanding labral tear. He went on to opine that there was no causal relationship between the labral tear and the degenerative osteoarthritis: "in this particular case especially, the degenerative arthritis was there already with significant loss of cartilage, down to two millimeters even on the earliest films. That's something that takes decades or a lifetime to develop. He had treatment of his labral tear and the subsequent x-rays two years later showed no changes in his arthritis by radiographs. There was no worsening, no larger osteophytes, no further loss of cartilage. So I would not consider any treatment of his labrum to be in any way related to the arthritis that he has or that it caused any worsening or acceleration of his arthritis." (Rx1).

Essentially, Dr. Karlsson testified that the degenerative changes seen on films as early as 5/22/14 were chronic and not something that would have occurred within weeks or even years of the 5/22/14 films. The labral tear was treated via surgery, and that left the Petitioner with a longstanding degenerative hip, which he opined is the current source of his pain and unrelated to the work accident. He further opined that Petitioner's labral tear did not cause or accelerate Petitioner's right hip arthritis, as Petitioner had significant preexisting chronic changes, and none of the x-rays between 5/22/14 and 6/1/16 showed the degree of arthritis present had worsened. Any further treatment to the right hip, in his opinion, would have been unrelated to the accident and would be related to the preexisting condition. (Rx1).

On cross, Dr. Karlsson agreed that he had no knowledge of any pre-accident films of the Petitioner's right hip. He also agreed he was aware of all of the surgical procedures that Dr. Freedberg had performed on 3/28/16. His report stated that the Petitioner's current condition of ill-being is degenerative arthritis of the right hip, and that he previously had a degenerative labral tear and degenerative paralabral cyst. He agreed that a total hip arthroplasty would be reasonable given the Petitioner's current right hip condition per his report, but testified that he has concern for the surgery due to both the Petitioner's age as well as whether he was truly having symptoms severe enough to warrant it given the lack of atrophy in the right leg. (Rx1).

On redirect, Dr. Karlsson testified that its well-known that degenerative arthritis can cause a degenerative labral tear, while the labral tear or cyst would not cause degenerative osteoarthritis. Therefore, it's possible that the labral tear could be caused by his degenerative arthritis, while the labral tear leading to his degenerative arthritis is not a possibility. (Rx1).

Following surgery, Petitioner testified he initially had severe pain. With therapy, it progressively improved. At some point he had to attempt stairs, and this caused pain. He plateaued at some point, and he testified he never became pain free.

Petitioner testified he is under restrictions limiting him to 45 pounds of lifting, no push/pulling over 45 pounds and no excessive stair use. At Competitive Concrete Cutting, Petitioner testified he makes deliveries out to the field, does some work on equipment in the shop, does sales and drives around to job sites talking to contractors. The parties have stipulated that Petitioner was making $1,630.89 per week when he was working for Respondent. (See Arbx1). At his new job, Petitioner testified that he initially earned $20 an hour working 40 hours a week ($800.00 per week), and currently makes $25 an hour ($1,000.00 per week).

On work days where he drives a lot, as when performing sales work, his right hip is extremely painful, particularly after he gets out and starts walking again. He also testified that his hip is very painful whenever he has to walk up or down stairs. He noted that prolonged sitting causes pain, and when this occurs he has to get up periodically and keep things moving and must avoid putting a lot of weight on the right hip. Petitioner testified that he continued to follow up with Dr. Freedberg for about six months after he returned to work, but as the only treatment he received was medication, and he wanted to limit himself to only over-the-counter pain medications. He takes Tylenol daily. Petitioner testified that he would undergo the recommended hip replacement surgery if it were authorized.

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:

It is the Law of the Case that Petitioner suffered a work accident and that Petitioner's condition of ill-being in his right hip as of the prior 2/5/15 hearing date was causally related to said work accident. This is based on the prior Arbitrator's decision in this matter, which was affirmed and adopted in its entirety on Review. Respondent now contests the relatedness of Petitioner's current condition of ill-being, post repair of his acetabular labral tear. The argument, supported by the opinions of Dr. Karlsson, is essentially that the right hip degeneration was preexisting, and while he also believed the labral tear was preexisting, he opined that this had been addressed via surgery, and therefore the only remaining cause of Petitioner's right hip symptoms is the preexisting degenerative condition.

The Arbitrator initially notes that Dr. Karlsson has essentially opined that Petitioner suffered no significant work accident, and that all of the conditions of ill-being in Petitioner's right hip are not causally related to the work accident. These opinions conflict with the Commission's prior determinations in the Arbitrator's view. The Commission's prior decision in this case recognized multiple conditions of ill-being in Petitioner's right hip, including both an acetabular labral tear and preexisting osteoarthritis. As noted in unrebutted fashion, Petitioner had no pain or other symptoms in his right hip prior to his work accident despite this preexisting osteoarthritis, and despite having to perform food deliveries on a daily basis.

The prior decision addressed the likelihood that the accident exacerbated Petitioner's osteoarthritis, noting that Respondent's former Section 12 examiner, Dr. Cherf, conceded such a possibility, but opined that such an exacerbation would only be temporary because it was caused by "one simple slip." The Arbitrator, and subsequently, the Commission) did not find this theory of only a temporary exacerbation convincing.

Dr. Karlsson opined that Petitioner's labral tear did not cause or accelerate Petitioner's right hip arthritis, stating that such a significant arthritic condition must occur degeneratively over the course of many years. However, it was already established in the prior proceeding that Petitioner had osteoarthritis prior to the date of accident, and that Petitioner's preexisting osteoarthritis only became symptomatic on the date of his work accident. The law in Illinois is that when a work accident aggravates a preexisting condition, causation is established. It is not necessary for Petitioner's arthritis to have been entirely or even most significantly caused by his labral tear, or even by the accident - all that must be shown is that the accident is a cause of the condition. The preponderance of the evidence, as set forth in the Commission's prior decision, demonstrates that the accident aggravated Petitioner's arthritic condition in his hip.

Ultimately, Dr. Karlsson's testimony hinges on his opinion that Petitioner's hip arthritis was significant, and that Petitioner's x-rays between May 2014 and June 2016 showed no change in the degree of arthritis. Again, the Arbitrator's review of the prior decision indicates the Commission found that the degenerative condition of the hip was aggravated and causally related to the accident. Dr. Freedberg opined the initial post-accident x-rays showed only mild degenerative hip disease bilaterally, right greater than left, while subsequent diagnostic imaging showed Petitioner's hip condition progressing. This was the opinion the prior Arbitrator found most persuasive. The awarded arthroscopic surgery by Dr. Freedberg clearly included an attempt to resolve at least part of the degenerative condition via removal of the acetabular articular cartilage defect with microfracture, removal of loose bone ossicles and femoral head osteoplasty.

While he reasonably opines that the Petitioner had a preexisting right hip arthritis and labral tear, Dr. Karlsson does not comment on the impact of the injury on the causal relationship of the condition in terms of creating new symptoms without a return to a baseline condition, the possibility that while a labral tear may have existed it may have been made worse and accelerated, or how the reasonable and compensable prior surgery failed to resolve the post-accident symptoms.

The Petitioner had no prior existing problems. He had an injury where he not only tore his labrum, but he had a full thickness articular cartilage loss along with multiple loose bodies. Conservative measures ultimately were unsuccessful, which led to the previously awarded surgery. The Arbitrator finds Dr. Freedberg's testimony more persuasive than that of Dr. Karlsson. The Commission previously determined that the labral tear was causally related to the accident, and Dr. Karlsson has opined that this labral condition was preexisting. It is unclear to the Arbitrator how his opinion can somehow support a separation of that degenerative labral condition from any other remaining preexisting degenerative conditions in terms of the fact that the Commission previously found the preexisting labral tear was aggravated and related to the accident. Again, there is no evidence Petitioner had any prior right hip problems, and the evidence strongly supports that the Petitioner's right hip condition has never been the same since the accident.

Most importantly in this case, in the Arbitrator's view, the defense presented by the Respondent seeks to relitigate a causation issue that has previously been settled as the Law of the Case. A Respondent generally has the right to challenge the ongoing nature of a previously found causal relationship. Here, however, the Respondent appears to be arguing that somehow there is a separation between the labral tear and other degenerative conditions in the hip and that the prior Arbitrator found only that the labral tear was related. The Arbitrator in this hearing disagrees with this argument. There is no persuasive evidence presented in the hearing which would lead the Arbitrator to conclude that the Petitioner's right hip condition is somehow no longer causally related to the accident following the Commission's prior finding that the condition was related to the accident.

For all of these reasons, the Arbitrator finds that Petitioner's current condition of ill-being in his right hip is and remains causally related to his work 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:

Respondent disputes its liability to pay for Petitioner's treatment on the basis of causation. However, as discussed above, the Arbitrator has found that Petitioner's right hip condition remains causally related. Further,

Dr. Karlsson opined that Petitioner's medical treatment had been reasonable and necessary. (Rx2.) As such, the Arbitrator finds that Respondent is liable to pay all related, outstanding medical bills, totaling $27,674.19, pursuant Sections 8(a) and 8.2 of the Act. As such, the Respondent's liability for this awarded amount is limited to that allowed by the Fee Schedule.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As mentioned above, the Arbitrator has found that Petitioner's current condition of ill-being is causally related to his workplace accident. Dr. Freedberg stated that based on his last exam, he continued to recommend a total hip arthroplasty for Petitioner. Significantly, this is based on the failure of arthroscopic surgery resolving Petitioner's symptoms, and no other real options other than living with the pain via medication, as Petitioner has been doing. He testified that he wants to have the surgery to try to resolve his pain. Dr. Freedberg testified that while the Petitioner is still at a fairly young age, he is confident that a hip replacement could last the Petitioner for his lifetime. Dr. Karlsson's report and testimony indicate that he believed that it would be reasonable for Petitioner to proceed with right hip replacement, though he would not recommend it given Petitioner's age and questions as to the degree of Petitioner's complaints. Dr. Freedberg's opinion on the longevity of the prosthetic despite Petitioner's age is noted, and the Arbitrator sees no persuasive evidence indicating a lack of credibility in the Petitioner's complaints of pain and other symptoms in the right hip. The Arbitrator finds it relevant that both he and the prior Arbitrator appear to concur on this factor. Therefore, the Arbitrator views Dr. Karlsson's opinion as favorable towards the recommended surgery being reasonable.

Overall, the Arbitrator finds that the preponderance of the evidence reflects that the recommended right total hip arthroplasty is reasonable and necessary pursuant to Section 8(a) of the Act, and Respondent shall authorize the recommended surgery pursuant to both Sections 8(a) and 8.2 of the Act.

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 parties have stipulated that, with regard to any claimed period of TTD to date, the Respondent has paid all applicable benefits, and that they are entitled to credit for same. The issue between the parties at this hearing involves liability for temporary partial disability benefits after 12/3/16. The Respondent has indicated that the only real dispute regarding this issue is the causal relationship of the Petitioner's ongoing right hip complaints to the work accident.

As the Arbitrator has determined that Petitioner's ongoing right hip condition of ill-being is causally related to his work accident, the Arbitrator also finds that Petitioner is due partial temporary disability benefits for his time spent working at a reduced rate of pay.

The parties have stipulated that Petitioner was making $1,630.89 per week when he was working for Respondent. (Arbx1) The Petitioner began his new job working full time on 12/4/16 earning $800.00 per week and continued earning that rate of pay through 2/25/17. At that point, his full-time wages increased to $1,000.00 per week. The Arbitrator finds that Petitioner is due $6,567.99 in TPD benefits for the period (13 weeks x $830.89 x 2/3) from 12/4/16 through 3/5/17, and $26,617.55 in TPD benefits for the period (62 and 3/7 weeks x $630.89 x 2/3) from 3/6/17 through the hearing date, 5/16/18.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH BERGLIND,

Petitioner,

vs. NO: 09 WC 44138
20 IWCC 0073

CITY OF CHICAGO,

Respondent.

ORDER

This matter comes before the Commission on Respondent's Petition to Recall the Commission Decision to Correct Clerical Error Pursuant to Section 19(f). The Commission grants Respondent's Petition.

With regard to the Petition to Correct Clerical Errors, the Commission agrees with the alleged clerical errors, and thus grants said Petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision and Opinion dated January 29, 2020, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner Maria E. Portela.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision and Opinion on Review shall be issued simultaneously with this Order.

DATED: FEB 2 1 2020
MEP/ypb
049

Maria E. Portela

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH BERGLIND,

Petitioner,

vs. NO: 09 WC 44138
20 IWCC 0073

CITY OF CHICAGO,

Respondent.

CORRECTED DECISION AND OPINION ON PETITION UNDER §19(h) OF THE ACT

This matter comes before the Commission on Petitioner's 19(h) Petition, filed on April 28, 2015, for a finding of medical causation as well as payment of temporary total disability benefits, payment of medical bills and authorization for payment for prospective medical care. A hearing was held before Commissioner Portela on April 16, 2019, in Chicago, Illinois, and a record was made.

An Arbitration hearing was held on February 6, 2013, and a decision was issued on December 12, 2014. Neither party reviewed the decision which became final. The relevant inquiry before us is whether Petitioner's condition of ill-being regarding his shoulders and right elbow remains causally related to his work injury and whether he is entitled to additional temporary total disability benefits, medical expenses, prospective medical treatment and a future hearing to determine a new amount of permanent partial disability.

At the 2013 hearing, Respondent stipulated as to causal connection pertaining to both the right and left shoulders and the September 14, 2009 work accident. At issue at the time of the Arbitration hearing was whether Petitioner's left and right elbow conditions were causally related to the work accident, medical and nature and extent. Petitioner was paid for his lost time associated with the September 14, 2009 work accident and did not seek temporary total disability benefits at the time of the original hearing. Respondent has since stipulated to temporary total disability for the time period from July 2, 2015 through May 25, 2018 and August 2, 2018 through April 12, 2019. However, Respondent disputes temporary total disability payments from May 26, 2018 through August 1, 2018.

Bilateral Shoulders

In the underlying case at Arbitration, the parties agreed that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment with Respondent. Respondent challenged the alleged injuries to the right and left elbows, but the Arbitrator found that the Petitioner's injuries to the left and right shoulders were causally connected to the Petitioner's accident on September 14, 2009. (Arb. Decision, p. 14)

Two days after the accident, Petitioner sought treatment from MercyWorks. Petitioner initially only sought treatment for his shoulders, but by October 7, 2009, when he went to see Dr. Wolin, he presented with complaints to his bilateral shoulders and bilateral elbows. Dr. Wolin treated Petitioner from October 7, 2009 through May 4, 2010. Dr. Wolin sent Petitioner for physical therapy, as well as diagnostic exams (MRIs and MR arthrograms) of his bilateral shoulders and bilateral elbows. Dr. Wolin causally connected the bilateral shoulders to the September 14, 2009, accident at the November 24, 2009 office visit, wherein he stated: "bilateral osteoarthritis with partial cuff tear right and labral changes on the left. While the osteoarthritis preexisted this most recent episode the partial cuff tear and the labral changes appear related to the work injury." (TA Px3)

By April 20, 2010, Dr. Wolin opined that Petitioner's options were shoulder surgery due to the condition of his shoulders, or an FCE. Petitioner wanted to avoid surgery. (TA Px3) As of May 14, 2010, Dr. Wolin noted the restrictions of the FCE were permanent but recommended that Petitioner see Dr. Goldberg for a discussion of shoulder arthroplasty. (TA Px3) Petitioner has not sought treatment from Dr. Wolin since May of 2010. Petitioner returned to work under the limitations as set forth in the FCE in June of 2010.

Petitioner was seen by Dr. Brian Coe for his bilateral shoulder injuries on December 7, 2010. He noted Petitioner sustained an internal derangement of both shoulders, right shoulder partial rotator cuff tearing and left shoulder glenoid labral tearing with aggravation of degenerative arthritis in both shoulders as a result of the September 14, 2009 work accident. Dr. Coe opined that there was a causal connection between the work accident and Petitioner's current condition of ill-being and recommended future medical treatment. Dr. Coe opined that the additional treatment would include the possibility of surgery (bilateral shoulder joint arthroplasties) as discussed by Dr. Wolin. (TA Px16)

Petitioner worked for the next 5 years, until July 21, 2015, without missing any significant amount of time from work. In that time period, Petitioner's condition continued to deteriorate. There has been no change in the bilateral shoulder condition since the prior hearing, and there was a recommendation for bilateral shoulder surgery at the time of the initial hearing. (TA Px3 and TA Px16).

Since the time of the Hearing on Arbitration, Petitioner has been under the medical care of Drs. Wolin, Goldberg and Chudik for his bilateral shoulder condition. (Px1, Px9 and Px10) Petitioner was also treating with Dr. Wolin for the right elbow condition. (Px1) At no point did any of these physicians release Petitioner to return to work or release Petitioner from medical care. Both Drs. Chudik and Goldberg recommended bilateral shoulder replacement. (Px10) The Commission considers the medical opinion of Dr. Chudik to be persuasive in finding that

Petitioner's current bilateral shoulder condition is causally connected to the September 14, 2009 work accident.

The Commission notes the fact that a referral for a contemplated bilateral shoulder replacement was made back in 2010 is most persuasive in finding that Petitioner's bilateral shoulder condition is causally related to injuries sustained in the September 14, 2009 work accident. All of the testimony in this case by Petitioner as well as the experts is consistent with the fact that it was reasonable for Petitioner to want to delay such extensive and invasive surgery.

Respondent's argument that Petitioner was able to return to work within the FCE restrictions and that is therefore indicative that his condition was further deteriorated merely by his activities of daily living has some merit. However, it is more persuasive that but for the accident of September 14, 2009, Petitioner's condition may not have been aggravated to the extent of possible surgery being recommended in the first place. The issuing of three reports by Dr. Marra, likely at the direction of Respondent, wherein it appears his causation opinion was altered, also detracts from the credibility of his opinion. All physicians agree that Petitioner's condition warrants bilateral shoulder replacement and Petitioner has met his burden that this need is causally connected to the September 14, 2009, accident.

<u>Right Elbow</u>

At the hearing before the Commission on April 16, 2019, Respondent did not submit any medical evidence disputing the causation of the right elbow condition. Dr. Wolin causally connected the right elbow condition to the September 14, 2009 work accident. Petitioner had proof of prior good health and a change in same immediately following and continuing after the injury. Petitioner testified that since the February 6, 2013 hearing, he had not sustained any new accidents involving his bilateral shoulders or right elbow. His symptoms persist to the present date and he has been under continuous medical treatment.

Regarding the right elbow, Petitioner met his burden of proof as to causation. Respondent's own expert agreed in 2016 that Petitioner's need for surgery was related to the original work accident (Px18), and Petitioner never seemed to fully recover from his elbow injuries despite the multiple conservative and invasive treatments. Petitioner had ongoing and continuous care as it related to the right elbow and it appears Petitioner was taken off of work due to his ongoing and consistent complaints regarding the right elbow. No physician – either treating or Section 12 – found Petitioner to be magnifying his symptoms. Additionally, Respondent's expert agreed that Petitioner's right elbow problem was a permanent condition prohibiting him from returning to his previous employment as an ironworker and at a minimum, an FCE would be required to determine new restrictions. Based on that evidence, Petitioner was clearly not at maximum medical improvement, and there was no evidence introduced to dispute Dr. Wolin's causation opinion that Petitioner's right elbow condition was related to the 2009 work accident.

Petitioner argues that he is entitled to payment of the medical bills from Dr. Wolin, Dr. Chudik and Athletico, temporary total disability benefits from July 2, 2015 through April 16, 2019, authorization of payment for the bilateral shoulder replacement recommended by Dr. Chudik and an evaluation with Dr. Gryzlo. The Commission agrees.

As Petitioner's condition has deteriorated and destabilized since the rendering of the 2014 Arbitrator decision, the 19(h) Petition is an appropriate remedy for seeking additional benefits. *Poor v. Industrial Commission*, 298 Ill.App.3d 719 (1998).

Both parties set forth persuasive arguments, but ultimately, the Commission finds that Petitioner did meet his burden of proof regarding causation as to the current condition of ill being in the shoulders as well as his right elbow. Accordingly, Petitioner should be awarded the medical expenses, prospective medical treatment, and temporary total disability and a hearing to determine a new amount of permanent partial disability should be held at a future date.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) is hereby granted as outlined above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,075.60 per week for a period of 197 6/7 weeks, commencing July 2, 2015 through April 16, 2019, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,523.00 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for prospective surgery as recommended by Dr. Chudik as well as a further elbow examination in the form of a second opinion visit with Dr. Gryzlo under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

DATED: FEB 2 1 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

MEP/dmm
O:121019
49

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

LADANNA BROWN,

Petitioner,

vs. NO: 18 WC 21449
18 WC 21740

CUSTOMIZED DISTRIBUTION SERVICES,

Respondent.

20 IWCC0119

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical, occupational disease, and the admissibility of certain medical records, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d

14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator issued one Decision for both referenced claims above: 18 WC 21449 alleged left arm/shoulder injuries which manifested on June 14, 2018 as a result of Petitioner's repetitive duties. Claim No. 18 WC 21740 pertained to Petitioner's neck and right arm/shoulder injuries as a result of a June 14, 2018 specific injury at work. Respondent filed its Petition for Review in the above-referenced claims and confirmed that the Review pertained only to Petitioner's alleged injuries to the left shoulder and neck. Respondent did not dispute Petitioner's right shoulder injury. Thus, the Commission affirms and adopts the Arbitrator's findings and conclusions in its entirety as it relates to the right shoulder.

The Commission also affirms and adopts the Arbitrator's findings of accident and causal connection with respect to Petitioner's neck injury. There is no dispute that Petitioner injured her right shoulder on June 14, 2018 when she reached back with her right arm to sound the rear horn of the forklift. Petitioner not only reported pain in her right shoulder, but she also reported neck complaints on that same date to Gateway Regional Occupational Health Services, the company clinic. There is also no dispute that Petitioner was required to drive the forklift backward. Each of these activities required Petitioner to twist her body, as well as turn her head and neck back. Petitioner's testimony that she constantly turned her head back while driving the forklift was consistent with the company clinic records and the rest of the medical records in evidence. Petitioner's treating physician, Dr. Solman, opined that driving the forklift in the position Petitioner described was a competent cause for fatigue and strain to the cervical spine. Dr. Solman's opinion is more persuasive than Respondent's Section 12 examiner, Dr. King, who blamed Petitioner's complaints on degenerative findings in her cervical spine. Even if Petitioner had degenerative findings in her cervical spine, Petitioner reported no pain, treatment, or claims for the neck prior to June 14, 2018. The Arbitrator relied on this chain of events, Dr. Solman's opinions, and the medical records demonstrating abnormal findings during examinations and diagnostic imaging to reach his conclusions. The Commission finds that the preponderance of the evidence supports Petitioner's claim of injury to the neck and affirms the Arbitrator's Decision in this regard. Therefore, the Commission finds Petitioner's Claim under No. 18 WC 21740 compensable.

With respect to Claim No. 18 WC 21449 pertaining to Petitioner's left arm/shoulder injuries which allegedly manifested on June 14, 2018 as a result of Petitioner's repetitive duties, the Commission reverses the Arbitrator's findings of accident and causal connection. 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. *Peoria Cnty. Belwood Nursing Home v. Indus. Comm'n*, 115 Ill. 2d 524, 530 (1987). Additionally:

> The categorization of an injury as due to repetitive trauma and the corresponding establishment of an injury date are necessary to fulfill the purpose of the Act to compensate workers who have been injured as a result of their employment. *Belwood Nursing Home,* 115 Ill. 2d

> at 530-31. The recognition of such a date allows an employee to be compensated for injuries that develop gradually, without requiring the employee to push his body to a precise moment of collapse. (Citation omitted). There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet a legal definition of 'repetitive.' The issue at hand is causation. *Edward Hines Precision Components v. Indus. Comm'n*, 356 Ill. App. 3d 186, 194 (2005).

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. Ill. Indus. Comm'n*, 157 Ill. App. 3d 470, 477 (1987).

In the case at bar, Petitioner's treating physician, Dr. Solman, opined that Petitioner's left shoulder condition was the result of her work-related cumulative activities of driving a forklift backwards over a period of six months for Respondent. However, Petitioner testified that the first time she felt pain in her left shoulder was on the date of accident, June 14, 2018. Petitioner also confirmed that prior to June 14, 2018, she did not have any pain, treatment, or claims for the left shoulder. The medical records immediately after the June 14, 2018 accident did not mention any issues with the left shoulder, and Petitioner did not bring up any concerns relative to her left shoulder until more than two months after the reported work injury. Dr. King denied causation on this basis – there was no specific mechanism of injury as to the left shoulder on June 14, 2018 and there were no documented left shoulder complaints from the onset.

It is Petitioner's burden to establish that her left shoulder condition is work-related. Here, there is no evidence that Petitioner injured her left shoulder in any work-related accident on June 14, 2018 and there is no evidence of any left shoulder injury that developed gradually or otherwise. Dr. Solman's lone opinion in support of causation for the left shoulder is without basis or support in the record. Therefore, the Commission finds that Petitioner failed to establish by a preponderance of the evidence the she sustained an injury to her left shoulder as the result of her repetitive duties as a forklift driver and which allegedly manifested on June 14, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 3, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable, necessary, and causally related medical services for Petitioner's neck and right shoulder injuries, and as set forth in Petitioner's Exhibit 3 totaling $1,700.86. Respondent shall pay the awarded medical bills pursuant to Sections 8(a) and 8.2 of the Act. Any medical bills incurred for the left shoulder are hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to the right shoulder surgery recommended by Dr. Solman and physical therapy for Petitioner's cervical spine. Any and all prospective medical requested for the left shoulder is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $431.60 per week for 33 weeks, commencing August 21, 2018 through November 25, 2018, and from December 17, 2018 through April 29, 2019, 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 $7,306.81 for temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Exclude Petitioner's Exhibit 2 (PX2) as violating Section 16 is denied.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,700.00. 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 the Circuit Court.

DATED: FEB 2 1 2020

D. Douglas McCarthy

DDM/pm
O: 2-11-20
052

Stephen J. Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with the result reached by the majority. I write separately as I do not agree with the majority's admission of Dr. Solman's hearsay opinion statements. I would sustain Respondent's objection and strike such statements from the record.

As the Court noted in *RG Construction Services v. Illinois Workers' Compensation Commission*, "[t]he provisions of Section 16 at issue in this appeal assist in accomplishing that goal by easing the *foundational requirements* for the admission of a treating physician's records. *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC, ¶ 50, 976 N.E.2d 1 (stating the 2005 amendments to section 16 were meant 'to ease the *foundational requirements* for the admission of medical bills and records')." (Emphasis added). 2014 IL App (1st) 132137WC, ¶ 39. The amendments to Section 16 of the Act were undertaken to allow the admission of medical records to be more efficient not to shield objectionable hearsay statements.

Certainly, treating physicians' records "are likely to contain medical opinions relating to a variety of aspects in the care, treatment, and evaluation of the employee." *RG Construction Services* at ¶ 39. Such opinions are offered as part and parcel of the care and treatment of a patient. An opinion offered relating to a causal relationship between an accident and a claimant's resulting condition of ill-being is neither necessary nor relevant to the diagnosis or treatment provided by a doctor. Such statements are hearsay and do not qualify under the exception defined in the Rules of Evidence- Rule 803(4)- Statements for Medical Diagnosis or Treatment. *Illinois Rules of Evidence*- Rule 803(4) (2011).

Again, as the Court noted in *RG Construction Services*, "'under certain circumstances the probability of accuracy and trustworthiness [of a document] may serve as a substitute for cross-examination under oath.' *United Electric Coal Co. v. Industrial Commission*, 93 Ill. 2d 415, 444 N.E.2d 115, 117 (1982)." 2014 IL App (1st) 132137WC, ¶ 42. The Court went on to explain the Supreme Court's holding in *United Electric Coal Co. v. Industrial Commission.* In *United Electric Coal Co.*, the Supreme Court allowed a hearsay causation opinion into evidence despite the employer's objection to the same. The Court reasoned that the opinion testimony offered by the treating physician was, in part, based upon the opinions provided by the employer's examining expert physician. In such circumstances, the Court reasoned the opinions offered were trustworthy.

Dr. Solman's records contain the following opinion statements:

> I believe that the pathology seen on the MRI flows directly from the June 14, 2018 injury and was not related to incomplete healing of the rotator cuff. I believe within a reasonable degree of medical certainty that, if LaDanna had had incomplete healing of her rotator cuff at the time of her 2013 surgery, then she certainly would have had ongoing pain and would have possibly had the need for further treatment had she not gained all of her strength back and had had continued pain. She had none of these issues. She went back to her full, unrestricted duties and had no issues with the right shoulder until the June 14, 2018 injury. In my opinion, there does not necessarily have to be anything on an MRI that looks "acute" to say that an injury is acute. If she sustained a tear at the time of the incident on June 14, 2018, then her MRI could certainly look the way that it does and that is with a high-grade partial thickness

> tear…I would agree with Dr. King that the work incident of June 14, 2018 is not the prevailing factor in the development of her left shoulder pain but rather the left shoulder is a result of six months' history of work driving a forklift backwards placing an undue strain on the left shoulder and her cervical spine. PX2.

Such statements are hearsay and do not qualify as an exception under Rule 803(4) as the statements were not made for the purposes of diagnosis or treatment. Dr. Solman is testifying in writing and responding directly to the opinions of Dr. King, Respondent's examining physician. Moreover, the opinions were offered in direct response to questions posed by Petitioner upon her presentation of Dr. King's reports to Dr. Solman. T. 34. Unlike *United Electric Coal Co. v. Industrial Commission*, there is nothing in the record which indicates these opinions are inherently trustworthy. As such, I would sustain Respondent's objection and redact this portion of Dr. Solman's records.

For the reasons stated above, I dissent as to the admission of Dr. Solman's objectionable hearsay statements, but I concur with the ultimate decision reached by the majority.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

50 1 ACC0116

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

BROWN, LaDANNA Case# **18WC021449**

Employee/Petitioner

18WC021740

CUSTOMIZED DISTRIBUTION SERVICES

Employer/Respondent

20IWCC0119

On 6/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0656 GLASS & KOREIN LLC
MICHAEL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

2871 LAW OFFICES OF LUCY T UNGER
MARY FLANAGAN-DEAN
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

20IWCC0119

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)

LaDanna Brown,
Employee/Petitioner

v.

Customized Distribution Services,
Employer/Respondent

Case # **18** WC **21449**

Consolidated cases: **18WC 21740**

20IWCC0119

An *Application for Adjustment 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 **Collinsville**, on **April 29, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. X What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. X Other **Admissibility of certified treatment records**

FINDINGS

On the date of accident, **June 14, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**22,011.60**; the average weekly wage was $**647.40**.

On the date of accident, Petitioner was **52** years of age, with **0** dependent children.

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

Respondent shall be given a credit of $**7,306.81** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,306.81**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $431.60/week for 34 weeks, commencing August 21, 2018, through November 25, 2018, and from December 17, 2018, through April 29, 2019, date of hearing, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $7,306.81 resulting in a shortfall of TTD of $7,367.59.

Respondent shall pay reasonable and necessary medical services of $1,700.86 set forth in PX3 in accordance with the Fee Schedule, as provided in the Sections 8(a) and 8.2 of the Act. Further, Respondent shall pay for the right shoulder surgery recommended by Dr. Solman, a MRI of the left shoulder, and for physical therapy attributable to Petitioner's neck and left shoulder.

Respondent's Motion to Exclude PX2 as violating Section 16 is overruled.

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.

20IWCC0119

Robert M. Harris

Signature of Arbitrator Robert M. Harris

Date: June 3, 2019

JUN 3 - 2019

LaDANNA BROWN, Employee/Petitioner

v.

CUSTOMIZED DISTRIBUTION SERVICES, Employer/Respondent
Case No: 18WC 21740 consolidated with 18WC 021449

MEMORANDUM OF DECISION OF ARBITRATOR – 19(b)

STATEMENT OF FACTS

Petitioner, LaDanna Brown, alleges specific trauma on June 14, 2018 to her neck and right shoulder while reaching up and backwards to blow the horn on the rear of a forklift while having to drive backwards for Respondent, Customized Distribution Services. That allegation bears claim #18WC 021740. Petitioner also alleges repetitive/cumulative injuries to her left shoulder through June 14, 2018 from the same work activity while gripping the steering wheel with her left arm. That allegation bears claim #18WC 021449. The claims were previously consolidated.

At hearing, Respondent disputed that Petitioner sustained an accident on the date of injury alleged. Respondent disputed liability and claims that all unpaid medical bills for treatment rendered are not related to said work injuries. Respondent disputes causal connection between Petitioner's medical conditions in her neck and both shoulders as they relate to her work activities. Respondent agrees that notice was given of the accidents within the time limits stated by the Act. The parties agree that Petitioner's average weekly wage is $647.40. At the time of the alleged injuries, Petitioner was 52 years old, single with 0 dependent children. Petitioner claims an entitlement to temporary total disability for a total of 34 weeks through the date of hearing. This represents the periods August 21, 2018 through November 25, 2018 and December 17, 2018 through April 29, 2019. Respondent claims there is no entitlement to temporary total disability, although the parties stipulate the Respondent paid $7,306.81 in temporary total disability. This hearing was brought pursuant to Section 19(b), and Petitioner also seeks prospective medical treatment for her neck and both shoulders.

Petitioner was the only witness to testify on her behalf. Respondent called Deverick Spraggins and Chris Couture as witnesses for Customized Distribution Services.

Petitioner testified she is currently 53 years old. From October, 2017 through date of hearing, Petitioner testified that she is employed by Customized Distribution Services located in Edwardsville. Her job

title as of June 14, 2018, was warehouse operator. Petitioner's job duties as of that date included driving a forklift. Petitioner testified it was mandatory that she drive the forklift backwards. Before working for Respondent, she worked at Olin for 26-1/2 years **(TR13 - 14)**.

Petitioner testified that she had a previous right shoulder claim with Olin that was settled in 2014. Before June 14, 2018, she had no prior claims for her neck or her left shoulder. With regard to the previous right shoulder claim, she testified that she underwent right shoulder rotator cuff repair by Dr. Rotman in June, 2013; he returned her to full duty at Olin in November, 2013; and Dr. Rotman released her from care in December, 2013. At the time Petitioner was released from care by Dr. Rotman, she was still in pain and weak, although she was not in "much pain". By June, 2014, Petitioner no longer had pain in her right shoulder, and her strength was getting to be 100% **(TR15-16)**. Between June, 2014 and June 18, 2018, Petitioner had no problems with her right shoulder and took no medication for either her neck, right shoulder or left shoulder **(TR16-17)**.

Petitioner testified in relation to photos offered into evidence of the forklift that demonstrate Chris Couture sitting on a forklift grabbing the horn on the back of the forklift with his right hand. Petitioner testified that the purpose of the horn is to blow to let everyone know that you are approaching. Blowing of the horn is something that is done continuously when driving backwards. When driving backwards, Petitioner would have to turn her neck as much as possible to the right looking over her right shoulder for oncoming traffic as she is otherwise unable to see what's behind her **(TR17-19)**. Petitioner testified she grabs the steering wheel differently than what is depicted in the photos. Petitioner testified that, when driving backwards, she is gripping the steering wheel with her left hand in order to control the forklift. Petitioner testified that because she has to grip the steering wheel because it has a lot of play, she has to hold the steering wheel tight to control it, and that is what she believes led to the onset of left shoulder symptoms. Petitioner testified it is difficult to maneuver one-handed while going backwards because not all of the forklifts are in the best condition – some of them you have to grip the wheel to keep from losing control of the steering **(TR19 - 21)**.

On June 14, 2018, when Petitioner reached backward and up to grab the horn with her right hand, she testified she felt and heard a pop in her right shoulder. She immediately felt a burning and tingling sensation which she immediately reported to her supervisors, John Dunlop and Billy Mitchell. Once Petitioner reported the work injury, Billy called for a taxi to take her to Gateway for a drug test which was done the same day **(TR22)**.

At Gateway, Petitioner testified they gave her a urine test and she saw a medical provider who examined her, gave her a script for some medication, and gave her a light duty work release statement **(TR23-24)**. Petitioner followed up with Gateway on June 18, 2018 at which time they examined her, gave her a script for medication, gave her a new light duty script and ordered an MRI for the right shoulder. Petitioner testified that during her examinations at Gateway, she was in a lot of pain, she was nervous, and she guarded her right shoulder and neck. Petitioner did continue to work light duty thereafter **(TR24-25)**.

Petitioner then went to see Dr. Corey Solman on August 17, 2018. She chose Dr. Solman on the recommendation of friends **(TR25-26)**. When Petitioner first saw Dr. Solman, she testified she told him about the previous right rotator cuff surgery she underwent. Dr. Solman took x-rays, examined Petitioner, prescribed medication, gave her a light duty note and ordered a MRI for both shoulders **(TR26-27)**.

Respondent commenced paying temporary total disability benefits on August 21, 2018, after Petitioner presented Respondent with Dr. Solman's work restrictions as they would not accommodate same **(TR27)**. Before approving any MRIs, Petitioner testified Respondent sent her to see Dr. King for a Section 12 examination. Petitioner testified Dr. King examined her for less than five minutes. During the examination, Petitioner testified she was nervous, still in pain and guarded her right shoulder and neck. Following the examination with Dr. King, after receiving Dr. King's report, Petitioner's counsel told Petitioner to attempt to return to work full duty. Weekly temporary total disability benefits were terminated after November 25, 2018 **(TR27-28)**. Petitioner testified that when she went back to work full duty, she did okay until they put her back on the forklift. Petitioner testified that when that happened, she told them she couldn't handle it, and the employer sent her back to Gateway. Gateway examined her the same day, gave her a script for medication, and re-ordered the MRI for her right shoulder. They also sent her back to work again with light duty restrictions **(TR29)**. Petitioner testified work comp then started up weekly TTD benefits on December 17, 2018 **(TR30)**.

Petitioner testified she finally had the MRI in January, 2019. Petitioner was seen again at Gateway on January 14, 2019, at which time they gave her a script for medicine, told her she would probably be having surgery, and wished her good luck. Petitioner was told that she would no longer have to come back to them as they gave her a script to go back to work with light duty and referred her back to Dr. Solman.

Petitioner testified she then saw Dr. Solman on January 25, 2019. When she returned to Dr. Solman, after he reviewed the MRI of the right shoulder, he recommended right shoulder surgery. Petitioner testified Dr. Solman ordered her completely off work **(TR30-33)**. Petitioner testified that on or after February 18, 2019,

work comp terminated her TTD again **(TR33)**. Despite termination of benefits, Petitioner testified she remained under work restrictions of Gateway and off work orders of Dr. Solman **(TR34)**.

Petitioner testified her attorney sent her Dr. King's reports. Petitioner testified she saw Dr. Solman on March 22, 2019, in follow up. Petitioner was not seen his office notes, but she brought Dr. King's reports to Dr. Solman in order to find out what was going on with her treatment. Petitioner testified her attorney did not ask her to bring those reports to Dr. Solman **(TR 34-35)**.

Petitioner testified that, from the June 14, 2018, accident to the present, her right shoulder has remained painful. The pain starts radiating from behind her right ear, down the right side of her neck and into the right shoulder. Petitioner only has right sided neck pain which has been constant since June 14, 2018. Similarly, since June 14, 2018, Petitioner has had constant left shoulder pain which is on the top to the end of the shoulder below the bone **(TR35-36)**. Petitioner testified that being away from work has helped the symptoms in her neck and both shoulders. Petitioner testified her current pain rating in the right shoulder is a 7 to 7-1/2; neck pain is a 7; and left shoulder pain is a 4, out of a zero to 10 scale **(TR37-38)**.

Petitioner testified she is willing to undergo right shoulder surgery recommended by Dr. Solman. Petitioner testified Dr. Solman ordered she remain off work when she was last seen in March **(TR38)**.

Petitioner testified she reviewed a two-minute video that Respondent marked as **RX7** for hearing. Petitioner testified there is a difference between the forklift operators depicted in the video and where she actually worked in the racks. The job depicted in the video is loading or unloading a trailer which she did not do. Petitioner worked retrieving full pallets in the racks that are visible in the background of the video. Additionally, Petitioner testified that, unlike the video, she was required to drive a forklift backwards and to hold the rear horn with her right hand. In the video, the operator was not driving backwards that much and was not holding a rear horn because it didn't look like a rear horn was even on the forklift depicted in the video. Petitioner clarified that the position of the rear horn is above her right shoulder and behind her, although she did not have an estimate as to how far behind her it was **(TR39-40)**. Finally, Petitioner testified on direct that, if Dr. Solman is recommending a left shoulder MRI and physical therapy for her neck, she is willing to proceed with both **(TR40)**.

Prior to cross, the Arbitrator asked Petitioner the reason she is required to drive the forklift backwards. Petitioner responded by testifying that was the way she was told to drive **(TR40-43)**. On cross-examination, Petitioner testified she had no prior left shoulder or neck treatment before June, 2018 and never had any pain or discomfort in her left shoulder before June, 2018. Petitioner reiterated she had no pain in her right shoulder

between June, 2014 and June 14, 2018 **(TR44-45)**. On cross-examination, Petitioner testified she did mention her left shoulder pain to Gateway Occupational as a result of gripping the steering wheel, but was not sure at which specific visits she mentioned the left shoulder **(TR48)**. Petitioner testified she told Respondent on the date of the incident that she was having pain in both shoulders. She did have a primary care physician who retired. Petitioner testified she saw her primary care doctor before undergoing the prior right rotator cuff surgery, but did not see her primary care doctor after she was released from Dr. Rotman's care **(TR49-52)**.

Petitioner testified she was not exactly sure how many months she was driving a forklift because they would pull her to do other things during the 8 months of employment leading up to June 14, 2018. During that time, Petitioner worked as a dock clerk, she worked as a case picker, she wrapped pallets, and she did work in the dock office apart from the dock clerk position. Petitioner was not sure how many months she worked in each of these positions. Even when Petitioner was working in the dock office, she was being pulled out of the office to be put on the forklift. Petitioner testified she also used a forklift while wrapping pallets and when she was working as a case picker. The only position when Petitioner was not using a forklift was her work as a dock clerk. Even then, they would take Petitioner off and put her back on the floor. In total, Petitioner testified she spent more time on the forklift than she did in the office **(TR54-58)**.

The Arbitrator asked Petitioner to describe how Petitioner grips the steering wheel with her left hand, and she described gripping the top of the steering wheel with her left hand only **(TR61-62)**. On re-direct, Petitioner acknowledged that she never reviewed the records from Gateway **(TR62)**.

Respondent called Deverick Spraggins as its first witness. Spraggins testified he has been employed at Respondent for seven years and as a supervisor for two **(TR64)**. Spraggins testified he's familiar with Petitioner's job duties and recalls her being hired in October, 2017. Spraggins testified Petitioner was first hired as a case picker for the first approximate month and a half, but she wouldn't drive a forklift in that capacity. Thereafter Petitioner was assigned to wrap pallets which does not involve driving a forklift, but he had no idea how long she worked wrapping pallets **(TR65-66)**. Spraggins did not recall whether she handled any more machinery. After her assignment of wrapping pallets, Petitioner was assigned as a coordinator which involved passing out orders and typing orders into a computer, but not driving a forklift. Thereafter, Petitioner became a dock clerk which also did not require driving a forklift. The only job that involved driving a forklift was pulling full pallets, and that would have been before June 14, 2018 **(TR67-69)**. Spraggins estimated that prior to June 14, 2018, Petitioner may have driven the forklift less than two months **(TR69)**.

Spraggins confirmed that driving a forklift requires the drivers to drive backwards because the mass of the forklift is too wide for the driver to be able to see in a good radius. Spraggins explained that "mass" refers to the pieces of equipment that are blocking the view in the front of the forklift **(TR70)**. Spraggins testified he has seen Petitioner drive the forklift with her left hand holding onto the top of the steering wheel. The seat is movable **(TR72)**.

On cross-examination, Spraggins acknowledged that if you move the seat forward that makes reaching behind to the horn on the back of the forklift further away. Spraggins advised that the purpose of holding onto the horn behind is for safety purposes **(TR73-74)**. Spraggins acknowledged that driving backwards in that fashion requires the driver to turn and look in the direction they are driving, namely turning one's neck to the right **(TR74)**. Not all of the forklifts have a rear horn **(TR74)**. As of June 14, 2018, Petitioner's job assignment was actually dock office, but Spraggins acknowledged that even if she was assigned elsewhere, she would be pulled to operate a forklift to pull full pallets **(TR76-77)**. Spraggins reiterated that in driving backwards, Petitioner would be required to keep her left hand gripping the steering wheel, and her right hand reaching behind her to grip the horn while she would have to look behind herself to the right off her right shoulder **(TR77-78)**.

Spraggins testified that all of the steering wheels are exactly the same in terms of their steering capabilities. Spraggins testified there is no give in the steering wheels from one to another. Spraggins acknowledged other supervisors could direct an employee such as Petitioner to go operate a forklift **(TR79)**. Spraggins testified he thought while Petitioner was case picking she would be operating a "walkie" as opposed to a forklift, although he does not know how many different forklifts she operated. Spraggins also does not know the number of forklifts in the building, although he believes there are more than ten. Spraggins claimed all are manual steering and drive exactly the same except for the fact some had a rear horn and some don't. Petitioner had three supervisors and any of them could have pulled her off some job and asked her to use a forklift without getting Spraggins' permission **(TR80-82)**.

The Arbitrator asked whether Spraggins ever observed Petitioner using her right hand to use the horn when he saw her driving a forklift. Spraggins responded "no", though he did hear her blasting the horn. Spraggins did see Petitioner turning her head to the right to look backwards **(TR83-84)**. On re-cross examination, while Spraggins testified he never saw Petitioner reaching behind her to sound the horn, it's required for safety, and Petitioner has never been cited for violating safety rules. Spraggins acknowledged Petitioner would be using her right hand behind her on the horn when driving backwards with her left hand

gripping the steering wheel **(TR85-86)**. Spraggins acknowledged he did not spend much time observing Petitioner driving. Spraggins lastly testified he does not recall seeing Petitioner drive backwards with the right hand extended to the horn on the back of the forklift **(TR86-87)**.

Respondent then showed a 2-minute video of the floor of Respondent's facility marked as **RX7** and called Chris Couture as a witness **(TR91-92)**. The driver of the forklift depicted in the video was Scott Hagler. Couture testified he has worked for Respondent for one year and six months **(TR94)**. Couture is now the safety training supervisor since August, 2018. Couture testified he got the video off the security camera. Couture testified the video demonstrates a fair and accurate representation of the forklift driving at CDS. Couture testified to his knowledge that was the type of forklift that LaDanna Brown drove. Couture testified that case picking would not use a sit-down forklift, there is replenishment which you use a stand-up for, and everything else would use a sit-down forklift. Couture also described what a full pallet individual would do. Despite the fact that the forklift operator in the foreground of **RX7** was driving forwards, Couture testified that driving the forklift is essentially the same, although some jobs require more backward driving than others **(TR96-98)**.

On cross-examination, Couture acknowledged you do not see the forklift operators in the racks from the video. The forklift that was depicted in the video didn't have a rear horn **(TR99-100)**. Couture acknowledged he is the one depicted in the pictures that are **PX 5 & 6**. Couture acknowledged he would not rest his left hand on the center of the steering wheel while driving backwards **(TR100)**. Couture was asked by defense counsel to demonstrate how an operator would turn their body to operate the horn on the back of the forklift console when he posed for the pictures **(TR101)**. Couture acknowledged Petitioner testified that when she was driving backwards she would hold the horn behind her with her right hand and hold the steering wheel with her left hand while her neck was turned to the right in order to look behind her. Couture would not dispute that's how Petitioner drove **(TR102)**. The Arbitrator asked when he began working for Customized Distribution Services, and Couture advised November, 2017. Couture also advised that he only saw her drive a forklift once before the accident date **(TR102-103)**.

Petitioner was recalled as a rebuttal witness. She did not recall in the eight months up to June 14, 2018 how much time she was primarily pulling full pallets, although that's what she was doing on June 14, 2018 at the time of injury. When Petitioner was a case picker, she drove a forklift every time she picked because all the walk-behinds were taken by other employees. There are more forklifts than there are walk-behinds. There are more people on a shift than there are forklifts **(TR104-105)**. Petitioner totally disagreed with Spraggins' testimony that all the forklifts are identical in terms of the amount of give or tightness of the steering wheel

(TR106-107). Petitioner also testified the forklifts would not drive the same because not all of the masts are even the same size. Petitioner confirmed the forklift depicted in **PX5 and PX6** is typically the type of forklift with the grip for the horn in the back that she would use **(TR107)**.

Petitioner offered into evidence **PX1** – certified records of Gateway Occupational, which were admitted without objection. Petitioner offered into evidence the certified records of Dr. Solman as **PX2**, over the objection of Respondent set forth in **RX8**. The Arbitrator overruled the objection to **PX2** and admitted the certified records into evidence **(TR110-115)**. Petitioner offered into evidence **PX3,** the unpaid itemized medical bills which were admitted without objection **(TR116)**. **PX5** and **PX6** were the still photos defense counsel took of Couture, and they were admitted into evidence without objection **(TR117)**.

Petitioner did not object to any of the exhibits Respondent offered into evidence **(TR118)**. The Arbitrator entered into evidence **RX1, RX2, RX3, RX5, RX6, RX7, RX8** (with the understanding that **RX8** is a pleading, not evidence, **RX9** & **RX10** (again, **RX10** was a pleading, not evidence) **(TR118-127)**. Proofs were closed **(TR128)**.

PX1 are the certified records of the company doctors at Gateway Occupational Health. Petitioner was first seen on June 14, 2018 **(PX1 p.002 - 003 and 009 -010)**. Petitioner described operating a forklift which required her to have her right arm outstretched, and her head turned to the right to look over her shoulder as the workplace requires you to drive the forklift while looking backwards. When Petitioner reached to grab the horn which requires her to push a button with her right arm outstretched, she heard a pop in the right shoulder and instantly felt pain. Petitioner noted pain to the top of the right shoulder, up her neck and down her back. These records document that Petitioner's workplace sent her over for an evaluation. The records note a history of right shoulder rotator cuff surgery after a lifting injury. On examination, Petitioner was noted to have tenderness to palpation along the upper trap up over the scapula. Range of motion of the right shoulder was limited due to pain. Petitioner was unable to perform empty can test reliably due to her level of pain. X-rays of the right shoulder **(PX1 p.006)** document calcific tendonitis, mild AC joint degenerative changes, and post-operative change from prior rotator cuff repair. Petitioner was assessed by Occupational staff as having a right shoulder sprain with calcific tendonitis. Petitioner was given work restrictions of no use of the right arm, no lifting over 5 pounds. Petitioner was prescribed medications and was to return for follow-up **(PX1 p.008)**.

Petitioner was next seen on June 18, 2018 **(PX1 p.004-005)**. Physical exam of the right shoulder demonstrated range of motion limited due to pain, tenderness to palpation over the upper trap and right scapula, limited forward and abduction to 90 degrees which was somewhat increased passively, but the patient

complained of pain. With empty can test, the patient demonstrated some strength against resistance, but it was an unreliable exam due to perceived poor effort. Assessment was right shoulder strain remaining symptomatic and calcific tendonitis of the right shoulder. Petitioner was ordered to remain on modified duty with no work using the right arm, no lifting over 5 pounds, and an order was issued for a MRI of the right shoulder to investigate any underlying internal derangement. Petitioner was encouraged to continue with medications and was to return to the Clinic for reassessment after the MRI had been performed.

Petitioner was next seen at Gateway Occupational Health on December 17, 2018 **(PX1 p.012 - 014).** Petitioner came back complaining of right shoulder pain thinking this was a new work injury. However, after reviewing the chart, discussing the case with patient and the company, the doctor believed this all related to Petitioner's original right shoulder work injury of June, 2018. Petitioner's memory and recollection of details was spotty as far as dates and events, but Petitioner was unable to get an MRI on her own and continued to have pain and difficulty moving her right shoulder. On Petitioner's first full day back at work case picking, she developed increased pain in the right shoulder to the point that she had difficulty raising it above her head and also complained of radiation of the pain up towards the right side of the neck with swelling. The pain level is 8 out of 10. On examination of Petitioner's neck, she had flexion and extension limited to 30 degrees in each direction and rotation limited to 40 degrees bilaterally due to right neck pain and tenderness to palpation with the right upper and mid trapezius muscle into the lateral deltoid region. No significant AC tenderness or bicipital groove tenderness was noted. Petitioner's pain increased with abduction past 80 degrees, with resisted abduction, internal and external rotation, and flexion and extension of the right elbow. The doctor's assessment at the time was that this all related back to the original right shoulder injury from June 14, 2018, with an aggravation going back to full duty. The doctor did not believe Petitioner was prepared or ready for full duty and that there was no specific re-injury on December 16, 2018. He reiterated Petitioner should have the MRI scan of the right shoulder as he believed she does have a significant re-injury of her right rotator cuff dating back to June. Petitioner's symptoms indicate that this has never fully healed. Petitioner was again prescribed medication and placed on restrictions with no work using the right arm or hand; no lifting over 10# and no forklift driving. Petitioner was to follow-up after the MRI scan for reassessment **(PX1 p. 0012 – 0014)**.

Petitioner was seen at Gateway Occupational Health on January 14, 2019 **(PX1 p.015-017)**. Petitioner noted the pharmacy refused to fill her medications because they were not "covered". Physical exam demonstrated tenderness to palpation on the right trapezius and lateral deltoid. Range of motion was limited with adduction of greater than 80 degrees due to pain with a negative empty can test. Review of the MRI

demonstrated post-operative appearance of the rotator cuff; partial thickness bursal-sided tearing of the supraspinatus tendon, fluid signal in the deltoid muscle overlying the lateral aspect of the humeral head, mild glenohumeral joint osteoarthritis, and trace glenohumeral joint effusion. Petitioner was assessed with a rotator cuff tear of the right shoulder and was given restrictions of no work using the right arm or hand and no lifting over 10#. Petitioner was prescribed additional medication and was to continue to treat with Dr. Corey Solman. Petitioner was discharged from Gateway's care.

PX2 are the certified records of OSISTL/Dr. Corey Solman. Petitioner was first evaluated by Dr. Solman on August 17, 2018 **(PX2 p.002-007)**. Petitioner was seen for evaluation of her bilateral shoulders and cervical spine. Petitioner alleged work-related injuries on or about June 14, 2018. Petitioner described the manner in which she drove backwards in which she had to hold the steering wheel with her left hand, turn her body to the right, and look backwards in order to drive the forklifts, while sounding the horn on the right side thereof. Petitioner described that on June 14, 2018 she was driving backwards with her forklift and reached up to sound the horn at which time she felt a pop and pain in her right shoulder. Petitioner documented being seen by Occupational Medicine. Dr. Solman then summarized the records he reviewed from Gateway Occupational.

Petitioner described neck pain from tossing and turning throughout the day, occasional numbness and tingling with her hands. With regard to her left shoulder, Petitioner noted increased pain since she had to start driving backwards as she's turning her body and advising that this does strain the shoulder. Petitioner has had no surgery or previous issues with the left shoulder. Certain movements hurt, and even though she was doing light duty at the time of his evaluation, she had some improvement in her shoulder pain, but it still did hurt. Petitioner reported she did have to drive with her left hand all the time because the horn is on the right side. There is no horn on the opposite side of the forklift. Dr. Solman noted Petitioner did have a previous rotator cuff repair as a result of a work-related injury. Petitioner he reported that after the open approach rotator cuff repair was performed, it took her about 8 months to get all of her strength back to be able to get back to her regular job while she was working for Olin.

In the cervical spine, physical exam demonstrated mild discomfort with extremes of Spurling's maneuver, no radiation of pain and no significant tenderness over the paracervical muscles or anterior scalene muscles bilaterally. Right shoulder exam demonstrated tenderness to palpation over the AC joint and bicipital groove, pain with O'Brien's testing, range of motion was limited to about 130 degrees of forward flexion, 90 degrees of abduction, and 50 degrees of external rotation. At 130 degrees of forward flexion, she had impingement type pain and resisted motion any further. She had full strength in her internal and external

rotators. There was diminished strength of her supraspinatus with pain. Examination of her left shoulder revealed tenderness to palpation over the AC joint and bicipital groove. With an active compression test, Petitioner had some popping anteriorly with a mildly positive O'Brien's sign. Range of motion was full in all planes to 170 degrees of forward flexion, 90 degrees of abduction, and 60 degrees of external rotation. She had full internal and external rotation strength. Supraspinatus strength was diminished with pain in the thumbs-down position. X-rays were taken of the bilateral shoulders which, on the left, revealed Type I acromion with mild AC joint changes only. X-ray of the right shoulder demonstrated evidence of the previous surgery with an anchor in the lateral portion of the greater tuberosity. There was some calcific stippling in the subacromial space that did not follow the normal pattern of rotator cuff calcific tendonitis. Dr. Solman believed it would be more indicative of heterotopic ossification from trauma to the shoulder by way of her surgery. Dr. Solman also noted Type I acromion which appeared to be surgically produced, and some narrowing of the AC joint. Dr. Solman's impression was cervical spine pain and strain; right shoulder pain with possible recurrent rotator cuff tear, possible biceps tear or subluxation, an AC joint arthrosis; and left shoulder AC joint arthrosis, and biceps tenosynovitis, possible subluxation and possible rotator cuff pathology.

Regarding Petitioner's cervical spine, Dr. Solman opined the process of driving a forklift at least several hours a day in the posture that Petitioner described could serve to fatigue and strain the cervical spine musculature. Dr. Solman recommended Petitioner undergo a short course of physical therapy to rebalance the strength in the cervical spine and see if that would decrease some of her complaints in that area. Dr. Solman opined Petitioner's her work-related duties driving a forklift were a contributing factor in the development of her cervical spine pain that she is currently experiencing.

Regarding Petitioner's left shoulder, Dr. Solman opined it would be reasonable to conclude, as a result of Petitioner's work-related cumulative activities over six months at CDS Logistics driving a forklift backwards, that this could put strain on the left shoulder. Petitioenr's signs of biceps tenosynovitis and AC joint pain, with pain on supraspinatus testing, could be compensatory or she could have some primary pathology. Dr. Solman opined these would be a result of Petitioner's work-related duties over the course of her employment. The fact that light duty served to decrease some of her pain lends credence to the fact that the work-related activities were inciting the pain and are a contributing factor thereto. Dr. Solman recommended a course of physical therapy for the left shoulder and a MRI. Petitioner may also consider getting an injection in the shoulder to decrease some of her soft tissue complaints.

Regarding Petitioner's right shoulder, Dr. Solman opined the June 14, 2018 incident is a contributing factor to the development of her current right shoulder pathology and the pain she is experiencing. Dr. Solman opined there is no way to speculate what Petitioner's pathology is without getting a MRI. Dr. Solman was concerned Petitioner has a rotator cuff tear and he was concerned about a biceps or labral tear and even some AC joint arthrosis or an AC joint strain as a result of the work accident. Dr. Solman did not opine the rotator cuff repair of the right shoulder previously performed was a contributing factor to her current pathology. Dr. Solman also disagreed with the findings of the radiologist who stated that the stippled calcifications in the shoulder are indicative of calcific tendonitis. Dr. Solman again reiterated that the stippled calcifications don't follow a normal pattern of the rotator cuff, and he would not consider those calcific tendonitis lesions. Dr. Solman opined the stippled calcifications were the result of her previous open approach to the rotator cuff repair previously done. Dr. Solman did not opine that any of the calcified bodies seen on the x-rays were a contributing factor to her current pathology or need for treatment. Dr. Solman advised that he would see Petitioner following an MRI of both shoulders. Dr. Solman ordered no lifting, pushing or pulling of more than 5-10# with the left arm; no overhead lifting with the left arm; no use of the right arm for any lifting and no repetitive motions with bilateral arms greater than 10 times per hour. Petitioner was also order not to type.

Petitioner was next seen by Dr. Solman on January 25, 2019 **(PX2 p.008-012)**. On follow-up, her interim history included Petitioner's attempt to return to work in November, 2018. Petitioner still had pain in the bilateral shoulders, right worse than left. Petitioner was finally able to get the MRI of the right shoulder.

Examination of the right shoulder demonstrated moderate tenderness to palpation over the AC joint and bicipital groove. Petitioner had a positive O'Brien's test. Range of motion was to 130 degrees of forward flexion with positive impingement signs, 90-95 degrees of abduction and 55-60 degrees of external rotation. Petitioner had normal strength of her internal and external rotators with the arm at the side. Strength of the supraspinatus was diminished.

Examination of the left shoulder demonstrated continued moderate tenderness over the AC joint and bicipital groove. Petitioner had popping anteriorly with positive O'Brien sign. Range of Motion was full. Strength of the internal and external rotators was normal. Supraspinatus strength was diminished in the thumbs-down position.

Dr. Solman reviewed the right shoulder MRI which showed what appeared to be high-grade partial thickness tearing through the previous area of rotator cuff repair indicative of pathology.

Dr. Solman's assessment was right shoulder recurrent rotator cuff tear, biceps tendon pathology, and acromioclavicular joint arthrosis; continued left shoulder pain with possible rotator cuff tear, possible labral tear, and biceps pathology. Dr. Solman reiterated his recommendation that Petitioner get a MRI of her left shoulder. Regarding the right shoulder, Dr. Solman opined Petitioner's rotator cuff was torn at the site of the previous repair and opined her mechanism of injury is consistent with the re-tear of her tendon. Dr. Solman again indicated the June 14, 2018 incident was a substantial contributing and prevailing factor in the development of Petitioner's recurrent right shoulder rotator cuff pathology and also the need for further treatment. Dr. Solman recommended Petitioner undergo a right shoulder arthroscopy with revision rotator cuff repair, biceps tenodesis, labral debridement, subacromial decompression, and distal clavicle excision. At that time, Dr. Solman ordered Petitioner to remain completely off work, and he advised she may take anti-inflammatory medicine as needed for pain and inflammation.

Petitioner saw Dr. Solman in follow-up on March 22, 2019. Dr. Solman had the opportunity to review Dr. King's Section 12 report and supplement letter **(PX2 p.013-017)**. Physical exam of the right shoulder again revealed moderate tenderness over the AC joint and bicipital groove, positive O'Brien's test, range of motion to 140 degrees of forward flexion with positive impingement signs, 90-95 degrees of abduction, and 60 degrees of external rotation. Petitioner again had normal strength of her internal and external rotators but diminished strength of the supraspinatus. Examination of the left shoulder revealed moderate tenderness of the AC joint and bicipital groove. Petitioner had popping anteriorly with a positive O'Brien's sign. Range of motion was otherwise full. Petitioner had diminished strength of her supraspinatus in the thumbs-down position and normal strength of internal and external rotators.

In his records under "impression", Dr. Solman noted right shoulder recurrent rotator cuff tear, biceps tendon pathology, and acromial clavicular joint arthrosis, and continued left shoulder pain with possible rotator cuff tear, possible labral tear and biceps pathology. Dr. Solman continued to recommend a MRI for her left shoulder. Regarding the right shoulder, Dr. Solman again opined Petitioner needed right shoulder arthroscopy with revision rotator cuff repair, biceps tenodesis, and distal clavicle resection. Dr. Solman commented on Dr. King's belief that Petitioner's shoulder problems are due to her previous rotator cuff repair, and that the previous repair showed incomplete healing without evidence of an acute tear. In response, Dr. Solman noted Petitioner had the rotator cuff repaired in 2013 and, after eight months, was able to get back all of her strength and able to get back to her regular job duties without problems while she was working for Olin. Dr. Solman noted Petitioner did not have any issues with the right shoulder and did not have any evaluations of the right

shoulder during the time between her recovery from that surgery and the June 14, 2018 work injury. Dr. Solman reiterated his opinion that the mechanism of injury of June 14, 2018 was a relatively classic mechanism to cause a strain, a partial thickness rotator cuff tear, or even a full thickness rotator cuff tear. Dr. Solman opined the pathology seen on the MRI flows directly from the June 14, 2018 injury and was not related to incomplete hearing of the rotator cuff. Dr. Solman opined that if Petitioner had had incomplete healing of her rotator cuff at the time of her 2013 surgery, then she certainly would have had ongoing pain and would have possibly had the need for further treatment had she not gained all of her strength back and had had continued pain. Dr. Solman stated there does not necessarily have to be anything on an MRI that looks "acute" to say that an "injury is acute". If Petitioner sustained a tear at the time of the incident on June 14, 2018, then her MRI could certainly look the way it does, and that is with a high-grade partial thickness tear. Dr. Solman did not opine that the calcified tissue was related to the recent incident, and the calcified tissue is not what is causing Petitioner's pathology and pain. Dr. Solman agreed with Dr. King that the work accident of June 14, 2018 is not the prevailing factor in the development of Pwetitioenr's left shoulder pain, but rather the left shoulder is the result of 6 months history of work driving a forklift backwards placing an undue strain on the left shoulder and her cervical spine. Dr. Solman reiterated Petitioenr she should obtain a MRI of the left shoulder and, if she had no significant pathology on the MRI, her symptoms may improve significantly with a course of injections and physical therapy. Dr. Solman ordered Petitioner to remain off work and to take anti-inflammatory medications along with Tramadol for pain.

The last two pages of the certified records from Dr. Solman are the MRI without contrast of the right shoulder dated January 10, 2019. The impression of radiologist Dr. Allam was post-operative appearance of rotator cuff repair; partial thickness bursal-sided tearing of the supraspinatus tendon; fluid signal in the deltoid muscle overlying the lateral aspect of the humeral head that may be post-surgical, although hematoma was not excluded in the setting of trauma; mild glenohumeral joint osteoarthritis; and trace glenohumeral joint effusion.

PX3 are the unpaid bills of Gateway Occupational Health and Dr. Corey Solman demonstrating total bills of $1,700.86.

PX5 & PX6 are photos of Chris Couture on a forklift with a rear horn referenced by Petitioner in her testimony.

RX1 is the deposition transcript of Dr. David King. Dr. King testified as to the records he reviewed **(RX1 p.7-9)**. Dr. King testified as to the history provided which was consistent with the histories previously provided to Gateway Occupational and Dr. Solman, as well as the onset of pain **(RX1 p.9)**. Petitioner provided

Dr. King a history of prior rotator cuff repair wherein she described recovering very well from that surgery and having no issues leading up to June 14, 2018. Petitioner described progressive right shoulder pain and weakness on top of her shoulder following the accident. Petitioner stated the pain radiates up her neck where she pointed to the trapezial region on the right (RX1 p.10). Regarding the left shoulder, Petitioner stated she injured it on June 14, 2018, as well, but she did not give any mechanism of injury to the left shoulder. Petitioner just described it as resting on the steering wheel when the other events occurred. Pain in the left shoulder was mostly in the left shoulder region but some into the trapezial region, as well **(RX1 p.10-11)**.

Dr. King assessed Petitioner with right shoulder pain with a previous rotator cuff repair, left shoulder pain non-work related and cervical degenerative disc disease **(RX1 p.13)**. Dr. King determined there was a possibility of a recurrent rotator cuff tear but noted cogwheeling when testing her strength. Dr. King did not note any exam findings indicative of a biceps issue. Dr. King did not note tenderness at her AC joint. While Petitioner did have arthritis at her AC joint, Dr. King did not feel that was really the source of her pain. Petitioner had generalized tenderness through her paraspinous musculature, and there did not appear to be any signs of a nerve issue coming from the neck **(RX1 p.14-15)**. Dr. King determined there was enough between her claimed injury and the exam to recommend an MRI to look for an acute injury to the right shoulder **(RX1 p.15)**.

Dr. King denied any mechanism of injury to Petitioner's left shoulder. Regarding Petitioner's neck, she was noted to have extensive degenerative changes in her neck and no signs of radicular symptoms. Dr. King noted that while it may bother Petitioner to turn her neck because of her arthritic condition, he did not see any aggravation or a specific injury to the neck based upon the description of the activities **(RX1 p.15-17)**. Dr. King then recommended putting heat on Petitioner's neck and possible use of Advil or Tylenol **(RX1 p.17)**. Dr. King opined at the time of his examination in November, 2018 that Petitioner was able to perform her normal job duties **(RX1 p.18)**.

Dr. King testified that, as part of his post MRI addendum, he personally reviewed the MRI of Petitioner's right shoulder. Dr. King opined Petitioner had 50% of her tendon which appeared to be intact and healed in the normal post-operative appearance, and 50% of it which was irregular, which had not healed, but he did not see any acute or fresh tear. While the radiologist called it "a partial tear", Dr. King preferred to refer to it as "partial healing" of her previous rotator cuff repair **(RX1 p.19)**. Dr. King opined that he did not believe the MRI confirmed an acute injury from the June 14, 2018 event. Dr. King did not opine the work injury of June

14, 2018 caused an aggravation of the right shoulder although it may have caused some "temporary discomfort" **(RX1 p.20)**. Dr. King did not recommend restrictions **(RX1 p.21)**.

On cross-examination, Dr. King acknowledged doing 3-5 legal medical evaluations per week **(RX1 p.22)**. Dr. King testified about 50% of his Illinois legal medical evaluations are done at the request of the Petitioner's side and 85% are done at the request of the defense side in Missouri work comp cases. Dr. King also acknowledged he treats patients with work comp injuries in the State of Missouri wherein it is the employer who chooses the medical provider **(RX1 p.23)**. Dr. King's charge for the initial evaluation was $1,500.00, his charge for the addendum report was $800.00, and his charge for the first hour of the deposition was $2,000.00 **(RX1 p.23-24)**. Dr. King charged a total of $4,300.00 for his defense opinions.

Dr. King acknowledged on cross-examination there was no indication in the operative report of June 26, 2013, that Dr. Rotman was only partially or incompletely able to reattach the rotator cuff to the tuberosity **(RX1 p.24-25)**. Dr. King saw no post-operative records from Dr. Rotman indicating any suspicion that the rotator cuff was incomplete or became partially separated **(RX1 p.26)**. Dr. King acknowledged Dr. Rotman placed Petitioner at maximum medical improvement with regards to the right rotator cuff repair on December 3, 2013, and that she had started back at full-duty on November 11, 2013 **(RX1 p.26-27)**. Dr. King acknowledged that returning to full duty after the prior rotator cuff repair meant her returning to her former job at Olin in which she would have to lift cases of ammunition weighing up to 45 lbs **(RX1 p. 27)**. Dr. King acknowledged that when Petitioner was released from care in December, 2013, Dr. Rotman noted she's at full duty, she has done very well, and she was discharged at this time.

Dr. King noted the records defense provided him failed to show any treatment for either shoulder or Petitioner's neck between January 1, 2014 and June 14, 2018 **(RX1 p.28-29)**. Dr. King was not provided any records indicating Petitioner was unable to work full duty between January 1, 2014 and June 14, 2018. Dr. King was provided no records or other information indicating she was symptomatic in either of her shoulders between mid-February, 2014 and June 14, 2018 **(RX1 p.29)**. Dr. King reiterated his initial evaluation belief that Petitioner possibly sustained an injury to the rotator cuff of the right shoulder on June 14, 2018 when she described her arm away from her body when she claims to have felt a pop in her right shoulder as she was grabbing the horn behind her **(RX1 p.29-30)**. On the questionnaire filled out by Petitioner at the time she was evaluated by Dr. King, she noted a pain rating of 7 at the time and 8 at its worse. Petitioner also indicated the pain was aching, throbbing and burning. Petitioner also noted weakness and loss of motion on the form **(RX1 p.30)**.

Dr. King confirmed an MRI will not tell you how much pain a person is in and you don't just treat based on imaging studies nor do you just treat based on subjective complaints. Rather, it is a combination of the imaging studies, subjective complaints and physical exam findings, among other things, that are factored into treatment decisions **(RX1 p.32)**. Regardless of causation, Dr. King testified that if Petitioner had 8 out of 10 pain, he would do a series of injections and physical therapy, but possible arthroscopic surgery would be very low on the list as she already had it repaired, over 50% of it intact, and the chances of her getting better from another repair are were low in his opinion. Dr. King would not impose restrictions for her "incomplete healing of the rotator cuff" **(RX1 p.32-33)**. Dr. King acknowledged that from the records he reviewed, Petitioner was persistently symptomatic in her right shoulder from June 14, 2018 through the present **(RX1 p.33-34)**. Regardless of causation, Dr. King would not recommend any testing or treatment for the left shoulder or the neck. Dr. King testified he knows Dr. Solman very well and knows him to be a competent Board Certified Orthopedic Surgeon **(RX1 p.34)**. Dr. King disagreed with Dr. Solman's recommendations. Dr. King did not believe there was objective evidence to do some of the procedures recommended by Dr. Solman, but he acknowledged that there have been times that Dr. King has been incorrect as a treater **(RX1 p.36)**.

As to the photographs provided to Dr. King, he agreed Petitioner was not depicted in the photographs. Dr. King also agreed that if Petitioner's upper torso and arms were shorter than the man depicted in the photos, he agreed she would have to raise her right arm higher to reach back to the horn on the forklift than the individual depicted in the photos. Dr. King also acknowledged that the guy in the photos was not even gripping the steering wheel as he was posing for those photos. Dr. King also acknowledged that in order to not only sound the horn behind the driver while driving in reverse, one would actually have to turn their head to the right to make sure they are not striking anyone or anything behind them. Dr. King also acknowledged they would have to grip the steering wheel while driving in reverse **(RX1 p.37-38)**. Dr. King acknowledged that in neither of his reports had he offered any explanation for Petitioner's ongoing complaints in the right shoulder since the work event of June 14, 2018 **(RX1 p.39)**.

On re-direct, Dr. King was simply asked questions about his understanding of Petitioner's former job duties at Olin **(RX1 p.40-41)**.

RX2 is a transcript of the recorded statement taken of Petitioner on June 20, 2018 by Becky Wagoner of The Hartford. Therein, Petitioner gave a description of driving backwards and grabbing the horn and hearing a pop in her right shoulder. Petitioner advised that thereafter she was advised not to lift over 5 pounds with the left as it was hurting. Petitioner was overcompensating for the right. Petitioner acknowledged having worker's

compensation claims before with a previous company. Petitioner was asked if there were no known injuries to her right arm previously. Petitioner said yes. Petitioner advised she was 5'5" and ¾" and not sure about her weight. Petitioner denied any outside activities, hobbies, sports or anything like that where her injuries get in the way.

RX3 is the TTD paid to Petitioner consistent with the amounts stipulated to by the parties on Arbitration EX1.

RX5 is the printout from the Workers' Compensation Commission showing a settlement date of March 17, 2014 for a right shoulder claim with an accident date of May 28, 2013. Petitioner received 12.5% of the body as a whole attributable to the right shoulder injury.

RX 6 is a modified/amended job duty offer made to Petitioner on June 18, 2018.

RX 8 is a Memorandum in Support of Respondent's Objection to Opinions prepared in anticipation of litigation which the Arbitrator considered at the hearing as a pleading as opposed to evidence.

RX 9 is the certified records of Dr. Rotman from the prior work injury to the right shoulder. This includes the December 3, 2013 office note releasing Petitioner from care noting that Petitioner is at full duty and has done very well. The office note of October 24, 2013 demonstrated that Dr. Rotman released her to return to full duty November 11, 2013. The records also include a re-evaluation from Alton Physical Therapy of October 23, 2013. It was noted Petitioner reported that overall she has little pain in the shoulder unless she does a sharp quick movement then it will cause pain. Petitioner stated that she was able to perform more of her regular activities without difficulties. Petitioner was noted to have met 100% of the goals involving improvement in pain and 80% of the goals met regarding improvement in range of motion. At **page 55 & 56, RX9** includes the operative report of Dr. Rotman from June 26, 2013 wherein he repaired the right shoulder rotator cuff tear with three core sutures placed into the tendon, a hole made into the tuberosity, sutures brought through the hole and then tied securing the rotator cuff back to the tuberosity. For further strength, Dr. Rotman placed a triple sutured anchor into the greater tuberosity and placed each limb of the triple sutured anchor medial to the outer row in a mattress fashion getting a double row repair.

RX10 is Respondent's Response to Petition for Immediate Hearing filed the day before hearing. This was viewed by the Arbitrator as a pleading in which Respondent disputes the repetitive trauma allegation, the specific accident allegation based upon its opinion of Dr. King, as well as the lack of any repetitive left shoulder activities in the course of claimant's work driving a fork lift. Respondent denied notice of left shoulder and

neck complaints occurring at the timeframe alleged by Petitioner, but subsequently withdrew that and stipulated to notice at hearing.

CONCLUSIONS OF LAW

ISSUE (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and ISSUE (D): What was the date of the accident?

The Arbitrator incorporates the Statement of Facts into this Issue and all that follow.

The Arbitrator finds and concludes Petitioner proved by a preponderance of the credible evidence she sustained accidental injuries arising out of and in the course of her employment with Respondent on June 14, 2018, as follows below:

"In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n,* 167 Ill.2d 77, 81, 212 Ill.Dec. 250, 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Industrial Comm'n,* 66 Ill.2d 361, 366, 5 Ill.Dec. 854, 362 N.E.2d 325 (1977). That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. There is no dispute that Petitioner sustained some injury during work hours while at Respondent's place of employment. Therefore, Petitioner's claims of injury occurred in the co urse of her employment.

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. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Stated otherwise, "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." *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665. There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with her employment; (2) personal risks; 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, 247 Ill.Dec. 22, 731 N.E.2d 795, 806 (2000). Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology,* 314 Ill.App.3d at 163, 247 Ill.Dec. 22, 731 N.E.2d at 806–07. Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Potenzo v. Illinois Workers' Compensation Comm'n,* 378 Ill.App.3d 113, 117, 317 Ill.Dec. 355, 881 N.E.2d 523, 527 (2007).

In the present case, there can be little dispute driving a forklift is a dangerous occupation that exposes its driver-employees to hazards not experienced by the general public. Further, there is no real dispute that a forklift operator driving for Respondent must drive backwards and, in so doing, it is foreseeable and likely that a driver such as Petitioner must awkwardly reach behind and upward to grip and sound the rear horn as part of her job duties. The frequency of sounding the horn is also not in dispute as Respondent's witness agreed it was to be sounded continuously. Therefore, Petitioner's right shoulder was exposed to a risk of harm to a greater degree than the general public – if the general public is even ever exposed to such a risk. Further, there can be no credible doubt that Petitioner's job duties of driving a forklift - especially backwards and being vigilant against accidents while driving and maneuvering her body to use the horn - exposed her to a constant a risk and danger of injury distinctly associated with her employment.

Petitioner described a specific event wherein she was required to reach behind and away from her in order to sound the horn with her right arm at which time she noticed a pop in the right shoulder and the immediate onset of right shoulder pain. All of the medical providers agree that such movement of the arm could cause a rotator cuff tear or at least cause a sprain. As such, the Arbitrator finds the Petitioner did sustain an injury to the right shoulder that arose out of and in the course of her employment with Respondent on June 14, 2018.

The Arbitrator also concludes that Petitioner sustained an injury to the right side of her neck that arose out of and in the course of her employment with Respondent. This was based on the fact Petitioner was required to turn her head and neck completely to the right in order to look backwards which served to strain her cervical spine. The frequency of this activity in the scope of her required duties, like the strain on the right shoulder, exposed Petitioner to peculiar risk of injury due to her employment duties as well as to a degree greater than the general public.

The Arbitrator also finds Petitioner sustained an injury on 14, 2018 to her left shoulder that arose out of and in the course of her employment. This is supported by the fact Petitioner was required to grip the steering wheel with her left hand which she described as requiring a firm grip while her upper torso was turned to the right in order to look behind her while driving backwards. Again, Petitioner was exposed to a risk of injuring the left shoulder due to exposure to a peculiar risk of injury due to her employment duties as well as to a degree greater than the general public.

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

The Arbitrator finds and concludes Petitioner proved by a preponderance of the credible evidence she proved a causal connection exists between her current condition of ill-being and the accidental injuries sustained on June 14, 2018, as follows below:

Whether Petitioner sustained a re-tear of her rotator cuff or an aggravation of a pre-existing asymptomatic tear, Petitioner has remained symptomatic in the right shoulder since the date of onset. The medical evidence demonstrates that during a four-year period preceding the date of injury, Petitioner had no pain complaints, no diminished strength, no treatment, no limitations, and otherwise no problems requiring use of medication for the right shoulder.

In *Sisbro v. Industrial Commission*, 797 N.E.2d 665 (2013), our Supreme Court addressed causal connection in pre-existing condition cases. It was noted that recovery for a pre-existing condition will depend on the employee's ability to show that a work related accidental injury aggravated or accelerated a pre-existing disease such that the employee's current condition of ill-being could be said to have been causally connected to the work related injury and not simply the result of the normal degenerative process of the pre-existing condition citing *Caterpillar Tractor Co. v. Industrial Comm'n,* 440 N.E.2d 861 (1982). The Supreme Court went on to note that is axiomatic that employers take their employees as they find them citing *General Electric Company v. Industrial Commission*, 433 N.E.2d 671 (1982). The Supreme Court noted that "when workers physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. Thus, even though an employee has 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. The accidental injury need not be

the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being" citing *Rock Road Construction v. Industrial Commission*, 227 N.E.2d 65 (1967). Further, under the "Chain of Events" legal theory of recovery, where it is demonstrated a previous condition of good health exists, then an accident, and a subsequent injury resulting in disability, may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury *International Harvester v. Industrial Commission*, 93 IL2d 59, 442 NE2d 908 (1982).

The Arbitrator notes that Respondent's Section 12 examiner, Dr. King, offered no explanation for Petitioner's lack of symptoms in the four years preceding the date of injury nor did he offer an explanation or her persistent complaints of right shoulder pain after the June 14, 2018 injury.

Further, Dr. Solman opined that one need not have "acute" findings on MRI in order to sustain "an acute injury". Even the company doctors at Gateway opined that Petitioner's ongoing right shoulder complaints are related to a condition stemming from the work injury of June 14, 2018. Dr. Solman's opinion is consistent with the Supreme Court's finding in *Sisbro* and the chain of events.

For these reasons, the Arbitrator determines that Petitioner's ongoing right shoulder symptomatic condition of ill-being is causally related to the work injury of June 14, 2018.

Next, Petitioner testified her right sided neck pain has not subsided since the date of injury. Given the absence of any right neck complaints predating the accident, the mechanism of injury wherein she was required to turn her neck completely to the right in order to look behind her while driving the forklift, and her persistent neck pain since, the Arbitrator finds that Petitioner's neck strain and current condition of ill-being related thereto is causally connected to the work injury of June 14, 2018. This is supported by the findings of Dr. Solman, the documentation of right sided neck pain by Gateway, and the chain of events.

Finally, Petitioner's symptoms in her left shoulder have been persistent since June 14, 2018. There is an absence of any left shoulder symptomatology predating June 14, 2018. Based upon the chain of events and the opinions of Dr. Solman, the Arbitrator finds that Petitioner's current condition of ill-being in her left shoulder is causally related to her work activities through June 14, 2018.

ISSUE (L): What temporary benefits are due?

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence entitlement to a further period of 34 weeks of TTD, commencing August 21, 2018 through November 25, 2018 and from December 17, 2018 through April 29, 2019.

The Arbitrator notes Petitioner was sent home from work on August 21, 2018 while on light-duty restrictions imposed by Respondent's company physicians at Gateway Occupational. Petitioner remained off work at the direction of Respondent through November 25, 2018. Petitioner thereafter attempted to return to full-duty and was again placed on light-duty restrictions by the company doctors at Gateway Occupational commencing December 17, 2018. It is noteworthy Petitioner remained on restrictions imposed by Dr. Solman, as well, during that period. Temporary total disability benefits appear to have been terminated once Dr. King issued his addendum to his Section 12 report.

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).

Not only may the Commission decide which medical view is to be accepted, ***it may attach greater weight to the opinion of the treating physician.*** International Vermiculite Co. v. Industrial Comm'n, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); ARA Services, Inc. v. Industrial Comm'n, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Accordingly, the Arbitrator finds and concludes causation has been proven by a preponderance of the credible evidence and attaches greater weight and credibility to the opinions of Petitioner's treating physician Dr. Paletti rather than the dissenting opinions of Dr. Nogalski.

Accordingly, the Arbitrator finds and concludes the opinions of Dr. Solman and the medical providers at Gateway Occupational are more persuasive than the opinions expressed by Dr. King. Therefore, Petitioner shall be entitled to a further period of temporary total disability through the date of hearing. As such, and pursuant to Section 8(a) of the Act, Respondent shall pay Petitioner temporary total disability at the rate of $431.64 per week for 34 weeks commencing August 21, 2018 through November 25, 2018 and from December 17, 2018 through April 29, 2019. Respondent shall be given credit of $7,306.81 resulting in a shortfall of temporary total disability through date of hearing of $7,367.59.

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

The Arbitrator finds and concludes the medical bills submitted as PX3 are reasonable, necessary and causally related to Petitioner's work injuries. As such, Respondent shall pay same in accordance with Sections 8(a) and 8.2, the Fee Schedule. The Arbitrator also finds and concludes Petitioner is hereby awarded the surgery to her right shoulder proposed by treating physician Dr. Solman, an MRI of her left shoulder, and physical therapy to Petitioner's cervical spine and left shoulder. In rendering this Decision, the Arbitrator finds the opinions of Gateway Occupational and Dr. Solman to be more persuasive and credible than the opinions of Dr. King.

ISSUE (O) Other - Admissibility of certified treatment records from Dr. Solman

Regarding the admissibility of the treatment records of Dr. Solman, the Arbitrator previously overruled Respondent's objection to their admissibility. The Arbitrator reaffirms that ruling now.

Respondent asserted that Dr. Solman's comments in his treating records regarding Dr. King's IME report violated Section 16 of the Act because Respondent asserted these comments were prepared by a treating provider in anticipation of or use in litigation. Respondent argued so based on its assertion that, "The only logical reason for this comment is to prepare for litigation of the workers' compensation case." However, this assertion (which was not argued as an inference the Arbitrator could draw) was and remains unsupported by any evidence and is without any factual basis. Respondent provided no reasons or facts as to why Dr. Solman's comments were included in his treating records and for what specific purpose they were included (although the Arbitrator could potentially draw a reasonable inference that these comments were included for the purpose of use in litigation, the Arbitrator declines to draw that inference absent any evidence to support such an inference). Respondent raises no new arguments that were not addressed previously and by the Appellate Court of Illinois, First District, in the case of *RG Construction Services v. IWCC*, 2014 WL 7507518 (Ill. App. 1st Dist., rehearing denied Feb 3, 2015). In *RG Construction Services*, the Court noted that Respondent asserted, "it is undeniable that the doctors' records contain opinions beyond medical and surgical matters admissible pursuant to Section 16." That is exactly what Respondent herein argues. However, the Court also in

RG Construction Services noted that Respondent cited no authority for this statement other than Section 16 itself – the identical scenario this case presents. Further, the Court noted that "we are not persuaded by the employer's position that the simple inclusion of medical opinions within a treating physician's records is sufficient to exclude them from admission pursuant to Section 16. As found in *RG Construction Services*, Respondent did not present a reasoned argument to support its position, but merely asserts a conclusion (that the records were prepared for use in litigation) without a basis to support this conclusion. Accordingly, the Arbitrator affirms its prior ruling.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

Dated: June 3, 2019

STATE OF ILLINOIS)		
) SS.		
COUNTY OF MADISON)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARY MORRIS,

Petitioner,

vs. NO: 17 WC 25116

MARTIN & BAYLEY, INC.,

Respondent.

20IWCC0120

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

The Commission finds that Petitioner is entitled to a surgical consultation as recommended by Dr. Miller. Dr. Miller examined Petitioner on September 19, 2018. At that time, he noted that Petitioner had some physical therapy through her Medicaid as it was not approved by her workers' compensation insurance. Despite her therapy, Petitioner continued to have ongoing discomfort and disability. Dr. Miller noted that her pain was most likely related to the chronic nature of her sprain and that she did not have adequate therapeutic exercises. He again recommended physical therapy, and a referral to a podiatric surgeon if therapy was not available. As Petitioner has not succeeded

with conservative treatment, the Commission finds that Petitioner is entitled to a surgical consultation as recommended by Dr. Miller. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 22, 2019, 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 $319.00 per week for a period of 77-6/7 weeks (August 6, 2017 through February 12, 2018 and March 30, 2018 through March 20, 2019), 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 Petitioner is entitled to prospective medical treatment consisting of a surgical consultation as recommended by Dr. Miller.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,063.98 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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 $23,800.00. 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: FEB 2 1 2020

D. Douglas McCarthy

DDM/tdm
O: 2/11/20

052

L. Elizabeth Coppoletti

Stephen Mathis

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

MORRIS, MARY
Employee/Petitioner

Case# **17WC025116**

MARTIN & BAYLEY INC
Employer/Respondent

20IWCC0120

On 5/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0355 WINTERS BREWSTER CROSBY ET AL
LINDA J CANTRELL
111 W MAIN ST PO BOX 700
MARION, IL 62959

1109 GAROFALO SCHREIBER STORM
MONIKA TRUJILLO
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF **Williamson**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Marry Morris
Employee/Petitioner

v.

Martin & Bayley, Inc.
Employer/Respondent

Case # **17** WC **025116**

Consolidated cases: ______

20IWCC0120

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **March 3, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$9,871.19**; the average weekly wage was **$425.48**.

On the date of accident, Petitioner was **37** years of age, **married** with **3** dependent children.

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

Respondent shall be given a credit of **$9,192.84** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,192.84**.

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

ORDER

Respondent shall pay Petitioner TTD benefits of $319.00/week for 77 6/7 weeks, commencing 8/6/17 through 2/12/18 through 3/30/18 through 3/20/19, as provided in Section 8(a) of the Act. Respondent shall be given a credit of advance TTD payments of $4,380.00.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $302.00 to Shawnee Health Services, $7,758.08 to SIH, $3.90 to Southern Orthopedic Associates, and hold Petitioner harmless for all reasonable and necessary medical expenses paid by IHFS, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$9,192.84** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$9,192.84**.

Respondent shall be given a credit of $any and all 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.

20IWCC0120

Signature of Arbitrator

5/19/19

Date

ICArbDec19(b)

MAY 22 2019

Mary Morris v. Martin & Bayley, Inc.
Case No. 17-WC-025116

STATEMENT OF FACTS

Petitioner, Mary Morris, was a 37-year old female who worked for Respondent, Martin & Bayley, Inc., a/k/a Huck's Convenience Store, since September, 2016. It is undisputed that Petitioner sustained injuries on March 3, 2017 arising out of and within the scope of her employment with Respondent. The issues in dispute are causation, medical expenses, TTD and prospective medical.

Petitioner was a cashier and food attendant at the Marion, Illinois location. Petitioner testified that on March 3, 2017, while performing her cashier duties, she stepped down off of a two to four-inch step between the cash register and the kitchen to get the license plate of a customer that drove off without paying for fuel. [T10, 21]. She testified she twisted her ankle causing her left leg to go underneath her and fall to the floor. [T10, 21]. Petitioner heard a loud pop and injured her left ankle. [T10, 21]. The Kitchen Manager came to Petitioner's assistance and helped her off the ground. [T10]. Petitioner testified she worked a double shift that day, from 4:00 a.m. to 12:00 p.m. and 2:00 p.m. to 10:00 p.m. [T10-11]. The accident occurred at approximately 3:40 p.m. [T10].

Petitioner testified she was not able to put pressure on her foot after the accident and it felt like a ball under her heel. [T11]. She went to the emergency room at Herrin Hospital the next day where she reported she stepped off a ledge and heard a snap in her left foot/ankle. [PX6-113]. X-rays were performed that revealed soft tissue swelling. [PX6-120]. Petitioner was prescribed an air cast, Ibuprofen, Hydrocodone, crutches, and was ordered to apply ice, elevate her foot and no weight bearing. [PX6-115-116]. Petitioner was placed on light duty work until she followed up with her primary care physician. [PX6-126]. Petitioner was evaluated at Shawnee Health Services (SHS) on 3/7/17 for soft tissue and joint swelling, limited motion, and trauma pain to her left ankle worse with weight bearing of any sort. [PX4-058]. Petitioner was ordered to continue off work, ice, elevate, limit weight bearing and to continue using the air splint and crutches. [PX4-059-060].

Petitioner returned to SHS on 3/15/17 with complaints the air cast was not helping with pain and she could only walk on her toes with minimal weight. [PX4-056]. She received a refill of Hydrocodone and ordered to remain off work. [PX4-056, 061]. On 3/29/17, Petitioner's primary care physician ordered a CT Scan to rule out tendon rupture and ordered Petitioner to remain off work. [PX4-053, 062].

Petitioner returned to SHS on 4/12/17 with continued complaints of left ankle/foot pain and limitations. [PX4-046-049]. Petitioner was ordered to remain off work and X-rays were ordered. [PX4-049, 063]. X-rays were performed on 4/13/17 that revealed no fracture. [PX4-075, PX5-130-134]. A CT Scan was performed on 4/19/17 that revealed subcutaneous edema throughout the heel with suspected plantar fasciitis. [PX5-135-141].

An MRI was recommended for further assessment. [PX4-074]. Petitioner was ordered to remain off work pending physical therapy. [PX4-064-065].

Petitioner began physical therapy at Herrin Hospital-Rehab Unlimited on 4/26/17 two times a week for four weeks. [PX6-156-165]. On 5/1/17, Petitioner reported to the therapist she continues to have a sensation of walking on a ball. [PX6-155]. On 5/4/17, Petitioner was seen at SHS where she received a refill of Hydrocodone, ordered to ice and elevate her foot, apply analgesic cream and a heating pad, and was ordered to remain off work. [PX4-041-045, 066]. On 5/8/17, Petitioner's therapist noted swelling around the entire ankle joint that was addressed with edema taping. She was encouraged to continue ice and elevation, along with home exercises, and a better fitted ankle brace was ordered. [PX6-152]. On 5/10/17, Petitioner's therapist noted slight improvement with range of motion but swelling around the ankle and entire foot persisted. [PX6-150]. On 5/15/17, Petitioner notified her therapist her foot was turning blue and swelling up her calf after being on her feet more than usual. [PX6-148]. On 5/17/17, Petitioner reported left ankle bruising and swelling. [PX4-038]. Petitioner was referred for orthopedic evaluation and continued off work. [PX4-042, 067]. On 5/24/17, Petitioner was still not able to improve to weight bearing and was making little progress. [PX6-145]. Her therapist recommending holding therapy until she underwent an orthopedic evaluation. [PX6-145]. Respondent paid for all six physical therapy visits. [RX10, page 5].

On 6/8/17, Petitioner was evaluated by Dr. John Krause for the purpose of a Section 12 opinion. [RX1]. Dr. Krause opined Petitioner's injuries are causally related to her work accident; that treatment to date was appropriate; that she should be treating with an orthopedic surgeon; that the recommended MRI was appropriate; that light duty work restrictions were appropriate; and that she had not reached maximum medical improvement. [RX1-page 3].

On 7/6/17, Petitioner returned to SHS with continued symptoms despite physical therapy. An MRI was ordered of the left heel to include the ankle and she was continued off work. [PX4-034, 068]. The MRI was performed on 7/21/17 that revealed a partial tear of the peroneus brevis, a partial tear of the anterior talofibular ligament, a sprain/partial tear of the calcaneofibular ligament, mild acute chronic changes of plantar fasciitis, edema within the calcaneal tuberosity, posterior tendinosis, and peroneus longus/brevis tenosynovitis. [PX4-030, 072-073]. Petitioner was continued off work pending orthopedic consultation. [PX-030].

On 7/31/17, IME Dr. Krause authored an Addendum to his initial report dated 6/8/17, stating his review of the MRI shows a sprain of the anterior talofibular ligament and calcaneal fibular ligament. [RX2]. Dr. Krause opined Petitioner did not require any additional treatment and had reached MMI and could return to work without restrictions.

On 8/10/17, Petitioner returned to SHS at which time she received a refill of Hydrocodone and ordered to remain off work pending orthopedic evaluation as the initial appointment was cancelled by Respondent to obtain an IME opinion. [PX4-026, 069].

On 8/16/17, Petitioner was evaluated by Dr. Bret Miller at The Orthopedic Institute of Southern Illinois. [PX5-76-85]. Dr. Miller ordered an ankle brace and recommended physical therapy for six weeks. [PX5-082]. Dr. Miller opined Petitioner may need to be referred to an orthopedic surgeon if she did not improve with conservative treatment. [PX5-082]. Dr. Miller opined Petitioner could work with the ankle brace as long as her duties did not create excessive swelling or discomfort in the ankle. [PX5-082, 085]. Petitioner testified the orthopedic referral to Dr. Miller was not authorized by Respondent and she submitted the treatment to Medicaid, despite IME Dr. Krause's opinion on 6/8/17 that it was "unreasonable that the patient is not treating with an orthopedic surgeon". [T14, RX1, page 3].

On 8/29/17, Petitioner began a second round of physical therapy at Herrin Hospital twice a week for four weeks as referred by Dr. Miller. [PX6-166-168]. Bruising was noted on the dorsum of Petitioner's left ankle near the joint, tenderness on the entire dorsum, left and right sides and on the bottom of the foot. [PX6-170-171]. On 9/5/17, the therapist reported new bruising on Petitioner's *right* foot; however, Petitioner testified she has only experienced bruising to her left foot. [PX6-179, T-28]. The discharge summary dated 9/20/17 reports Petitioner continues to have pain and limited range of motion restricting her activities and exercises. Therapy was discontinued pending consultation with Dr. Miller. [PX6-193, 196]. Petitioner attended six visits of physical therapy through September 20, 2017. [PX6-166-198]. Pursuant to Respondent's medical payment ledger, Respondent did not pay for these physical therapy visits. [RX10].

On 9/07/17, SHS refilled Petitioner's prescription for Hydrocodone and ordered her to continue physical therapy, treatment with orthopedic, and remain off work until follow up in six weeks. [PX4-022, 070].

On 9/27/17, Petitioner returned to Dr. Miller at which time he ordered four weeks of physical therapy, three times a week, and ordered Petitioner to continue wearing the ankle brace and return to work with sitting duties only. [PX5-087-092]. Respondent did not honor Dr. Miller's work restrictions and Petitioner remained off work. [T14-15]. Petitioner testified that Respondent did not authorize or pay for the appointment with Dr. Miller on 9/27/17 or the recommended physical therapy and she submitted the medical expenses to the Illinois Department of Public Health. [T 13-15]. Petitioner did not receive additional therapy as recommended by Dr. Miller until February, 2018. [PX6-199].

On 11/17/17, Dr. Miller's deposition was taken to establish that his recommendation for additional physical therapy was reasonable and necessary treatment. [PX7]. Dr. Miller testified continued therapy may improve the chronicity of Petitioner's condition and avoid surgical exploration and repair of her peroneus brevis tendon tear. [PX7-254]. Dr. Miller opined that another MRI may be appropriate to rule out the development of a meniscoid lesion which could be the source of Petitioner's pain. [PX7-256]. Dr. Miller opined Petitioner has and is to remain on light duty restrictions until she receives the recommended treatment and she is not at maximum medical improvement. [PX7-256-258].

On 12/11/17, IME Dr. Krause authored a Second Addendum to his initial report dated 6/8/17, at which time he appreciated the additional findings on the MRI dated 7/12/17. [RX3]. Dr. Krause addressed for the first time the posterior tibial tendinosis and tenosynovitis with peroneus brevis tendinosis and tenosynovitis and chronic partial tears of the peroneus brevis. Dr. Krause opined that both conditions were degenerative and not related to Petitioner's work accident of 3/3/17. [RX3-page 1]. Dr. Krause appreciated the high grade partial tear of the anterior talofibular ligament and calcaneal fibular ligament. Dr. Krause opined that these injuries may have occurred on 3/3/17, but are ankle sprains. [RX3-page 1]. Dr. Krause opined Petitioner's ankle sprain has heeled, she has reached MMI with no restrictions, and no additional treatment was necessary.

On 2/1/18, Respondent's Utilization Review retroactively authorized nine of the eighteen physical therapy visits ordered by Dr. Miller on 8/16/17. [RX6]. This is inconsistent with Respondent's claims that it is not liable for any medical treatment after 7/31/17, the date Dr. Krause opined Petitioner reached MMI. Petitioner underwent *six* physical therapy visits from August 29, 2017 through September 20, 2017, which was submitted to Medicaid due to Respondent's refusal to timely authorize. [PX6-166-168].

On 2/12/18, Dr. Miller again ordered four weeks of physical therapy. [PX5-093]. Petitioner began a third round of physical therapy beginning 2/13/18 at Herrin Hospital twice a week for four weeks. [PX6-199]. She attended eight sessions and was discharged on March 8, 2018. [PX6-199-237]. On 2/16/18, the therapist noted little range of motion and swelling to the top of Petitioner's left foot and both medial and lateral sides of her left ankle, with the third and fourth toes slightly blue in color. [PX6-217]. Petitioner's foot was taped which did not reduce swelling. [PX6-218]. Petitioner's discharge note indicates range of motion improved some, but she continues to have significant pain and limitation in functional activities. [PX6-235]. The therapist recommended discontinuing therapy until Petitioner consulted with Dr. Miller. [PX6-235].

On 7/19/18, Respondent's Utilization Review retroactively denied authorization for physical therapy she received in February and March, 2018. [RX7]. However, Respondent stipulated it paid TTD benefits from 2/13/18 through 3/24/18 while Petitioner underwent therapy. The UR report further states Petitioner previously underwent 18 sessions of therapy from 8/16/17 through 10/16/17, which is not true. Petitioner underwent six therapy sessions from 8/29/17 through 9/20/17.

On 9/19/18, Dr. Miller recommended additional physical therapy as he was under the impression therapy was denied by workers' compensation and exhausted by Medicaid. [PX5-099-103]. Dr. Miller clarified his misunderstanding in a letter dated 12/11/18. [PX5-103]. Dr. Miller recommended additional physical therapy to avoid surgical intervention. [PX5-103]. He believes appropriate therapeutic exercises will improve her chronic condition. If additional conservative treatment is not authorized, Dr. Miller recommends a referral to a podiatric surgeon. [PX5-103].

On 1/31/19, Petitioner underwent a second Section 12 examination by Dr. Gary Schmidt. [RX4]. Respondent's counsel's letter to Dr. Schmidt requesting such IME

consists of eleven pages. [PX8]. Although Section 12 opinions are intended to be *independent*, counsel's summary of Petitioner's medical treatment is suggestive. Specifically, counsel notes, "Petitioner has been treating for an "ankle sprain" for almost two years with no improvement and is now being recommended potential treatment for a meniscoid type lesion (which has not been previously diagnosed or identified on diagnostic films)." [PX8-page 2]. Respondent does not mention that Petitioner's treatment was delayed due to Respondent's refusal to authorize recommended treatment. Respondent authorized six physical therapy visits in May, 2017 and did not pay for any medical treatment after July 25, 2017, with the exception of one visit to Dr. Miller on 9/19/18.

Counsel did not provide Dr. Schmidt with any radiological films or even Petitioner's initial follow up visit with her primary care physician following the emergency room visit. Dr. Schmidt's opinion was based solely on records as he was not provided any radiologic studies to review. [RX4-pages 1-2]. Dr. Schmidt opined no further treatment was required and no physical restrictions were appropriate.

On 2/15/19, Dr. Schmidt authored an Addendum to his initial report dated 1/31/19. [RX5]. Dr. Schmidt opined he certainly felt the first two courses of physical therapy were reasonable and necessary. Petitioner underwent physical therapy from April 26, 2017 through May 24, 2017 and again from August 29, 2017 through September 20, 2017. Respondent did not authorize the second session of therapy and currently argues it is not liable for payment of any medical expenses after Dr. Krause's opinion Petitioner reached MMI on 7/31/17. Pursuant to Dr. Schmidt's opinion, therapy for the period August 29, 2017 through September 20, 2017 should be Respondent's liability.

Petitioner testified she currently experiences swelling and bruising in her ankle/foot and it feels like she is walking on a golf ball. [T18]. She has difficulty walking long distances, standing for long periods of time, and climbing steps. [T18-19, 25]. Petitioner testified she experiences pain every day and wears an ankle brace on a daily basis. [T24, 26]. Petitioner prefers to be referred to a surgeon pursuant to Dr. Miller's recommendation. [T19].

Petitioner has consistently remained off work from the date of accident to the present. [T19]. Respondent has terminated her employment.

Petitioner testified she has no prior injuries to her left ankle/foot. [T22].

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 finds that Petitioner has met her burden of proof that Petitioner's condition was causally related to her work duties with Respondent. Petitioner testified

credibly that her ankle/foot symptoms have persisted since the date of accident. There is no evidence that Petitioner sustained prior injuries to her left ankle/foot. Radiologic studies are positive for soft tissue swelling, joint swelling, a partial tear of the peroneus brevis, a partial tear of the anterior talofibular ligament, a sprain/partial tear of the calcaneofibular ligament, mild acute chronic changes of plantar fasciitis, edema within the calcaneal tuberosity, posterior tendinosis, and peroneus longus/brevis tenosynovitis.

Petitioner was able to undergo twenty physical therapy sessions at intermittent periods due to the denial of benefits by Respondent. Respondent did not authorize or pay for fourteen of Petitioner's last therapy sessions. IME Dr. Schmidt opined 6 of those 14 therapy sessions were reasonable. Despite IME Dr. Krause's opinion that Petitioner should be treating with an orthopedic surgeon, Respondent did not authorize or pay for Petitioner's consultation with Dr. Miller on 8/16/17. The only treatment Respondent paid for after Petitioner's MRI follow up at SHS on 7/25/17 was one office visit with Dr. Miller on 9/19/18.

The Arbitrator finds Dr. Miller's testimony more persuasive than Section 12 examiners Dr. Krause and Dr. Schmidt. Dr. Krause initially opined Petitioner's injuries are causally related to her work accident; that treatment up to the date of his examination on 6/8/17 was appropriate; that Petitioner should be treating with an orthopedic surgeon; that the recommended MRI was appropriate; that light duty work restrictions were appropriate; and that she had not reached maximum medical improvement. Upon review of the MRI films on 7/31/17, Dr. Krause stated Petitioner was at MMI with no restrictions. Dr. Schmidt initially opined Petitioner was at MMI with no further treatment recommendations, despite not having reviewed radiological films or even Petitioner's initial follow up visit with her primary care physician following the emergency room visit. Dr. Schmidt's opinion was based solely on a records review.

Respondent stipulated Petitioner sustained a compensable accident; therefore, Respondent's inquiry as to why the Kitchen Manager was not present to testify about her fall is irrelevant. Respondent's inquiry as to the height of the step, whether Petitioner twisted or rolled her ankle, and whether she fell to the floor are also irrelevant. Petitioner reported in the emergency room she went down wrong off a little step and felt pain in her ankle and foot. [PX6-106]. The emergency room records indicate Petitioner denied "rolling" her ankle and Petitioner testified she twisted her ankle. Only the IME doctors mention a step measuring 8 inches or 2 feet in height. All of Petitioner's records state a small step/ledge and on Dr. Miller's questionnaire Petitioner reports a step "2-4 inches in height" which is consistent with her testimony. Petitioner testified she fell to the floor and her manager helped her up, which is not inconsistent with any history provided in her medical records.

Respondent's Exhibit 11 is a Laboratory Report dated 12/10/14, approximately 27 months prior to the subject date of accident. [RX11]. The Report shows Petitioner was positive for Hydrocodone at that time. Respondent did not pose any questions to Petitioner regarding this report, her use of Hydrocodone over two years before this accident, and submitted Exhibit 11 after Petitioner testified. There is no evidence as to

why Petitioner was taking Hydrocodone in December, 2014. Petitioner testified she had not taken any opioid pain medications for her back injury (surgery in 1991 for scoliosis), or other conditions identified by Respondent in cross-examination (shoulder injury from car accident in 2015). Petitioner did not testify she has never taken Hydrocodone and did not testified in any manner that would question her credibility regarding this issue. Respondent did not present a drug test to suggest Petitioner was taking Hydrocodone or any opioid on the date of the accident. In fact, Petitioner's emergency room records do not indicate Petitioner was taking any medication on 3/4/17, and her primary care records dated 3/7/17 show the only medication Petitioner was taking was Cyclobenzaprine, Diclofenac Sodium (NSAID), and Mirena, none of which are opiates, and Hydrocodone which was prescribed on 3/4/17 in the emergency room.

Despite Petitioner's consistent treatment, her symptoms have persisted. Petitioner has undergone considerable conservative treatment, including several ankle braces, medication, 20 sessions of physical therapy, ice, heat, elevation, taping, and light duty activities. Dr. Miller opined Petitioner may need to be referred to an orthopedic surgeon if she did not improve with conservative treatment. Petitioner testified she would like to be referred to a surgeon pursuant to Dr. Miller's recommendation.

For the foregoing reasons, the Arbitrator finds Petitioner met her burden of proof that her condition is causally related to her work duties with Respondent.

WITH RESPECT TO ISSUE (J), 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 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 1, 2 and 3 as provided in Sections 8(a) and 8.2 of the Act, and as itemized as follows:

Shawnee Health Service (PX1) $302.00
(The outstanding amount of $336.00 stated on the Request for Hearing is incorrect. The correct outstanding amount pursuant to PX1 is $302.00)
Southern Orthopedic Associates (PX2) $3.90
SIH – Herrin Hospital (PX3) $7,758.08

Respondent shall hold Petitioner harmless for any and all payments made by IDPH. Respondent

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS?

Petitioner has not been released from medical care by Dr. Bret Miller. Dr. Miller opined Petitioner may need to be referred to an orthopedic surgeon if she did not improve with conservative treatment. Petitioner testified she has not improved with conservative

treatment and would like to be referred to a surgeon pursuant to Dr. Miller's recommendation. The Arbitrator finds Petitioner is entitled to prospective medical care and Respondent is liable for Petitioner's referral to an orthopedic surgeon.

WITH RESPECT TO ISSUE (L), WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS?

Petitioner has consistently been ordered off work or restricted to light duty work which Respondent did not honor. Respondent shall pay TTD benefits for the period August 6, 2017 through February 12, 2018 and March 30, 2018 through March 20, 2019, for a total of 77 6/7 weeks at the state minimum rate of $319.00.

Respondent is entitled to a credit of $4,380.00 for advance TTD payments as stipulated by the parties.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALICIA RIVAS,

Petitioner,

vs. NO: 15 WC 17289

LEXINGTON HEALTH CENTERS,

Respondent.

20IWCC0121

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner's current lumbar condition is causally related to her April 25, 2015 work-related accident. The Petitioner is, therefore, entitled to TTD benefits from July 31, 2015 through December 21, 2018, the date of Arbitration and all reasonable and necessary medical expenses. The Commission further finds that Petitioner is entitled to prospective medical treatment as recommended by Dr. Templin.

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 finds that the evidence supports Dr. Templin's opinion relative to causal connection and the need for prospective medical treatment. Petitioner sought medical treatment for her back pain following her undisputed work accident. Examination revealed a positive straight leg raise and spasms in the paraspinal muscle along with tenderness from L4-SI and in the right joint during her May 8, 2015 examination. She was diagnosed with lumbago, a lumbar disc herniation, lumbar radiculitis, and a lumbar sprain. PX.2. The MRI from July 9, 2015 confirmed that the L4-L5 and L5-SI disc herniation was indenting the thecal sac. PX.6. Petitioner continued to undergo medical treatment including therapy and injections without success. Petitioner then underwent a discography on December 11, 2015 that revealed unequivocal concordant discogenic pain at L4-L5 and L5-SI, with the CT scan showing that the disc herniation at L4-L5, L5-SI was indenting the thecal sac. *Id.* Petitioner underwent another MRI on July 18, 2016 that revealed a 2mm degenerative retrolisthesis of L5 over the SI vertebra, which was noted to be a new finding since the prior MRI. There was also disc disease with degenerative changes at L4-L5 and L5-SI causing varying degree of central canal and neural foraminal stenosis. PX.13.

A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro Inc. v. Indus. Comm'n,* 207 Ill. 2d 193, 205 (2003). 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. *Id.* at 204-205. It is axiomatic that employers take their employees as they find them. *Id.* at 205. Thus, 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. *Sisbro Inc.* at 205.

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." *International Harvester v. Industrial Comm'n,* 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982).

Despite the objective evidence, Dr. Singh was of the opinion that there was no herniation and that Petitioner could work without issue as she was malingering. The Commission is not persuaded by Dr. Singh's opinion that Petitioner sustained a resolved pre-existing lumbar muscular strain and that her condition was related to her degenerative disc disease at L4-L5 and L5-SI. Dr. Singh's opinion ignores that the Petitioner was working without issue at the time of her undisputed accident. It was only after her accident that she began to undergo medical treatment on a regular

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basis and that she has had consistent complaints since the accident. The Commission finds no credible evidence that Petitioner's condition was related to her pre-existing degenerative disc disease or that her condition resolved following her work accident. Rather, the evidence establishes that Petitioner sustained a work-related injury causing her to become symptomatic.

The Commission finds the opinion of Dr. Templin more persuasive. Dr. Templin noted that the MRI revealed mild degenerative changes at L4-L5 and L5-SI and that there was a disk herniation extending caudally from the L5-SI disc space that was impinging the SI nerve root on the right. PX.17. pg.15. Dr. Templin noted that the fact that the injections provided 3 days of relief confirmed the impingement and could explain the pain extending into Petitioner's right leg. *Id.* He noted that the degenerative changes were not the source of her pain. Because of this, Dr. Templin has recommended a right L5-SI lumbar hemilaminectomy with discectomy.

While the Petitioner may have had exhibited some signs of symptom magnification during Dr. Singh's examination, the Commission is not persuaded by Dr. Singh's finding as the majority of the objective testing confirmed that presence of the herniation and that it was indenting the nerve root. Further, Dr. Templin noted that his findings were consistent with Petitioner's complaints and that he did not think she was exaggerating. He also noted that while Petitioner was histrionic, it was largely due to her frustration with her continued symptoms. Furthermore, Dr. Vargas noted that Petitioner did not exhibit any Waddell signs during his July 30, 2015 examination. PX.8. The Commission finds that the credible evidence does not support Dr. Singh's findings of symptom magnification.

Accordingly, the Commission finds that Petitioner's current lumbar condition is causally related to her April 25, 2015 accident. As her condition is causally related to her work accident, the Commission awards Petitioner prospective medical treatment consisting of a pre-surgical MRI and a right L5-SI lumbar hemilaminectomy with discectomy as recommended by Dr. Templin.

Following the work accident, Petitioner was given light duty work restrictions and she was terminated July 30, 2015. She was subsequently taken off work on October 6, 2015 and has not been released back to work at the time of arbitration. The Commission finds that Petitioner is entitled to TTD benefits from July 31, 2015 through December 21, 2018, representing 176-2/7 weeks.

After reviewing the medical records, the Commission finds that the medical treatment contained within Arbitrator's exhibit 1 was reasonable and necessary, and causally related to her work accident. Therefore, the Commission finds that Petitioner is entitled to medical expenses totaling $172,873.09.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 15, 2019, 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 $482.00 per week for a period of 176-2/7 weeks (July 31, 2015 through December 21, 2018), that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $172,873.09 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical treatment as recommended by Dr. Templin.

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

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

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

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

DATED: FEB 21 2020

D. Douglas McCarthy

DDM/tdm
O: 2/5/20
052

Stephen Mathis

DISSENT

I respectfully dissent. I would affirm and adopt the well-reasoned decision of the Arbitrator.

L. Elizabeth Coppoletti

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

RIVAS, ALICIA
Employee/Petitioner

Case# **15WC017289**

LEXINGTON HEALTH CARE CENTERS
Employer/Respondent

20IWCC0121

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

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

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

2234 CHEPOV & SCOTT LLC
NICHOLAS CLIFFORD
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CHICAGO, IL 60656

5578 LAW OFFICES FRANCESCA D LARSEN
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150 N MARTINGALE RD SUITE 225
SCHAUMBURG, IL 60173

STATE OF ILLINOIS)
)SS.
COUNTY OF **DuPage**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Alicia Rivas
Employee/Petitioner

v.

Lexington Health Care Centers
Employer/Respondent

Case # **15** WC **017289**

Consolidated cases: _____

20IWCC0121

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Wheaton**, on **12/21/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [x] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **4/25/15**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**37,596.00**; the average weekly wage was $**723.00**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $**5,000.00 compensation advance** for other benefits, for a total credit of $**5,000.00**.

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

ORDER

Accident: The Arbitrator finds that an accident occurred that arose out of and in the course of employment by Respondent.

Notice: The Arbitrator finds timely notice of an accident was given to Respondent.

Causal Connection: Petitioner failed to prove the current condition of ill-being is causally related to the injury.

Medical: Based upon the opinion of Dr. Kern Singh, physical therapy several times per week for 4 weeks was reasonable and necessary. Respondent's Utilization Review non-certified Petitioner's injections and discography. Respondent shall pay medical bill from Adventist Glen Oak Hospital ($964.78), Herron Medical Center ($850.00) and Lakeshore MRI ($4,041.30) per fee schedule. All other medical bills are denied.

Prospective Medical: The Arbitrator finds that Petitioner failed to prove prospective medical care is reasonable, necessary, and related. Therefore, prospective medical benefits are denied.

TTD: The Arbitrator finds Petitioner was temporarily and totally disabled from July 31, 2015, through January 20, 2016. Respondent shall pay Petitioner temporary total disability benefits of $482.00 per week for 24 6/7 weeks commencing July 31, 2015, through January 20, 2016. Respondent is entitled to a $5,000.00 credit for the advance dated November 24, 2015.

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

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

20IWCC0121

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

Signature of Arbitrator

May 11, 2019
Date

ICArbDec19(b)

MAY 15 2019

STATEMENT OF FACTS:

On April 25, 2015, Alicia Rivas, (hereinafter "Petitioner") was a 52-year-old housekeeper for Lexington Health Care Centers (hereinafter "Respondent") in Bloomingdale, Illinois. Petitioner testified that on April 25, 2015, she injured her low back while moving a dresser across a plastic floor (TR. p. 13). She testified that she provided notice to a manager named Mirna, but could not recall her last name (TR. p. 19).

Petitioner sought initial medical treatment on April 26, 2015, at Glen Oaks Hospital. She underwent x-rays and was advised to follow up with another doctor. (Pet. Ex. 1) She returned to work after taking a few days of vacation. (TR. p. 42)

Petitioner testified she next sought treatment on May 8, 2015, with Dr. Ravi Barnabas at Herron Medical Center. Petitioner underwent MRI on July 9, 2015, at Lake Shore Open MRI. Physical therapy was prescribed. Petitioner initially underwent physical therapy at Alivo Physical Therapy and later began attending therapy with Dr. George Radice. (TR. p. 23)

Dr. Barnabas eventually referred Petitioner to a pain management physician, Dr. Axel Vargas, on July 30, 2015. Petitioner underwent a course of epidural steroid injections on September 25, 2015, October 9, 2015 and October 30, 2015. (TR. p. 26)

Dr. Vargas referred Petitioner to Dr. Ronald Michael on January 18, 2016. Petitioner testified that he performed a series of procedures that were not of any benefit. (TR. p. 27) Dr. Michael referred Petitioner to Rehab Dynamix for physical therapy. Therapy was performed at Rehab Dynamix from March 3, 2016 through March 18, 2016. (TR. p. 28) Petitioner did not submit Dr. Michael's records or bills into evidence at Arbitration. (TR. p. 70)

On July 7, 2016, Petitioner sought treatment with Dr. Cary Templin at Hinsdale Orthopaedics. Petitioner does not recall who referred her to Dr. Templin. (TR. p. 45) Dr. Templin prescribed a second MRI which was performed on July 16, 2016. He referred Petitioner to a pain management physician, Dr. Sharma, who performed an injection on October 26, 2016. Petitioner returned to Dr. Templin on December 13, 2016. He prescribed surgery consisting of a right L5-S1 lumbar hemilaminectomy and discectomy. During Dr. Templin's deposition testimony, he admitted on cross examination that Waddell Testing had not been performed. (TR. p. 42) Petitioner last received medical treatment with Dr. Templin on April 4, 2018, wherein a third MRI was prescribed. Petitioner had scheduled the MRI, but it was later cancelled without explanation. As of the date of trial, Petitioner had yet to undergo the MRI, but believes she will have the imaging study at some point in time. (TR. p. 33) Petitioner has not worked since July 30, 2015. (TR. p. 37) As of the date of the hearing, Petitioner had not sought medical care in over eight months, nor had she rescheduled the MRI. (TR. p. 38)

Petitioner testified that she had never had any back injuries prior to April 25, 2015, yet she admitted on cross examination to having received physical therapy and treatment for her back in the past due to a work injury in 2012. Despite denying she had ever injured or received medical treatment

for her lumbar spine, she admitted that she had undergone a MRI in the past and received treatment at Concentra. (TR. p. 39-41)

Petitioner has not worked since July 30, 2015, and has not attempted to seek employment. She has not applied for SSDI. (TR. p. 48)

Eduardo Davila testified on behalf of Petitioner. He is employed doing pastoral work for a church named Greenhouse Movement. (TR. p. 54) He has known Petitioner since 2016 and testified that he serves as her pastor. He sees Petitioner an average of two hours per week and drives her to church. Mr. Davila also testified that he drove Petitioner to her attorney's office on a few occasions. He testified he observed that Petitioner's mobility is limited. (TR. p. 57)

Petitioner was examined on behalf of Respondent under section 12 of the Act by Dr. Kern Singh of Midwest Orthopaedics at Rush. The first examination took place on December 10, 2015. Physical examination revealed 5/5 positive Waddell Findings. He diagnosed Petitioner with a lumbar muscular strain and opined Petitioner was capable of returning to work light duty. Dr. Singh did request to review the MRI of the lumbar spine dated July 9, 2015, in order to determine causation, future treatment, and maximum medical improvement. (Resp. Ex. 1)

After reviewing the MRI films dated July 9, 2015, Dr. Singh issued an addendum report on January 20, 2016. He diagnosed Petitioner with a lumbar muscular strain and pre-existing degenerative disc disease at L4-5 and L5-S1. He also stated that she sustained a lumbar soft tissue muscular strain that had resolved. His reasoning was based upon the fact that the MRI did not reveal any neural impingement that would correlate with her right leg pain. He also stated that Petitioner's disc protrusion was central in nature at L4-5 and L5-S1 and did not contact the L5 or S1 nerve roots. He also opined that Petitioner's pain and leg pain were inconsistent with a L5 or S1 radiculopathy. Based upon the physical examination and diagnostic studies, Dr. Singh declared Petitioner to have reached maximum medical improvement and that she was capable of returning to work full duty. (Resp. Ex. 2)

Dr. Singh examined Petitioner again on April 27, 2017. She reported that her symptoms were unchanged in nature. Waddell findings were again positive 5/5. She was self-limiting with range of motion. She was asked to heel and toe walk, but was unable to do so, but was able to step onto a stepstool and onto the examination table, which was inconsistent with her inability to heel and toe walk. Petitioner exhibited what Dr. Singh classified as "extreme symptom magnification" throughout the examination, with deep breathing, facial grimacing and hyperactivity upon examination. Dr. Singh examined a second MRI that took place on July 18, 2016. He again diagnosed Petitioner with a resolved pre-existing lumbar muscular strain and degenerative disc disease at L4-5 and L5-S1. He thought that these conditions were in no way related to the work injury in any capacity, as Petitioner exhibited nonanatomic pain complaints and extreme symptom magnification. Furthermore, Dr. Singh did not believe Petitioner was suffering from a disc herniation at L5-S1, nor did he believe she was in need of surgery. He based his opinion upon the radiological report, along with his own interpretation of the films. Dr. Singh opined that L5-S1 disc herniation would cause S1 radiculopathy, which was not present upon examination. He found no difference between the MRI of July 9, 2015, and that of July 18, 2016.

There were no new findings at L5-S1. Dr. Singh also opined that treatment, including a VascuTherm unit, injections, discogram, and extensive physical therapy, were not reasonable or necessary due to the fact that she had no anatomic complaints and no neurological deficit. Based upon a reasonable degree of medical and surgical certainty, Dr. Singh opined that, at best, four weeks of physical therapy, three times per week, was the only treatment necessary. He again reiterated his January 20, 2016, opinion that Petitioner had reached maximum medical improvement and continued to be capable of full duty work. (Resp. Ex. 3)

In addition to Dr. Singh's reports and addendum opinions, Respondent's Utilization Review of the three epidural steroid injections, as well discography, were found to be non-certified by Coventry Workers' Comp Services. (Resp. Ex. 7 & 8)

DISPUTED ISSUES:

In support of the Arbitrator's decision relating to whether an accident occurred that arose out of and in the course of employment by Respondent (Issue C), the Arbitrator finds the following facts:

The Arbitrator finds that Petitioner sustained an injury to her low back while moving a dresser while employed by Respondent on April 25, 2015. The injury was a result of an employment related risk. Therefore, the Arbitrator finds an accident occurred that arose out of and in the course of employment by Respondent.

In support of the Arbitrator's decision relating to whether there was timely notice of an accident given to Respondent (Issue E), the Arbitrator finds the following facts:

Petitioner testified that she provided notice of the April 25, 2015 accident to her manager, Mirna. Notice was provided to Mirna on the date of the injury (TR. p. 19). Therefore, the Arbitrator finds that timely notice of an accident was given to Respondent as required under the Illinois Workers' Compensation Act.

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

The Arbitrator heard Petitioner's testimony and has carefully considered both Petitioner's treating records, opinions of section 12 examiner, Dr. Kern Singh, as well as the deposition transcripts from Dr. Cary Templin and Dr. Singh. The Arbitrator finds the medical opinions of Dr. Singh to be more credible. As a result of the April 25, 2015, injury, Petitioner suffered a resolved lumbar strain. Petitioner's examinations were fraught with symptom magnification and nonanatomic pain complaints. Based upon Dr. Singh's review of Petitioner's MRI films, any of Petitioner's alleged ongoing pain complaints are the result of pre-existing degenerative disc disease at L4-5 and L5-S1. (Resp. Ex. 1-4)

The Arbitrator finds that the testimony of Mr. Eduardo Davila adds little to Petitioner's evidence. He met Petitioner in 2016. His testimony indicates that he did not know Petitioner prior to the April 25, 2015, date of injury. Mr. Davila lacks sufficient knowledge of Petitioner's condition prior to the date of work injury to be of any relevance as to the cause of any current alleged physical deficits. (TR. p. 55)

In support of the Arbitrator's decision relating to whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services (Issue J), the Arbitrator finds the following facts:

Based upon the testimony of Dr. Kern Singh, the Arbitrator finds that 4 weeks of physical therapy for three times per week was reasonable and necessary. (Resp. Ex. 3) Based upon Respondent's utilization review reports, all three epidural steroid injections, as well as discography, were not medically necessary. (Resp. Ex. 7 & 8) Dr. Singh also opined that treatment, including a VascuTherm unit, injections, discogram, and extensive physical therapy, were not reasonable or necessary due to the fact that Petitioner had no anatomic complaints and no neurological deficit. (Resp. Ex. 3)

Based upon the foregoing, Respondent shall pay the medical bill from Adventist Glen Oak Hospital in the amount of $964.78 (Pet. Ex. 1), Herron Medical Center in the amount of $850.00 (Pet. Ex. 2), and Lakeshore MRI in the amount of $4,041.30. (Resp. Ex. 6) These bills are to be paid per fee schedule. All other medical bills are denied as they were not reasonable and necessary.

In support of the Arbitrator's decision relating to whether Petitioner is entitled to any prospective medical care (Issue K), the Arbitrator finds the following facts:

The Arbitrator has considered the evidence from both the Petitioner's treating physicians and Respondent's expert, and finds Dr. Singh more credible. At most, Petitioner sustained a resolved lumbar strain and suffers from pre-existing lumbar disc degeneration. Petitioner does not suffer from herniated discs at either L4-5 or L5-S1. This conclusion is based upon Dr. Singh's review of both sets of MRI films, as well as physical examination. Petitioner exhibited nonanatomic pain complaints. If there was a herniation at L5-S1, Petitioner would have S1 radiculopathy, which was not present. Petitioner exhibited symptoms of extreme symptom magnification at both the December 10, 2015 and April 27, 2017 IME's, as well as positive 5/5 Waddell signs. Dr. Singh has opined that a surgery is not medically necessary, nor is it related to the April 25, 2015 date of injury.

As of the date of Arbitration, Petitioner had not sought medical treatment in over eight months. Based upon the foregoing, Petitioner's request for prospective medical benefits is denied.

In support of the Arbitrator's decision as to TTD benefits in disputed (Issue L), the Arbitrator finds the following facts:

After April 25, 2015 accident, Petitioner was taken off work by Dr. Vargas on July 31, 2015. Petitioner was initially examined by Dr. Kern Singh on December 10, 2015. (Resp. Ex. 1) Based upon physical examination, Dr. Singh found 5/5 Waddell findings were present, suggesting symptom magnification. In his report, Dr. Singh requested to review the MRI that had been performed on July 9,

2015. After reviewing the MRI of the lumbar spine dated July 9, 2015, Dr. Singh issued an addendum report on January 20, 2016. (Resp. Ex. 2) Based upon his review of the MRI films, Dr. Singh diagnosed Petitioner with a resolved lumbar muscular strain and pre-existing degenerative disc disease at L4-5 and L5-S1. The MRI did not reveal any neural impingement that correlated with Petitioner's right leg pain. He opined that the disc protrusion was central in nature at L4-5 and L5-S1 and did not contact the L5 or S1 nerve roots. Petitioner's pain is inconsistent with L5 or S1 radiculopathy. As of January 20, 2016, Dr. Singh opined that Petitioner had reached maximum medical improvement and could return to work without restriction. The Arbitrator has reviewed the deposition transcripts of both Dr. Kern Singh and Dr. Cary Templin and finds the medical opinion of Dr. Kern Singh to be more credible. (Resp. Ex. 4; Pet. Ex. 17)

Therefore, based upon the foregoing facts, the Arbitrator finds that Petitioner reached maximum medical improvement and was capable of full duty work as of January 20, 2016. Petitioner was therefore temporarily and totally disabled from July 31, 2015, through the date of Dr. Singh's addendum dated January 20, 2016, or 24 and 6/7 weeks. Respondent is entitled to a $5,000.00 credit for the advance that was stipulated to in Arbitrator's Exhibit 1.

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF WILLIAMSON)	☐ 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

Nathaniel Head,

Petitioner,

20IWCC0122

vs. No. 17 WC 38035

State of Illinois/Big Muddy River Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's permanency award with respect to the neck injury. The Commission finds some impact on the future earning capacity (factor (iv) of the factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act)) and a somewhat greater degree of disability (factor (v)) than the Arbitrator found. The medical records show Petitioner had a very good result from the cervical disc replacement surgery and was released to return to work full duty. During his last follow-up visit, Petitioner complained to Dr. Gornet of pain with increased activities. At the arbitration hearing, Petitioner credibly testified to residual soreness, which is worse at the end of the workday. Petitioner therefore no longer volunteers for overtime. Petitioner similarly limits himself with respect to his hobbies. The Commission increases the permanency award to 17.5 percent of the person as a whole. The Commission agrees with the Arbitrator that the injury to the right shoulder caused no permanent disability.

20IWCC0122

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $634.61 per week for a period of 87.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 17.5 percent of the person as a whole.

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

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

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

DATED: FEB 24 2020
d-02/05/2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

DISSENT

I respectfully dissent. I would affirm and adopt the decision of the Arbitrator.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEAD, NATHANIEL
Employee/Petitioner

Case# **17WC038035**

SOI/BIG MUDDY RIVER C C
Employer/Respondent

20IWCC0122

On 8/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

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

0502 STATE EMPLOYEES RETIREMENT
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0558 ASSISTANT ATTORNEY GENERAL
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CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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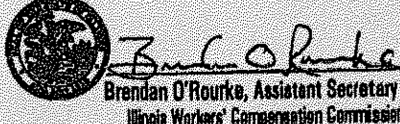
1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 13 2019



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

20 IWCC0122

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

Nathaniel Head
Employee/Petitioner

v.

SOI/Big Muddy River C.C.
Employer/Respondent

Case # 17 WC 38035

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 July 17, 2019. By stipulation, the parties agree:

On the date of accident, November 26, 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 $54,999.88; the average weekly wage was $1,057.69.

At the time of injury, Petitioner was 38 years of age, married, with 2 dependent child(ren).

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

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. At trial, the parties stipulated TTD benefits had been paid in full.

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 permanent partial disability benefits of $634.61 per week for 75 weeks because the injuries sustained caused the 15 % loss of use 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 24, 2019, through July 17, 2019, 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.

William R. Gallagher, Arbitrator

August 7, 2019
Date

AUG 13 2019

Findings of Fact

Petitioner filed an Amended Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on November 26, 2017. According to the Amended Application, Petitioner sustained injuries to his right and left shoulders, back, neck and body as a whole when he stopped an inmate who was falling from a wheelchair (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that all medical bills and temporary total disability benefits had been paid in full and the only disputed issue was the nature and extent of permanent partial disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Correctional Officer. On November 26, 2017, an inmate who was seated in a wheelchair fell onto Petitioner's left side which caused Petitioner to fall to the ground with both the inmate and wheelchair on top of him. As a result of the accident, Petitioner sustained an injury to his right shoulder and neck.

Petitioner initially sought medical treatment at SSM Health Express Clinic on November 27, 2017. At that time, Petitioner complained of bilateral shoulder pain, right more than left, as well as low back pain. Petitioner was diagnosed with a lumbosacral strain as well as right and left shoulder strains. Petitioner was prescribed medication and discharged (Petitioner's Exhibit 3).

Petitioner was again seen at SSM Health Express Clinic on December 4, 2017. Petitioner still had bilateral shoulder pain, but primarily in regard to the right shoulder. Petitioner was directed to continue with his medication and to follow up with his primary care physician or an orthopedic specialist if his symptoms continued (Petitioner's Exhibit 3).

Petitioner subsequently came under the care of Dr. Nathan Mall, an orthopedic surgeon, who initially evaluated him on December 11, 2017. Petitioner complained of bilateral shoulder pain, primarily on the right, as well as upper and lower back pain. Dr. Mall ordered physical therapy and ordered an MRI arthrogram of Petitioner's right shoulder (Petitioner's Exhibit 4).

The MRI arthrogram was performed on December 27, 2017. According to the radiologist, it revealed no tears but did reveal mild tendinopathy of the supraspinatus and some mild AC osteoarthritic changes (Petitioner's Exhibit 6).

Dr. Mall saw Petitioner on December 27, 2017, and reviewed the MRI arthrogram which he opined was "fairly normal." Dr. Mall diagnosed Petitioner with a biceps strain and superior labral strain. He recommended Petitioner undergo a cortisone injection in the glenohumeral joint which he administered at that time (Petitioner's Exhibit 4).

Dr. Mall continued to treat Petitioner and when he saw him on January 26, and February 21, 2018, Petitioner complained of AC joint pain. Dr. Mall opined Petitioner had sustained a biceps strain and had AC joint inflammation. On both occasions, he administered an injection into the AC joint (Petitioner's Exhibit 4).

When Dr. Mall saw Petitioner on March 21, 2018, Petitioner continued to complain of right shoulder pain. At that time, Dr. Mall ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 4).

The MRI of Petitioner's cervical spine was performed on April 26, 2018. According to the radiologist, it revealed small foraminal disc protrusions at C3-C4 and C4-C5 as well as a central annular tear and protrusion at C6-C7 (Petitioner's Exhibit 8).

Dr. Mall saw Petitioner on April 26, 2018, and reviewed the MRI with Dr. Matthew Gornet, an orthopedic surgeon. He noted Dr. Gornet opined the MRI revealed some pathology in Petitioner's cervical spine (Petitioner's Exhibit 4).

In Dr. Gornet's medical record of April 26, 2018, he noted the MRI revealed an annular tear and disc herniation to the right at C6-C7. He opined Petitioner's ongoing symptoms were due to this and imposed light duty work restrictions. Dr. Gornet also referred Petitioner to Dr. Helen Blake for an epidural steroid injection (Petitioner's Exhibit 7).

Dr. Blake saw Petitioner on May 15, 2018. At that time, she administered an epidural steroid injection on the right at C6-C7 (Petitioner's Exhibit 9).

Dr. Gornet saw Petitioner on June 11, 2018. At that time, Petitioner complained of right trapezal pain, right shoulder pain and neck stiffness. Petitioner advised the injection administered by Dr. Blake did not provide any significant relief. Dr. Gornet opined Petitioner should undergo cervical disc replacement surgery at C6-C7. Dr. Gornet subsequently performed cervical disc replacement surgery at C6-C7 on June 20, 2018 (Petitioner's Exhibit 7 and 13).

On June 24, 2018, Petitioner experienced a sudden onset of chest pain. Petitioner went to the ER of Good Samaritan Hospital and was diagnosed with a pulmonary embolism. Petitioner was then airlifted to Missouri Baptist Hospital where he was treated for that condition (Petitioner's Exhibits 11, 12, 15, 16 and 17). Fortunately, Petitioner completely recovered from that condition. At trial, Petitioner testified he was not seeking any permanent partial disability benefits because of the pulmonary embolism.

Dr. Gornet continued to see Petitioner following surgery. Petitioner's recovery was prolonged primarily because of the pulmonary embolism. When Dr. Gornet saw Petitioner on June 24, 2019, he opined Petitioner was at MMI and could return to work without restrictions (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on January 23, 2019. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records provided to him by Respondent. At that time, Petitioner advised he was doing very well, but still had neck aches and pains especially with changes in the weather. Dr. Chabot opined Petitioner's neck and shoulder condition was related to the accident, the treatment Petitioner had received was reasonable and necessary, Petitioner could return to work without restrictions and Petitioner was at MMI (Respondent's Exhibit 2).

At trial, Petitioner testified he still experiences aches/pains in his neck and it is sore after he has worked all day. Petitioner stated that prior to the accident he worked overtime, but he now avoids overtime because after having worked eight hours, his neck is sore. Petitioner also stated he transferred to a less stressful position at the Centralia Correctional Center, a minimum security facility. Petitioner also testified that his participation in some of his hobbies and recreational activities has been adversely affected because of his neck symptoms.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability the extent of 15% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner worked for Respondent as a Correctional Officer and continues to work for Respondent in that capacity, but at a different facility which Petitioner stated is less stressful. The Arbitrator gives this factor moderate weight.

Petitioner was 38 years old at the time of the accident. He will have to live with the effects of this injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

Petitioner testified he previously worked overtime, but he now avoids it because of his neck symptoms at the end of the work day. However, Petitioner was released to return to work without restrictions and he was not directed by Dr. Gornet to avoid overtime. Further, there was no evidence tendered as to the amount of overtime earnings Petitioner had prior to the accident or what they might hypothetically be in the future. The Arbitrator gives this factor no weight.

As a result of the accident, Petitioner sustained a right shoulder strain and a herniated disc and annular tear at C6-C7. Petitioner received extensive conservative treatment for both his shoulder strain and disc injury, but Dr. Gornet ultimately performed disc replacement surgery at C6-C7. While Petitioner was able to return to work to his regular job, he still has symptoms referable to his neck consistent with the injury he sustained. 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 MADISON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DeAngelo Franklin,
Petitioner,

vs. No. 17 WC 27233

20IWCC0123

East St. Louis Police Department,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

20IWCC0123

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

Pursuant to §19(f)(2) of the Act, no appeal bond is set in this case. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

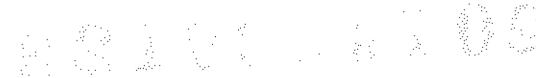
DATED: FEB 24 2020

Marc Parker

mp/wj
02/06/20
68

Barbara N. Flores

Kathryn A. Doerries



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRANKLIN, DeANGELO Case# **17WC027233**
Employee/Petitioner

20IWCC0123

EAST ST LOUIS POLICE DEPARTMENT
Employer/Respondent

On 11/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62220

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEANGELO FRANKLIN
Employee/Petitioner

Case # 17 WC 27233

v.

Consolidated cases: ____

EAST ST. LOUIS POLICE DEPARTMENT
Employer/Respondent

20 IWCC0123

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ____

FINDINGS

On **August 22, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$65,000.00**; the average weekly wage was **$1,250.00**.

On the date of accident, Petitioner was **45** years of age, *single* with **0** dependent child(ren).

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

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

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

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

ORDER

Respondent shall pay all reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) of the Act.

Respondent shall be given 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 § 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$750.00**/week for **25.3** weeks, because the injuries sustained caused the **10%** loss of the **left arm**, 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.

Edward Lee 11/2/18

Signature of Arbitrator Date

NOV 8 - 2018

FINDINGS OF FACT

This matter came before the Arbitrator on Petitioner's motion for hearing on all issues. The parties stipulated that the issues in the case were causal connection, medical care, and the nature and extent of the injuries. (T.4)

Petitioner is a Lieutenant for the City of East St. Louis Police Department. (T.8) The parties stipulated he sustained a work-related accident when, while patrolling at night on the 500th block of 8th Street, he saw a car run a stop sign. (T.9) He pulled the vehicle over and asked for the driver's license and insurance; and when the driver could produce neither, he wrote her name on a pad, went back to his car, and looked up her name in the police database. (T.9) He then discovered that her license was suspended/revoked, and there was a bench warrant. (T.9) Since Petitioner did not transport prisoners and had an unmarked car without a cage, he called for another unit. (T.9) Sergeant Cobb responded, and upon his arrival, Petitioner went back to the suspect and informed her that she was under arrest. (T.9-10) Because she had very small children in the back, however, Petitioner was going to allow her the courtesy of following him to the station. (T.9-10) Upon stating this, the arrestee said she was not going to the police department, put her car in drive, and took off. (T.10)

Petitioner and Sergeant Cobb went back to their police cars as fast as they could and "the chase was on." (T.10) The arrestee went up to the first cross street, which was Summit, almost struck Petitioner's car and Sergeant Cobb's car when they tried to box her in. (T.10) She then turned right, went another block after which Sergeant Cobb cut her off and Petitioner got behind her. (T.10) She then "just floored it" going south-bound on a one way street. (T.10) By the time the arrestee reached Martin Luther King Drive, Sergeant Cobb cut her off again, and this time Petitioner pulled immediately behind her. (T.10) Petitioner grabbed the car door and tried to yank her out, however, she weighed about 200 pounds and she wasn't budging. (T.10-11) Once Sergeant Cobb arrived at the car door, they were able to get her out, however, the suspect continued to pull, twist, and resist. (T.10-11) Petitioner tried to get one of her hands, and she yanked and injured Petitioner's left arm. (T.10-11) Petitioner and Sergeant Cobb narrowly had her into custody by the time other units arrived. (T.11)

During the night, Petitioner noticed some throbbing pain in his left arm, but it wasn't until he woke up the next day that he noticed swelling, soreness, and warmth. (T.11) Five days of rest, ice, and over-the-counter medication, provided little help. (T.12-13) Petitioner presented to Memorial Hospital East on August 27, 2017. (PX3) At the emergency room, the history was taken as follows:

> Patient presents for left elbow pain. States symptoms started 4 days ago when on shift as a police officer he [had] to wrestle somebody down. Denies falling directly on elbow. States he noted swelling to the lateral aspect of elbow afterwards and has had persistent pain. Denies other injuries. States had some numbness in his hand, but now resolved. *Id.*

Petitioner was given a diagnosis of likely extensor tendinitis, prescribed non-steroidal anti-inflammatories, given a tennis elbow support, and directed to follow up with an orthopedic surgeon. (PX3)

As Petitioner had seen an orthopedic surgeon for prior injuries, he returned to Dr. Nathan Mall on August 28, 2017. (PX4, 8/28/17) The history of the injury was taken, and Dr. Mall noted that Petitioner had persistent left elbow pain that gradually worsened from the date of injury. *Id.* Dr. Mall's clinical examination showed swelling, pain to palpation, pain with resisted wrist extension, negative flexion compression tests, and negative Tinel's test with good range of motion. *Id.* Dr. Mall's assessment was acute lateral epicondylitis. *Id.* He recommended a cortisone injection, which he believed typically worked better for an acute inflammatory condition, and prescribed physical therapy, which Petitioner started at SSM Physical Therapy. *Id.*; (PX5)

When Petitioner returned on September 18, 2017, he advised Dr. Mall that the injection only gave him temporary relief. (PX4, 9/18/17) Dr. Mall's clinical examination again showed pain to palpation over the left lateral epicondyle and pain resisted wrist extension; however, Petitioner's range of motion and motor function/sensation were normal. *Id.* Because of his numbness and symptoms in his left forearm, Petitioner's cervical spine was examined, and he had some pain to palpation in his neck. *Id.* Dr. Mall recommended a steroid pack along with an MRI of the left elbow. *Id.*

Dr. Mall saw Petitioner back on September 29, 2017, and reviewed the MRI taken at MRI Partners with Petitioner. (PX4, 9/29/17) Dr. Mall's assessment of the MRI as well and the radiologist's interpretation reflected a subchondral cyst as well as some mild lateral epicondylitis. *Id.* Dr. Mall's assessment was left lateral epicondylitis of the left elbow and radicular patellar osteoarthritis. *Id.* Dr. Mall believed that another cortisone injection into the glenohumeral joint was the preferred method of treatment. *Id.* Petitioner returned approximately one month later, and advised Dr. Mall that the injection significantly helped; however, said relief only lasted two weeks. (PX4, 10/23/17) Dr. Mall's examination was similar to those before, and he recommended another cortisone injection into the radiocapitellar joint. *Id.* He wanted to try one additional attempt at treating the area conservatively as opposed to moving forward with surgery. *Id.* When Petitioner returned with only temporary improvement, Dr. Mall recommended one last injection into the elbow joint to see if his symptoms would be relieved in combination with some anti-inflammatory medication. (PX4, 11/27/17)

Petitioner returned on December 27, 2017, for follow up of his left elbow and again stated he got significant relief from the last injection, but for only two weeks' time. (PX4, 12/27/17) Petitioner's symptoms of pain in the lateral aspect of his elbow remained consistent. *Id.* At this point, since all conservative measures had been exhausted, Dr. Mall recommended a left elbow arthroscopy debridement. *Id.*

This was done on February 22, 2018, in the form of an arthroscopic lateral epicondyle debridement and an extensor carpi radialis brevis release. (PX7) During surgery, Dr. Mall debrided the anterior capsule, the carpi radialis brevis, and performed a release from the interarticular space. *Id.* He also debrided the radiocapitellar joint, both anteriorly and posteriorly, where the majority of the chondrosis was noted. *Id.* Dr. Mall noted that there was only minimal arthritis present in the radiocapitellar joint. *Id.* On a follow up visit, Dr. Mall told Petitioner that the vast majority of what he did with the surgery was a release of his extensor carpi radialis brevis tendon to treat the lateral epicondylitis. (PX4, 3/7/18) Dr. Mall recommended range of motion exercises and physical therapy. *Id.*

Follow up visits revealed slow, steady improvement in Petitioner's elbow, but increased pain in his shoulder. (PX4, 4/4/18) The increased shoulder pain was treated with an injection that resulted in significant but only temporary improvement. *Id.*; (PX4, 5/2/18) When another injection produced only temporary relief, Dr. Mall recommended an MRI arthrogram of the left shoulder. (PX4, 5/2/18, 5/16/18) This showed some rotator cuff partial tearing; however, because Petitioner was asymptomatic with respect to the rotator cuff on clinical examination, Dr. Mall diagnosed Petitioner with left shoulder AC joint inflammation, associated with osteoarthritis. (PX4, 7/11/18) On July 11, 2018, Petitioner was placed at maximum medical improvement and released to return to work, full duty. *Id.*

On April 17, 2018, Respondent had Petitioner examined by Dr. Robert Bell. (PX8) He took the consistent history of the injury and reviewed records from Memorial Hospital, Dr. Mall, and MRI Partners of Chesterfield. *Id.* He noted that Petitioner still had some left elbow pain despite surgery and therapy. *Id.* Dr. Bell's examination showed no pain on flexion and extension; however, he noted that Petitioner's pain was localized over the posterolateral aspect of the radial head and around the capitellum. *Id.* He noted some loss of range of motion in Petitioner's left elbow with stiffness and an otherwise a normal examination. *Id.* Dr. Bell believed that Petitioner's "incident of August 22, 2017, would have been an aggravation of his preexisting arthritis/chondrosis" in his left elbow. *Id.* Dr. Bell believed the injections and medication were reasonable to treat Petitioner's elbow symptoms; however, Dr. Bell did not believe the surgery done by Dr. Mall, whose intraoperative findings Dr. Bell omitted from his report, was reasonable and necessary. *Id.* Despite the difference of opinion, he noted that Petitioner had improved following surgery, and only needed to get a little range of motion back before he was back to baseline. *Id.*

At Arbitration, Petitioner testified that despite the improvement from surgery and the injections following surgery, he still has daily soreness in his elbow. (T.17) He experiences this with motions such as using a wrench or screwdriver, opening jars, or loosening light bulbs. (T.17-18) He does not have the full strength back in his arm, and now that he's not participating in therapy or going back to the doctor for further injections, he can only moderate his symptoms by taking over-the-counter medication two to three times per day. (T.18) He demonstrated some

loss of range of motion for the Arbitrator with twisting and bending, and testified that his son helps him with anything that requires heavy lifting. (T.18-19)

Respondent introduced a number of exhibits showing that Petitioner had filed a number of other Worker's Compensation claims. (RX4-RX18, RX21) The Arbitrator noted however, that Petitioner testified at arbitration that he is a long time employee who works the night shift in the city of East St. Louis. (T.18, 13)

CONCLUSIONS OF LAW

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

The law holds that accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003). [Emphasis added]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *A.C. & S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist., 1999) citing *General Electric Co. v. Industrial Comm'n*, 433 N.E.2d 671, 672 (1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

Circumstantial evidence, especially when entirely in favor of the claimant, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724, 728 (1994); *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 910-911 (1982). Causal connection between accident and claimant's condition may be established by chain of events including claimant's ability to perform manual duties before accident, decreased ability to still perform immediately after accident, and other circumstantial evidence. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979). A doctor's testimony is not required to establish causation and the extent of disability when there is a clear causal chain apparent from the evidence and the injury is not of such a nature that it lies beyond the realm of knowledge of a layperson and requires the expertise of a medical expert to comprehend or establish the causal connection. *Gubser v. Industrial Comm'n*, 248 N.E.2d 75 (Ill. 1969); see also *Union Starch & Refining Co. v. Indus. Comm'n*, 224 N.E.2d 856, at 859; *Nunn v. Illinois Indus. Comm'n*, 157 Ill. App. 3d 470, 478, 510 N.E.2d 502, 506 (1987).

The evidence is clear that Petitioner was working with no difficulty prior to the traumatic injury of August 22, 2017, and that as a result of the incident he suffered a disabling injuries that required care and treatment. The only point on which Dr. Mall and Dr. Bell disagree is that of whether the surgery was reasonable and necessary. In addition to the opinion evidence, the

Arbitrator notes that the circumstantial evidence demonstrates a clear chain of events that led to Petitioner's condition of ill-being. Consequently, the Arbitrator finds that Petitioner met his burden of proof on the issue of causal connection.

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

Upon establishing causal connection, employers are responsible for reasonable and necessary medical care required by their employees to diagnose, relieve, and/or cure the effects of injury. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

Petitioner credibly testified at Arbitration that prior to his surgery, his elbow was in constant sharp pain. (T.14-15) He testified that neither three or four months' worth of injections nor the oral steroids were helping. (T.14-15) Dr. Mall likewise noted that Petitioner gained only temporary, transient relief from conservative modalities, which prompted him to recommend and perform surgery. (PX4) Petitioner testified that the surgery and post-operative injections improved his condition. (T.15) The Arbitrator therefore finds that Dr. Mall's surgical recommendation was reasonable and necessary to relieve Petitioner of the effects of his work-related injury.

Based upon the findings above, Respondent is hereby ordered to pay all reasonable and necessary medical expenses contained in Petitioner's group exhibit. Respondent shall have credit for any expenses paid, provided that it agrees to indemnify and hold Petitioner harmless from any claims made by any provider concerning the expenses for which it claims credit.

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

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

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

(ii) **Occupation**: Petitioner continues to serve as a Lieutenant for the East St. Police Department. Given the intensive and high-risk nature of his employment, the Arbitrator places greater weight on this factor.

(iii) **Age**: Petitioner was 45 years old at the time of his injury. He is young and must live and work for a considerable number of years with his disability. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time), the Arbitrator places greater weight on this factor. (AX1)

(iv) **Earning Capacity**: There is no direct evidence of reduced earning capacity contained in the record. The Arbitrator gives no weight to this factor.

(v) **Disability**: As a result of his work accident, Petitioner injured his left upper extremity. He required extensive conservative care and ultimately surgery to the left elbow when his symptoms proved refractory to conservative modalities, as well as an injection to his shoulder after his elbow surgery. (PX4) Despite the improvement from therapy, injections, and surgery, Petitioner continues to have daily soreness in his elbow. (T.17) He experiences this with motions such as using a wrench or screwdriver, opening jars, or loosening light bulbs. (T.17-18) He does not have the full strength back in his arm, and now that he's not participating in therapy or going back to the doctor for further injections, he can only moderate his symptoms by taking over-the-counter medication two to three times per day. (T.18) He demonstrated some loss of range of motion for the Arbitrator with twisting and bending, and testified that his son helps him with anything that requires heavy lifting. (T.18-19) The Arbitrator notes that Petitioner's complaints are fully corroborated and supported by the evidence in the record.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 10% loss of his left arm.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chaz Burkey,
Petitioner,

vs. No. 17 WC 16644

20IWCC0124

Carle Foundation Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and temporary total disability, 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 Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner testified he was a floor maintenance man whose duties included cleaning the floors – waxing, mopping and dust mopping them. On February 13, 2017, as he entered an elevator to bring a floor buffer to the basement, he caught his left ankle on the elevator floor and fell onto his knees. Although Petitioner was initially diagnosed with an ankle sprain, a March 27, 2017 MRI of his ankle revealed a thickening of and abnormal signal with the tibial posterior tendon consistent with tendinosis and a longitudinal tear. Petitioner was treated conservatively with work restrictions, a boot and a brace. Despite that, his ankle pain persisted. Petitioner testified that before his accident, he never experienced that pain in his ankle.

In addition to his left ankle tendon tear, Petitioner was diagnosed with congenital conditions including a pes planovalgus deformity and a gastro-soleus equinus of his left foot, conditions of which he was previously unaware. He was referred to a specialist, Dr. Sean Grambart, who on April 2, 2017 recommended the Petitioner undergo the following left foot and ankle procedures: tendon repair, Achilles tendon lengthening, subtalar joint arthrodesis, talonavicular joint arthrodesis with osteotomy for flatfoot reconstruction, and a calcaneus graft.

Dr. Grambart was deposed on November 17, 2017 and June 22, 2018. At his deposition, he acknowledged Petitioner's three congenital left foot deformities: equinus, flat-footedness and valgus. He testified that those conditions could place stress on Petitioner's posterior tibial tendon. Dr. Grambart opined that although Petitioner's February 13, 2017 work injury was consistent with a soft tissue sprain or twisting injury, his injury aggravated his tendon and necessitated surgery to repair the tendon. The reason Dr. Grambart recommended Petitioner undergo surgical procedures to correct his congenital deformities, in addition to repairing the tendon, was to minimize the pressure on Petitioner's tendon. Dr. Grambart testified that while it might be possible to surgically repair Petitioner's tendon without addressing his congenital foot deformities, he did not recommend doing so because Petitioner's flat foot condition would continue to be a deforming force which could continue to put pressure on Petitioner's tendon and break down the tendon repair. At arbitration, Petitioner testified that he wished to undergo further treatment to his left ankle.

Respondent had Petitioner examined by its expert, Dr. George Holmes on May 2, 2017. At that time, Petitioner complained of pain in his left ankle since his February 12, 2017 work accident. Dr. Holmes diagnosed Petitioner with a pes planus deformity, nonfunctioning posterior tibial tendon, midfoot arthritis and severe hindfoot valgus. At his December 17, 2018 deposition, Dr. Holmes opined that Petitioner's symptoms were not related to his work accident, but rather, to his longstanding pre-existing conditions. Dr. Holmes opined that Petitioner was at MMI, and that his work accident did not cause a ligament tear, effusion of the ankle, edema or hematoma consistent with any significant injury.

The Arbitrator found Dr. Holmes's causation opinion more persuasive: that Petitioner's left foot and ankle condition was causally related to his accident only through May 2, 2017 – the date Dr. Holmes found Petitioner to be at MMI.

The Commission views the evidence differently. Although Petitioner had pre-existing conditions in his left ankle and foot, he had no left foot symptoms or pain prior to February 13, 2017. Petitioner testified that prior to the accident he was unaware of the pre-existing conditions. Dr. Grambart explained why it was necessary to correct Petitioner's congenital deformities concurrently with Petitioner's tendon repair – to increase the likelihood that a tendon repair would not fail.

Employers take their employees as they find them, and even though an employee has a pre-existing condition that makes him more vulnerable to injury, recovery for a work-related accident will not be denied if it can be shown that the employment was a causative factor. *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 205 (2003). The Commission finds Dr. Grambart's opinions reasonable and more persuasive than those of Dr. Holmes. In particular, Dr. Holmes failed to

address or explain what, if not the accident, would have caused Petitioner's ankle to become immediately and continuously symptomatic after his accident, when it had not been before. The Commission finds the need to surgically repair Petitioner's congenital left foot and ankle conditions, in addition to his torn left tendon, to be causally related to his February 13, 2017 work accident.

For the foregoing reasons, the Commission finds that Petitioner proved his medical treatment for his left foot and ankle through the date of arbitration was causally related to his February 13, 2017 accident. The Commission reverses the Arbitrator's finding that Petitioner's medical expenses incurred after May 2, 2017 were not related, and finds the prospective treatment and surgery recommended by Dr. Grambart to be reasonable and necessary.

Because Petitioner was on restrictions which Respondent was unable to accommodate at the time they terminated him, the Commission also finds Petitioner is entitled to TTD benefits between June 25, 2017 and the January 16, 2019 date of arbitration.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 29, 2019, is hereby vacated, the Commission finding that Petitioner proved his current left foot and ankle condition of ill-being is causally related to his February 13, 2017 work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $332.69 per week for a period of 81-3/7 weeks, from June 26, 2017 through January 16, 2019, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay, pursuant to the fee schedule, the $170.00 bill of Carle Physician Group and the $245.00 bill of Carle Foundation Hospital, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective reasonable and related medical care to Petitioner's left foot and ankle, including the surgery recommended by Dr. Grambart, as provided in §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 shall pay to Petitioner interest under §19(n) of the Act, if any.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 24 2020

o-01/09/20
mp/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

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

BURKEY, CHAZ
Employee/Petitioner

Case# **17WC016644**

CARLE FOUNDATION HOSPITAL
Employer/Respondent

20IWCC0124

On 3/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1937 TUGGLE SCHIRO LICHTENBERGER
TODD D LICHTENBERGER
510 N VERMILION
DANVILLE, IL 61832

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY TOMASO
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824

STATE OF ILLINOIS)
)SS.
COUNTY OF **CHAMPAIGN**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHAZ BURKEY
Employee/Petitioner

Case # **17** WC **16644**

v.

Consolidated cases: ______

CARLE FOUNDATION HOSPITAL
Employer/Respondent

20IWCC0124

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

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [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, **February 13, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,466.09**; the average weekly wage was $**499.03**.

On the date of accident, Petitioner was **26** years of age, *single* with **1** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**2,168.96** for TPD, $**0** for maintenance, and $**4,413.11** for other benefits (medical payments), for a total credit of $**6,582.07**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his left foot and ankle is not causally related to the accident at work on February 13, 2017. Petitioner reached maximum medical improvement on May 2, 2017.

Respondent shall pay reasonable and necessary medical services from February 13, 2017, through May 2, 2017, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts previously paid. Respondent did not claim an 8(j) credit.

Petitioner is not entitled to prospective medical care and is not entitled to additional temporary total disability benefits beyond those previously paid.

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

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

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

Signature of Arbitrator

March 27, 2019
Date

ICArbDec19(b)

MAR 29 2019

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CHAZ BURKEY
Employee/Petitioner

20IWCC0124

v.

Case #: **17 WC 16644**

CARLE FOUNDATION HOSPITAL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This cause came before the Arbitrator on Petitioner's Section 19(b) Petition. The parties placed into the dispute the issues of causal connection, past medical treatment, prospective medical treatment, and temporary total disability benefits. The parties stipulated that Petitioner sustained an accident that arose out of and in the course of his employment. The parties further stipulated that at the time of the accident Petitioner was 26 years old, single, had one dependent child, and had an average weekly wage of $499.03. The nature and extent of Petitioner's injuries is not currently at issue.

Petitioner testified that on February 13, 2017, he was employed by Respondent as a floor maintenance person and had been so employed since May of 2016. His duties included cleaning the floors, which consisted of stripping, waxing, mopping, and dust mopping, and which required him to use an electric floor buffer. He described the operation of the buffer, in that he walked behind it and pulled the trigger for it to move. He did not push the equipment, but simply walked behind it. Toward the end of his shift, he was getting into the elevator to take the buffer to the basement. He testified that when it stopped, the elevator was slightly elevated above the floor. As he was getting onto the elevator with the buffer, his left foot caught on this elevated area and he fell inward. His foot and ankle went down, and he fell to his knees on the floor. He got back to his feet and immediately noticed throbbing pain in his left ankle. He put the buffer away and then reported the incident to his supervisor, who instructed him to either go home or go to the emergency room. He thought he could "walk it off" and proceeded to the parking lot, which was about half a mile away. He testified that he felt something wasn't right, so he went to the ER at that time.

Petitioner testified that at the emergency room, he was given work restrictions and advised to follow up with Occupational Medicine, which he did on February 17, 2017. He was diagnosed with an ankle injury and remained on work restrictions. Respondent accommodated his light duty restrictions and placed him in Valet Services on a part-time basis. He returned to the clinic on March 15, at which time he was referred for an MRI and put on restrictions of primarily sit-down work. He had an MRI on March 27, returned to the clinic on March 29, and was referred to Dr. Grambart at that time.

Petitioner testified that he saw Dr. Grambart on March 31, 2017, who advised there was some damage to the ankle and placed restrictions on his work. He continued to work light duty in Valet Services. He returned to Dr. Grambart on June 26, 2017, and was told his treatment options were either surgery or a California brace. He was referred for the prosthetic, and was fitted for it, but did not get the brace because his insurance would not pay for it. When he last saw Dr. Grambart on June 26, his work restrictions remained in place.

Petitioner testified that he was terminated by Respondent on June 25, 2017, because the department he worked in did not allow restrictions and Respondent could not find a place for him. He testified that he has not returned to Dr. Grambart since June 26, 2017, nor has he sought treatment elsewhere, because he does not have insurance or any way to pay for it. He testified that he continues to have problems with his left ankle, including daily pain, and would like to have further medical treatment. He has not looked for work anywhere since he was terminated, as he believes he would need to find a desk job, and that is not within his qualifications.

On cross-examination, Petitioner testified that he had not applied for any work because he did not believe he was qualified. He acknowledged that this was his opinion only and that he had not been told this by a prospective employer. Petitioner testified that he did not recall asking for a boot at the emergency room, rather than the Ace bandage that was recommended, but did not dispute what was contained in the medical record. He acknowledged that Dr. Chen, in Occupational Medicine, advised him that he was flat-footed, and testified that he had never previously been told of this condition. He testified that he did not recall either Dr. Chen or Dr. Grambart discussing with him the details and results of his MRI. He did not know what an equinus deformity or valgus deformity was, nor whether either were present before the accident.

Following the accident, Petitioner presented to Carle Hospital Emergency Department and reported that he twisted his left ankle while stepping onto an elevator at work. He rated his pain at 7/10. On examination, there was moderate swelling and tenderness to palpation surrounding the medial malleolus and slightly distal to the lateral malleolus. There was slightly reduced range of motion of the left ankle, but full range of motion of the toes. Ankle x-rays were negative for fracture, but showed slight atypical positioning of the talonavicular and navicular cuneiform articulations with mild inversion of the normal arch, possibly from pes planus. Assessment was acute left ankle pain. Petitioner advised he did a lot of walking at work and would prefer to have a Bledsoe boot instead of an ACE wrap, and same was applied. He was given work restrictions of no operating machinery and no climbing ladders, and was instructed to follow up with Occupational Medicine. PX1, RX1.

On February 17, 2017, Petitioner presented to the Occupational Medicine Department at Carle and was seen by Dr. Philbert Chen. It was noted that he had injured his left ankle four days prior, that he "evidently inverted the ankle", and actually fell and hit his knee on the ground. He complained of pain over the ankle as well as the knee. Examination of the knee showed tenderness over the lateral knee, full range of motion, and complaints as to the lateral collateral ligaments. There was no swelling or instability. Examination of the ankle showed minimal swelling, no ecchymoses, and complaints both medially and laterally. Assessment was history of left ankle inversion and contusion to the left knee. He was instructed to continue use of the boot, remain seated most of the time, no kneeling, squatting, or climbing, and return in two weeks. PX1, RX1.

Petitioner returned to Dr. Chen on March 3, 2017, and reported increasing discomfort, despite wearing the boot. He noted that his employer had been trying to accommodate him at work, but he was still getting up and moving around, which bothered him. On examination, there was mild swelling over the ankle, "nothing terrible", discomfort with weightbearing, and pain medially and laterally. Assessment was history of a left ankle inversion injury and a contusion to the left knee. Dr. Chen noted that the boot had failed to provide relief, and prescribed a different boot to use. He emphasized that Petitioner should remain seated most of the time, except for when going to the bathroom or for breaks. He changed the work restrictions to sit-down only and use of crutches for significant weightbearing or ambulation. PX1, RX1.

On March 15, 2017, Petitioner returned to Dr. Chen and reported he had been sitting down most of the time, about 90%, but was still having difficulty. He did not feel any better than when he was first injured and stated he could only work four to six hours before his ankle bothered him to the point that he had to go home. On examination, there was tenderness over both the medial and the lateral malleolus, minimal swelling, pain with range of motion, discomfort with weightbearing, and increased pain when on his tiptoes. It was noted that a lot of his pain was concentrated posterior to the lateral malleolus. Assessment was severe ankle sprain, rule out ligamentous tear. Dr. Chen ordered an MRI, continued with sit-down work only, and limited him to four to six hours a day, depending on Petitioner's tolerance. PX1, RX1.

On March 27, 2017, Petitioner underwent a left ankle/hindfoot MRI. It revealed (1) thickening and abnormal signal within the tibialis posterior tendon consistent with tendinosis and a longitudinal tear; (2) fluid collected within the tibialis posterior tendon sheath consistent with reactive change to the tendon injury; (3) possible mild sprain of the calcaneofibular ligament; (4) small amount of focal edema within the abductor hallucis muscle, which may indicate a mild muscular injury. PX1, RX1.

Petitioner followed up with Dr. Chen on March 29, 2017, who reviewed the MRI findings with him. Petitioner reported he was working with the sit-down restrictions but continued to be symptomatic. He was referred to the Orthopedic Foot Clinic for further evaluation and was to remain on the same restrictions in the interim. It does not appear that a physical examination was conducted on this date. PX1, RX1.

On March 31, 2017, Petitioner presented to Dr. Sean Grambart, a podiatrist in the Department of Foot and Ankle Surgery. Dr. Grambart noted that Petitioner was injured at work

when getting onto an elevator that was uneven and he stepped wrong, "had an eversion type of injury" and had immediate pain and tenderness in his left ankle. Petitioner denied having any pain in the ankle prior to the accident. He reported aching, shooting, pressure type pain in the medial and lateral aspects of the left ankle, which he rated as 7/10, and noted he was using Norco for pain control. PX1, RX1.

On examination Dr. Grambart noted there was swelling along the medial ankle area and tenderness along the posterior tibial tendon. Muscle strength was normal and equal to that on the right with plantar flexion and dorsiflexion. Eversion was intact. Inversion was weak, especially when the posterior tibial tendon was isolated. It was noted that Petitioner had gastric soleal equinus bilaterally; collapse of his midfoot bilaterally, worse on the left; and valgus position of the calcaneus bilaterally, worse on the left. Petitioner was unable to do a single heel raise test on the left. Forefoot abduction was noted, as was a fairly rigid flatfoot deformity on the left. The MRI findings were discussed with Petitioner. Ankle x-rays that day showed he had a valgus positioning of his talus, everted positioning of the calcaneus on the tibia, and forefoot abduction on the hindfoot alignment view. PX1, RX1.

Dr. Grambart's assessment was posterior tibial tendon tear, pes planovalgus deformity, and gastric-soleus equinus. He noted that the tendon tear was pretty substantial, and that Petitioner continued to have pain even with immobilization in a boot. He recommended surgery, to include (1) Achilles tendon lengthening; (2) subtalar joint arthrodesis; (3) talonavicular joint arthrodesis with osteotomy for flatfoot reconstruction; and (4) graft of the calcaneus. He noted that he would also repair the posterior tibial tendon tear at the same time, and further noted that "given his flatfoot it would just reoccur again". Petitioner was instructed to continue his current work restrictions. PX1, RX1.

On May 2, 2017, Petitioner was evaluated by Dr. George Holmes at Midwest Orthopaedics at Rush, Respondent's Section 12 examiner. Dr. Holmes obtained a history, reviewed treating records, and performed a physical examination. He noted Petitioner was taking Tramadol, using a Cam Walker boot, and was working light duty. On examination, he noted a pes planus deformity on both feet, somewhat greater on the left. Petitioner had difficulty doing a single heel rise test, had pain in the medial and lateral areas of the ankle, and had pain along the course of the posterior tibial tendon. Ankle and foot x-rays were obtained, which showed significant pes planus deformity "of relatively long duration", midfoot collapse, and hindfoot valgus. RX2, Dep.RX2.

Dr. Holmes opined that, although the extensive reconstruction surgery recommended by Dr. Grambart may be needed for Petitioner, it was not related to the work injury. He articulated several bases for his opinion. (1) He noted that Petitioner's foot configuration was a long-term deformity, present on a long-term basis, that the deformity was not created nor exacerbated by the ankle sprain at work, and that any exacerbation would have been temporary. (2) The Achilles tendinosis was longstanding. (3) The flatfoot deformity was longstanding. (4) The MRI did not show any significant collateral damage. The findings of calcaneofibular ligament (CFL) sprain and posterior tibial tendon dysfunction appeared to be of long-term duration and not an acute process. (5) The equinus deformity, for which Achilles lengthening was recommended, did not occur between the date of accident and the MRI nor the date of the IME.

Dr. Holmes noted that Petitioner was never casted in any equinus position and, therefore, the equinus deformity represented a longstanding equinus, known to accompany patients with longstanding pes planus or flatfoot deformity. RX2, Dep.RX2.

Thought not related to the accident, recommended treatment included trial of a UCBL or an AFO brace, both of which were traditionally used for patients with flatfoot deformity and which could provide a significant amount of relief. If the brace failed to provide relief, reconstruction in terms of a calcaneal osteotomy may be needed. He did not recommend a talonavicular arthrodesis, as the MRI did not demonstrate any arthritis in the joint. He noted that a medial slide calcaneal osteotomy and Achilles lengthening, and possibly a calcaneal lengthening, could be performed without need for a talonavicular arthrodesis. RX2, Dep.RX2.

With regard to restrictions, Dr. Holmes did not believe it was unreasonable for Petitioner to be on light duty, based on his foot configuration. He opined, however, that successful return to work could be anticipated if Petitioner successfully treated with an AFO or UCBL brace. Further, if surgery were undertaken, Petitioner would be off work three to four months. He reiterated that the need for current restrictions and any inability to work would be based on Petitioner's longstanding flatfoot deformity. He opined that, as to the work injury, Petitioner reached maximum medical improvement probably within four to six weeks of the injury. He noted that the MRI did not show any significant acute changes and, as such, there were no objective parameters that indicated an objective exacerbation of Petitioner's longstanding foot deformity. RX2, Dep.RX2.

On June 26, 2017, Petitioner returned to Dr. Grambart. Exam and history were unchanged. Petitioner provided the IME report to Dr. Grambart, and they discussed the findings therein. Dr. Grambart noted that they discussed conservative and surgical treatment options, and that Petitioner advised he would like to try the brace first and try to avoid surgery. Restrictions were continued. PX1, RX1.

Dr. Grambart testified by way of deposition over two different days, November 17, 2017, and June 22, 2018. He is a Board Certified Podiatrist. Dr. Grambart testified consistent with his treating records. He first saw Petitioner on March 31, 2017, upon referral by Dr. Chen. He took a history of the accident from Petitioner, who advised that he was injured when pulling a floor buffer into an elevator that was uneven. He testified that he asked Petitioner how his foot was positioned at the time of the injury and that description, combined with pain complaints on the inside of the ankle, represented an eversion type injury. He described an eversion type injury as one where the ankle rolls toward the center or middle of the body and the outside edge of the foot and the fifth toe are up in the air. Conversely, an inversion injury is where the ankle rolls away from the body and the big toe would be up in the air. PX4.

Dr. Grambart testified that he reviewed the MRI and noted a thickening and abnormal signal within the tibialis posterior tendon, consistent with a longitudinal tear, and some fluid collection within the tendon sheath. He further noted a possible mild sprain of the calcaneal fibular ligament and a small amount of fluid within the abductor hallucis muscle. He testified that with an eversion injury the posterior tibial tendon is stressed, in that as the foot twists, the tendon attempts to keep the foot in line or bring it back towards the inside. PX4.

Dr. Grambart testified that his diagnoses were a posterior tibial tendon tear, flatfoot deformity, a valgus position of the distal tibia, and equinus. He described the tendon tear as "pretty substantial", based on the MRI, swelling, and Petitioner's inability to do a single heel raise test. With regard to the posterior tibial tendon tear, Dr. Grambart testified,

> "*...it's hard to differentiate between acute and chronic with this, just because even if you had something chronic, it would still get swelling or have swelling within the tendon sheath, so I think it's hard to differentiate acute and chronic with these particular injuries just because you will have inflammatory changes no matter what.*" PX4.

When asked what caused the **posterior tibial tendon tear**, Dr. Grambart testified there were "potentially a couple of things" that caused it: (1) Petitioner's congenital abnormalities of flat-footedness, equinus deformity, and valgus deformity, which led to stress on the tendon; and (2) the reported mechanism of an eversion injury. As to what caused the **flatfoot deformity**, he testified that it was a combination of Petitioner's malaligned ankle, which can cause the valgus position, and the posterior tibial tendon tear. He explained that when the tendon tears, the foot becomes flatter, because the tendon is meant to help support the arch and once it tears it is like a stretched-out rubber band that has lost elasticity. As to the cause of the **equinus deformity**, he testified that Petitioner has a tight Achilles tendon, which contributes to a flatfoot deformity, and which puts pressure on the posterior tibial tendon. Dr. Grambart testified that the congenital equinus deformity and congenital valgus position of the distal tibia both put pressure on the foot, causing it to collapse down/flat foot, which also can aggravate the posterior tibial tendon. PX4.

With regard to causation and aggravation, Dr. Grambart testified that the combination of Petitioner's congenital equinus deformity and congenital valgus deformity both put pressure and cause his foot to collapse down (a "flatfoot") and can aggravate the posterior tibial tendon. In addition, an eversion injury can aggravate the posterior tibial tendon as well. He stated, "So he's kind of got a few different things working against him that puts a lot of pressure on his posterior tibial tendon." PX4.

Dr. Grambart testified that he discussed surgical reconstruction with Petitioner, and that Petitioner wanted to avoid surgery if possible. He prescribed an Arizona brace and gave Petitioner work restrictions of mostly sitting. He opined that the need for reconstructive surgery, as respects the "bone work"/realignment of the distal tibia, was congenital. He further opined that the tendon injury was aggravated from work, but noted that, "Given some of his foot structures, it could have just become worse just as he got older and the tendon lost its elasticity over time as well." PX4.

Dr. Grambart testified that Petitioner returned to see him on June 26, 2017, to discuss treatment options and to discuss the IME report. He disagreed with Dr. Holmes' opinion that the work accident merely caused a temporary strain/sprain of the left ankle, noting that the eversion injury would stress posterior tibial tendon area and Petitioner was not having pain prior to this accident. PX4.

On cross-examination, Dr. Grambart agreed that all three of Petitioner's congenital abnormalities (equinus deformity, flat-footedness, and valgus deformity) contributed to cause

undue stress and burden on his posterior tibial tendon. He conceded that it was possible that over time these congenital abnormalities, and specifically the equinus, would have led to posterior tibial tendon insufficiency or dysfunction. He testified that Petitioner "is at higher risk of putting stress on that tendon compared to someone that had a normal arch"; however, he continued to believe that there was an acute injury with the tendon. PX4.

On re-direct, Dr. Grambart testified that Petitioner's accident did not aggravate his congenital issues, but did aggravate the posterior tibial tendon. He stated that if Petitioner proceeded to surgery, simply repairing the tendon would not suffice, as the flat foot and malalignment would continue to place stress on the tendon. PX4.

Dr. Holmes testified by way of deposition on December 17, 2018. He is a Board Certified Orthopedic Surgeon, whose practice is devoted almost 100 percent to treatment of the foot and ankle. Dr. Holmes is a graduate of Yale, both for undergraduate studies and medical school. He is currently Chief of the orthopedic foot and ankle surgery section at Rush in Chicago. He is also head of the fellowship foot and ankle program at Rush and an associate professor at Rush. Dr. Holmes testified consistent with his report of May 2, 2017. RX2.

Dr. Holmes testified that following review of medical records and examination of Petitioner, he diagnosed pes planus deformity and incompetent or nonfunctioning posterior tibial tendon. He explained that Petitioner had arthritis in the midfoot, collapse of the midfoot, severe hindfoot valgus (where the heel turns to the outside, as if walking knock-kneed), arthritic changes, and decreased function of the posterior tibial tendon. He testified that these conditions were of a longstanding duration over a period of several years, based on the MRI, x-rays, and physical examination, and were not caused, aggravated, or accelerated by Petitioner's work accident of February 12, 2017. RX2.

Dr. Holmes testified that the severity of the pes planus deformity, from a forensic standpoint, could not have been initiated at the time of the injury. He explained that if he took any patient and transected the posterior tibial tendon, it was virtually impossible to get the degree of deformity noted on Petitioner's MRI, taken shortly after the injury, in that short period of time. Likewise, it was impossible to get the radiographic findings of arthritis in the foot in that time with immediate findings of no fracture or acute process. Simply put, the findings were so significant that they could not be acute in nature, as it would be impossible to get that degree of deformity in such a small amount of time. RX2.

With regard to whether the accident could have exacerbated the condition, Dr. Holmes testified that the MRI findings did not demonstrate that Petitioner had sustained a collateral injury that could have exacerbated his longstanding condition. Putting it in more simplistic terms, he noted that "you cannot kill a dead horse", meaning you cannot exacerbate the condition of the dead horse. He noted that, although Petitioner may have twisted his ankle in the injury, he did not sustain a ligament tear, an effusion of the ankle, edema, or hematoma that would be consistent with any significant injury, based upon the MRI, but rather sustained only a strain of the left foot and ankle. RX2.

Dr. Holmes testified that Petitioner did require additional care and treatment in the form of extended bracing and then possible surgery, but the treatment would be not be related to the work accident of February 13, 2017. RX2.

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

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Comm'n*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being with regard to his left foot and ankle is causally related to his work accident of February 13, 2017. In so concluding, the Arbitrator finds significant that both Dr. Grambart and Dr. Holmes testified that Petitioner has bilateral congenital conditions of flat-footedness, equinus deformity, and valgus deformity, none of which were caused by or aggravated by his work injury.

The doctors are further in agreement that these pre-existing congenital abnormalities place undue stress on the posterior tibial tendon and that, as a result of this stress, Petitioner's everyday use of his left ankle and foot continues to break down the elasticity of the tendon. The only disagreement between the doctors is whether the work accident caused an aggravation of the condition of the posterior tibial tendon. In this regard, the Arbitrator finds Dr. Holmes to be more persuasive. Dr. Holmes emphasized that the objective evidence of the MRI in March 2017 showed significant degeneration/fluid buildup at the tendon in question, which clearly came about well in advance of the work accident of February 13, 2017.

The Arbitrator finds that Petitioner suffered a simple ankle sprain/strain as a result of his work accident of February 13, 2017, and that he reached maximum medical improvement no

later than May 2, 2017, the date of Dr. Holmes' evaluation. The Arbitrator further finds that Petitioner's conditions of flat-footedness, equinus deformity, valgus deformity, and posterior tibial tendon tear are not causally related to his work accident of February 13, 2017.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the course of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Illinois Worker's Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered from February 13, 2017, through May 2, 2017, that being the date of Dr. Holmes' evaluation, were reasonable and necessary in Petitioner's care and treatment relative to his accident of February 13, 2017. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to providers. The parties further stipulated that no payments were made pursuant to Section 8(j).

The Arbitrator finds that Respondent is liable for medical bills from February 13, 2017, through May 2, 2017, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act and subject to prior payments. Respondent is not liable for medical bills for services rendered after May 2, 2017.

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

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to prospective medical care.

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 parties stipulated that Respondent paid TTD benefits from February 14, 2017, through February 20, 2017, and TPD benefits from February 21, 2017, through June 25, 2017, in the amount of $2,168.96 and is entitled to a credit in that amount. The only period in dispute is from June 26, 2017, through January 16, 2019, the date of arbitration.

In light of the Arbitrator's findings with respect to issue (F), that Petitioner reached maximum medical improvement on May 2, 2017, the Arbitrator finds that Petitioner is not entitled to additional temporary total or temporary partial disability benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA WILLIS,

Petitioner,

vs. NO: 15 WC 19686

STATE OF ILLINOIS DEPARTMENT OF TRANSPORTATION,

Respondent.

20IWCC0125

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability 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 makes the following corrections to scriveners' errors in the Arbitrator's Decision:

- On page three, in the second sentence in the second paragraph, the word "cubical" is changed to "cubicle."
- On page eight, in the first sentence in paragraph one and the last sentence in paragraph two under issue "F," the accident date is changed from "July 25, 2012" to "July 26, 2012."
- On page eight, in the first sentence in paragraph two under issue "F," the date is changed from "July 25, 2012" to "August 30, 2016."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 3, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under Section 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.

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013).*

DATED: FEB 2 5 2020
KAD/bsd
O:01/07/20
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIS, DEBRA
Employee/Petitioner

Case# **15WC019686**

STATE OF ILLINOIS-IDOT
Employer/Respondent

20IWCC0125

On 5/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOCIATES
KATHERINE PERRY
260 E WOOD ST
DECATUR, IL 62523

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

4993 ASSISTANT ATTORNEY GENERAL
CHELSA T GRUBB
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

MAY - 3 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Debra Willis
Employee/Petitioner

v.

State of Illinois - IDOT
Employer/Respondent

Case # **15** WC **19686**

Consolidated cases: _____

20IWCC0125

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Springfield**, on **October 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **July 26, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**47,898.00**; the average weekly wage was $**921.12**.

On the date of accident, Petitioner was **55** 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 under Section 8(j) of the Act. (See Order Language)

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 5, directly to the providers, as provided in Section 8(a) of the Act, and pursuant to fee schedule.

Respondent shall receive a credit for any and all medical bills paid by its group health provider, pursuant to Section 8(j) of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $552.67/week for 15 weeks, because the injuries sustained caused 3% loss of use of the person as a whole, as provided in Section 8(d) (2) of the Act.

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

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

April 29, 2019

MAY 3 - 2019

Signature of Arbitrator Date

20IWCC0125

FINDINGS OF FACTS

Petitioner is a 61-year old former employee of Respondent. The Petitioner testified she work for Respondent for approximately ten years, from February 2007 to September 15, 2016. From 2007 to September 2012, she worked as a Technical Manager II, which she described is a staff assistant position, in the Drug & Alcohol Unit. The Petitioner testified her job duties in both her position with the Drug & Alcohol Unit were to assist in the hiring process of highway maintainers through clerical work. In September 2012, the Petitioner transferred to the Traffic Safety Unit, where she maintained her position as a Technical Manager II performing clerical work. The Petitioner testified that this position involved substantial data entry. The Petitioner testified her daily duties involved looking at files, retrieving files from filing cabinets, making forms, scanning forms, making telephone calls, and typing lots of memos. The Petitioner testified that the memos she types were generally 50 words, unless the applicant had a positive drug test, which would require additional explanation. Her work hours were 8:00 a.m. until 4:30 p.m., but she would work some overtime during the hiring season, which spanned from August to January.

She testified that her position was primarily a desk job. She testified that she transferred work spaces throughout her employment, but on all occasions worked in a cubical. She testified that generally her computer monitor was in the corner of the cubical, and that she worked with a lot of paperwork. The Petitioner testified that both of her positions with the Respondent involved substantial data entry that involved transcribing information in physical forms into Respondent's computer system. She described that she would have papers in all directions, including to the right or left of the computer, on her lap, and occasionally on the floor. She testified she was looking all over her desk, lap and floor to gather information to enter into her computer. The Petitioner testified that she would deal with 500-700 different pieces of paperwork per day. The Petitioner

testified that throughout her employment the paperwork she dealt with was in physical form and was not available electronically on her computer screen.

Petitioner further testified that she was required to make and receive telephone calls as part of her employment. She testified that she did a lot of multitasking, where she would have forms on her desk or lap and reviewing those documents while speaking with district personnel on the telephone to relay relevant information. Petitioner testified that she was on the telephone "at least 70 percent of my workday." Petitioner testified that she held the telephone to her ear by resting the receiver on her neck and shoulder in order to keep her hands free to review papers on her lap or desktop. Petitioner testified that she did not have any padding, cushion, or shoulder guard on her telephone receiver, other than for a short time when she initially started working for Respondent in 2007 before her telephone was changed. She testified that the telephone was replaced some time during the two-year period she worked in her initial work station.

Petitioner testified that she was commuting from Decatur to Springfield for work, which was a 45-minute drive. She testified that she either drove or car pooled to work. She testified that she did not notice anything different about her neck or shoulders while driving opposed to other times.

Petitioner testified that she began noticing lots of pain, burning, and pulling in her neck and shoulders. She initially sought treatment on July 26, 2012 with Laura Law, PA-C at SIU Healthcare. PX 2. Petitioner complained of diffuse neck pain and right shoulder pain radiating into the right wrist for one week. PX 2. She reported the pain was "pulling and burning" but not numb or tingling. PX 2. She rated her pain at 9/10 and stated it worsened throughout the day. PX 2. She reported spending a lot of time on the computer at work entering information and that this work provoked her pain. PX 2. She reported taking over the counter Tylenol that reduced her pain to 6/10. PX 2. She further reported associated headache. PX 2. Petitioner reported that her work station had not undergone and ergonomic evaluation. PX 2. PA-C Law performed a physical examination which revealed right greater than left paracervical muscle tenderness and trapezius and rhomboid tenderness and tightness. PX 2. PA-C Law assessed frozen right shoulder and acute neck pain. PX 2. PA-C Law recommended

the Petitioner undergo an x-ray of her right shoulder and referred her to physical therapy. PX 2.

Petitioner testified that Respondent performed a workstation evaluation per Ms. Law's request. As a result of the evaluation, Petitioner testified that she received a new chair and her workstation was lowered. However, she testified that these changes did not provide any relief in the symptoms in her neck and shoulders.

On August 6, 2012, Petitioner presented to Decatur Memorial Hospital's Sports Enhancement & Physical Therapy for a physical therapy evaluation. PX 3. Petitioner began physical therapy that day and continued to receive physical therapy for her neck and shoulder until November 8, 2012. At her last appointment, Petitioner noted that she was feeling better, but still didn't feel "right."

On August 21, 2012, Petitioner returned to SIU Healthcare and was examined by Dr. John Bradley. PX 2. Petitioner reported that physical therapy was helping her neck and shoulder pain. PX 2. Dr. Bradley prescribed Cyclobenzaprine for neck and shoulder pain. PX 2.

On September 9, 2014, Petitioner returned to SIU Healthcare and was evaluated by Dr. Roshan Patel. PX 2. Petitioner reported right shoulder pain along the trapezius muscle that occasionally radiated down into the biceps groove and into the supinator muscle of the right forearm. PX 2. Petitioner reported similar pain the previous year that was managed conservatively with NSAIDs and physical therapy. PX 2. On physical examination, Dr. Patel noted some mild tenderness in the right trapezius area, pain with passive range of motion, and tenderness in the right deltoid. PX 2. Dr. Patel assessed unchanged right shoulder pain. PX 2. Dr. Patel recommended that Petitioner undergo additional physical therapy and ordered a right shoulder x-ray. PX 2. Dr. Patel's evaluation and recommendation for treatment were discussed with an agreed to by Dr. Patel's attending physician, Dr. Cesar Arguelles. PX 2.

On September 14, 2014, Petitioner underwent an x-ray of her right shoulder at SIU Healthcare. The x-ray showed mild degenerative change of the right shoulder but was otherwise negative.

On October 10, 2014, Petitioner returned to DMH Sports Enhancement & Physical Therapy. She reported

right shoulder pain. She began physical therapy that day and continued to receive physical therapy for her shoulder until November 28, 2014.

Dr. Cesar Arguelles testified via his evidence deposition, entered into evidence as Petitioner's Exhibit 4. Dr. Arguelles testified he is a board-certified family medicine physician with a certificate of added qualification in sports medicine. PX 4, p. 6. Dr. Arguelles testified that he had not personally examined Petitioner, but that he was indirectly involved in her care as he was the attending, or supervising physician over Dr. Patel. PX 4, p. 7. He noted that in the initial July 26, 2012 visit with Laura Law, Petitioner reported that she believed her job was exacerbating her neck and shoulder pain. PX 4, p. 10. Dr. Arguelles noted that Petitioner had reported that she spends a lot of time on the computer entering information. PX 4, p. 10. Dr. Arguelles further testified that Petitioner's employment was provocative of her symptoms, although not causative of her condition. PX 4, p. 12. Dr. Arguelles testified that working a desk job can contribute to shoulder pain because anything of a repetitive nature regarding the shoulder can contribute to existing shoulder pain. PX 4, pp. 19-20.

Petitioner was laid off by Respondent in 2016. She is currently employed by Homework Hangout, a training institute in Decatur, Illinois that assists the youth population between 16 and 24 years of age obtain job training and employment. Petitioner testified that she began her employment with Homework Hangout around January 15, 2017, and she is employed as a case manager for the Youth Employment Program. She testified that her current job duties involved reviewing program participant's applications for work programs and making recommendations that they either be hired or placed into a training program. She further testified that she travels to some work sites to pick up and drop off time sheets for the employed youth, but that she does not spend "a good portion" of her time driving. Additionally, the Petitioner provides training on Tuesdays and Thursdays from 4 to 7 p.m. Petitioner testified her current work hours are from 9:00 a.m. to 7:00 p.m. Monday through Thursday.

CONCLUSIONS OF LAW

Issue C: Did an accident occur that arises out of and in the course of the Petitioner's employment with the Respondent?

After a review of the entirety of the evidence, the Arbitrator finds that Petitioner did sustain a repetitive trauma accident with a manifestation date of July 26, 2012, which arose out of and in the course of Petitioner's employment by Respondent. The Arbitrator primarily relies on the testimony of Petitioner regarding her job duties and the testimony of Dr. Arguelles in rendering this decision. Petitioner testified that throughout her employment with Respondent she performed primarily data entry and clerical work. She testified that she would have papers in all direction, including to her right and left, on her lap, and occasionally on the floor. Petitioner testified that she was constantly moving her head around to look at various papers in order to synthesize information to enter into her computer software. Petitioner testified that she dealt with a large volume of paperwork, up to 500 to 700 pieces of paperwork per day. Further, Petitioner testified that she spent 70 percent of her work day on the telephone, and that she held the receiver on her neck and shoulder in order to keep her hands free. Petitioner further testified that she did not have a shoulder guard for the majority of her employment with Respondent. The Arbitrator finds that Petitioner testified credibly and has no reason to dispute that the Petitioner accurately described her job duties.

Dr. Arguelles testified that he believed Petitioner's employment was provocative of her symptoms, although not causative of the condition. Px 4, p. 12. Further, Dr. Arguelles testified that working a desk job can contribute to shoulder pain where there is repetitive use of the shoulder. PX 4, pp. 19-20. The Arbitrator finds that Petitioner has established repetitive use of the shoulder, primarily in holding the telephone with her shoulder and neck to her ear for 70% of her day for a period of approximately five years prior to the accident.

The Arbitrator notes that in order to find causation for a repetitive trauma injury, the Arbitrator need only find that the employment aggravates a pre-existing condition, not that the employment necessarily caused the condition. The Arbitrator finds ample evidence in the record to indicate that Petitioner's work activities aggravated a pre-existing condition to her neck and shoulders causing a flair up in symptoms.

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

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her July 25, 2012 work accident. The Arbitrator notes that Petitioner sustained a second, fall related accident at work on August 30, 2016. Petitioner testified that at that time the symptoms in her neck and shoulders became much worse. The Arbitrator finds this fall incident to be an intervening accident which severs causal connection for the prior injury.

However, the Arbitrator does find that Petitioner's condition up to July 25, 2012, was causally related to the injury. Petitioner testified that she had ongoing symptoms to the neck and shoulders throughout her medical treatment, which is supported by the medical records. Upon release from physical therapy for the shoulder on November 28, 2014, Petitioner continued to have ongoing pain complaints. Due to Petitioner's ongoing pain complaints through November 28, 2014, the Arbitrator finds that Petitioner's condition up until August 30, 2016, is related to her July 25, 2012, work accident.

Issue J: Were the medical services that were provided to the Petitioner reasonable and necessary

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

After a review of the entirety of the evidence, the Arbitrator finds that the medical services provided, as set forth in Petitioner's Exhibits 2 and 3, constitute reasonable and necessary medical treatment for Petitioner's work-related injury.

Petitioner's medical bills are set forth in Petitioner's Exhibit 5. Respondent is ordered to pay the medical bills set forth in Petitioner's Exhibit 5, directly to the providers, according to the fee schedule, as set forth in the Act. Respondent shall receive a credit pursuant to Section 8(j) of the Act for bills paid by its group health insurance.

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

With regards to nature and extent of the injury, the Arbitrator looks to the five factors as this is a post September 2011 case. With regards to the first factor, impairment rating, the Arbitrator finds that no impairment rating was made with regards to this case. Therefore, the Arbitrator gives no weight to this factor.

With regards to the second factor, occupation of the injured employee, the Arbitrator finds that Petitioner was employed as a Technical Manager II, which was primarily a clerical position involving data entry and desk work. The Arbitrator finds there was nothing labor intensive about Petitioner's employment. The Arbitrator further notes that Petitioner was subsequently laid off from her employment with Respondent and has obtained alternative employment as a case manager for Homework Hangout, which the Arbitrator finds is an equally non labor-intensive position. As the Arbitrator finds no evidence that the injury has prevented Petitioner from continuing with the same type of work, the Arbitrator places less weight on this factor.

With regards to the third factor, age of Petitioner, the Arbitrator finds that Petitioner was 55 years old at the time of the accident. The Arbitrator gives less weight to this factor as the Arbitrator has found that the injury

has not harmed employment prospects or Petitioner's ability to work.

With regards to the fourth factor, future earning capacity, the Arbitrator finds that Petitioner has not established a reduced earning capacity. She continues to work full time and would have been able to continue her work with Respondent if she had not been laid off. The Arbitrator therefore gives less weight to this factor.

With regards to the final factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner continued to experience pain and discomfort in her right shoulder and trapezius area. PX 2. Although physical therapy had alleviated her pain to an extent, the affects of physical therapy were short term and did not entirely relieve her pain. PX 2. In her last office visit with Dr. Patel, Petitioner was found to have mild tenderness in the right trapezius area, pain with passive range of motion, and tenderness in the right deltoid. PX 2. Dr. Patel noted her right shoulder pain was unchanged. PX 2. Petitioner underwent additional physical therapy at that time. However, her final physical therapy notes show that Petitioner was tender to touch of the right elbow and was having ongoing symptomology. PX 3. For the foregoing reasons, the Arbitrator gives greater weight to this factor.

After an assessment of all of the factors, the Arbitrator finds that Petitioner has sustained 3% loss of use of the person as a whole under section 8(d) (2) of the Act as a result of her work-related accident of July 25, 2012. As such, Respondent shall pay Petitioner $552.67 per week for a period of 15 weeks representing 3% loss of use of the person as a whole under section 8(d) (2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA WILLIS,

Petitioner,

vs. NO: 16 WC 33417

STATE OF ILLINOIS-IDOT,

Respondent.

20IWCC0126

DECISION AND OPINION ON REVIEW

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

The Commission strikes the paragraph on page 10, under issue "F: Is the Petitioner's current condition of ill-being causally related to the injury?" and substitutes the following: "As the Arbitrator denied Petitioner's claim for compensation because Petitioner's fall did not arise out of and in the course of her employment with Respondent, all other issues are moot."

Further, the Commission makes the following corrections to scriveners' errors in the Arbitrator's Decision:

- On page 5, paragraph one, the treatment date "September 14, 2009" is changed to "September 21, 2011."
- On page 8, paragraph two, the accident date is changed from "July 23, 2012" to "July 26, 2012."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 3, 2019, as modified above, is hereby affirmed and adopted.

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

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

Pursuant to Section 19(f)(1) of the Act, this decision is not subject to judicial review. *820 ILCS 305/19(f)(1) (West 2013)*.

DATED: FEB 2 5 2020
KAD/bsd
O:01/07/20
42

Kathryn A. Doerries

Thomas J. Tyrrell

Marie E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIS, DEBRA
Employee/Petitioner

Case# **16WC033417**

STATE OF ILLINOIS-IDOT
Employer/Respondent

20IWCC0126

On 5/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOCIATES
KATHERINE PERRY
260 E WOOD ST
DECATUR, IL 62523

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
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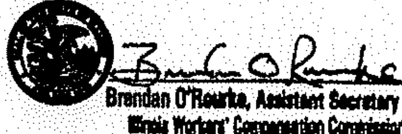
SPRINGFIELD, IL 62794-9208

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

MAY - 3 2019



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

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

Debra Willis Case # **16** WC **33417**
Employee/Petitioner

v. Consolidated cases:

State of Illinois- DOT
Employer/Respondent

20IWCC0126

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Springfield**, on **October 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 **August 30, 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 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 $**53,999.92**; the average weekly wage was $**1038.46**.

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 under Section 8(j) of the Act.

ORDER

Petitioner failed to bear her burden of proving by the preponderance or greater weight of the evidence that she sustained an accident arising out of and in the course of her employment and that her current condition of ill-being is causally connected; and, therefore, all claims for 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

April 29, 2019
Date

ICArbDec p. 2

MAY 3 - 2019

Findings of Facts

On August 31, 2016, Petitioner, Debra Willis, filled out an employee's notice of injury form for an accident on August 30, 2016, wherein Petitioner claims that she was walking to her car in the parking lot at the Illinois Department of Transportation when her shoe heel caught in a hole in the pavement and she fell injuring her left knee, shoulder, neck, left and right hands. (RX1) On October 31, 2016, Petitioner filed an Application for Adjustment of Claim for the injury listing her hands, shoulders, knees, and neck as the effected body parts.

Petitioner testified that she currently works for a program called Homework Hangout located in Decatur, Illinois. In that position Petitioner is a case manager for a youth employment program. Petitioner testified that she began working at Homework Hangout in January 2017. Petitioner testified that prior to her employment with Homework Hangout she worked for the State of Illinois, Department of Transportation from February 20017 through September 15, 2016. (TX 15-16)

Accident

Petitioner testified that after completing her work shift on August 30, 2016, she was exiting the building and walking to her car when her shoe "got caught in a hole in the pavement." (TX 29) Petitioner testified that both knees struck the ground and she put her hands out to break her fall. (TX 30) Petitioner testified that she did not have an assigned parking space, specifically stating "[y]ou park whatever is open to you other than visitor's parking or assigned staff parking or handicapped." (TX 32) Petitioner testified that she was not directed which entrance into the building she must use and tried to choose a parking spot that was closest to whichever entrance she planned to use. (TX 50-52) Petitioner's fall was witnessed by Magdalena Sparovich who filled out a witness report and this report was entered into evidence as Respondent's exhibit 4.

Petitioner testified that she initially treated for the injuries on September 2, 2016, with her primary care physician, Laura Law. Petitioner testified that she "felt terrible because of all the pain in my shoulders and my legs and my neck." (TX 34)

Medical treatment prior to the date of accident

Petitioner testified that she started to experience pain in her neck and shoulders and she initially sought medical treatment on July 26, 2012 with Laura Law at SIU. Submitted as Respondent's exhibit 2, is an initial medical report by Laura Law dated August 9, 2012, with a date of service on August 8, 2012. The report notes "no accident, has had R shoulder pain intermittently for years. . . hx of R arm pain (921/11), hx R frozen shoulder (11/3/11). . . diagnosis is frozen shoulder. . . no injury identified, has had same recurrent pain for over a year-not related/caused on the job but may be exacerbated by her work station. . . patient failed to get R shoulder x-ray done (ordered 7/26/12) . . . never given any work restrictions." (RX 2) Petitioner testified that she attended physical therapy and an ergonomic study of her work station was ordered which resulted in her receiving a new office chair. Petitioner testified that she did not experience any relief from the new chair. Petitioner testified that she attended physical therapy, but no surgery was ever performed. Petitioner's medical records indicate that on July 26, 2012, Petitioner rated her pain as a 9/10.

Medical Treatment

Petitioner's medical records for treatment of her shoulder and neck pain date back to February 11, 2009.

Petitioner treated on September 14, 2011, for left shoulder pain, which Petitioner stated starts while driving, and no other injury.

Petitioner then treated on September 14, 2009, with Joel Williams for right arm pain and neck pain. The note indicates she "cannot think of any particular trauma but thinks she may have bumped herself while getting into or out of her car."

Petitioner treated on September 29, 2011, for right arm pain, and shoulder pain. Petitioner indicated that head movements do not make it worse, but that it is affecting her blood pressure. An EMG was ordered.

Petitioner saw Dr. Bradley on October 11, 2011, for right arm pain and was diagnosed with frozen shoulder. An x-ray of the shoulder was ordered however Petitioner never went to get the x-ray.

Petitioner participated in physical therapy at Decatur Memorial Hospital's Sports Enhancement & Physical Therapy from August 6, 2012, through November 8, 2012. At her final appointment, the Petitioner noted she still didn't feel "right." (PX 2)

On August 21, 2012, Petitioner treated with Dr. Bradley and reported that the physical therapy was helping. She was prescribed Cyclobenzaprine for neck and shoulder pain. (PX 2)

On September 9, 2014, Petitioner treated with Dr. Patel. Petitioner reported right shoulder pain that radiated down into the biceps. Petitioner reported similar pain the previous year that was managed conservatively with NSAIDs and physical therapy and Dr. Patel diagnosed unchanged right shoulder pain. Dr. Patel recommended additional physical therapy and ordered a right shoulder x-ray. (PX 2)

On September 14, 2014, Petitioner underwent an x-ray of her right shoulder which showed mild degenerative change of the right shoulder, but was otherwise negative.

On October 10, 2014, Petitioner returned to DMH Physical Therapy wherein she reported right shoulder pain. Petitioner participated in physical therapy for her shoulder from October 10,

2014, through November 28, 2014.

Medical treatment subsequent to the date of accident

Petitioner treated with Laura Law, PA-C on September 2, 2016, November 11, 2016, and March 7, 2016. On November 11, 2016, Petitioner treated with Laura Law and reported her pain at worst was 8/10, she forgot to pick up the Fexiril pain medication prescription, and denied radicular pain into arms, reported no upper extremity paresthesias, and no loss of grip or arm strength. (RX 8)

Petitioner treated with Dr. Randy Stoklas, a psychologist, from September 21, 2016, through December 29, 2016 for stress, anxiety, and difficulty sleeping secondary to pain. (PX 3)

Petitioner completed physical therapy at Decatur Memorial hospital from October 4, 2016 through January 31, 2017. (PX 4) Petitioner testified that she received physical therapy for her "both shoulders, my neck, upper back area, my knees." (TX 37)

Petitioner treated with Dr. Justin Parker at SIU on December 12, 2016, and May 11, 2017. On May 11, 2017, Petitioner treated with Dr. Justin Parker at SIU. On this date Dr. Parker indicates "patient's knee discomfort has resolved," the MRI revealed some degree of underlying cervical spine arthritis and degenerative disc disease. (RX 8)

Petitioner treated with the Millennium Pain Center at Decatur Memorial Hospital on March 24, 2017; April 6, 2017; and April 28, 2017; June 7, 2017; and June 20, 2017. On March 25, 2017, Petitioner filled out an intake form for Millennium Pain Center, wherein Petitioner circled that she had back, neck, and head pain. Petitioner did not circle leg, arm, or other pain. On that form Petitioner marked "I have slight problems walking about" and "severe pain or discomfort" and "moderate problems doing my daily activities." (RX 6) Petitioner was prescribed Gabapentin and Tizanidine for pain but did not fill her prescriptions. (RX 6).

Current Condition of ill-being

On May 11, 2017, Dr. Parker indicated that "patient's knee discomfort has resolved," the MRI revealed some degree of underlying cervical spine arthritis and degenerative disc disease. (RX 8)

On direct examination, Petitioner testified that her last date of treatment was June 20, 2017, and that her pain was "mainly the shoulders and neck." (TX 40) Petitioner testified that she was currently taking prescription medication, but she could not identify it, and also Tylenol PM, as well as using pain creams. Petitioner testified that there was not anything she was unable to do at her current job secondary to pain. (TX 41)

The last date of treatment reported for Petitioner's hands was September 2, 2016. (PX 2)

Causation opinion from medical experts

At the request of Respondent, Dr. Williams examined Petitioner on July 5, 2018. Dr. Williams also reviewed Petitioner's records dating back to 2011 through June 20, 2017. During the physical exam, Dr. Williams noted Petitioner had full cervical range of motion with what appeared to be radiculopathy into her shoulders with no atrophy. Petitioner had full range of motion of both wrists and had a negative Tinel's, negative Phalan's, and negative median nerve compression tests on both wrists. Petitioner had negative Tinel's at the cubital tunnel and negative elbow flexation.

Dr. Williams opined that Petitioner has a trapezial spasm, which she has had since at least February 11, 2009. Dr. Williams further noted that in regards to Petitioner's shoulder Petitioner may have had a temporary exacerbation of a pre-existing problem, which he believed to be essentially resolved. Dr. William's did not provide an opinion on Petitioner's cervical spine or knees.

No records were presented by Petitioner that addressed causation for Petitioner's current condition of ill-being. Petitioner reported throughout her medical history that she had fallen and the fall is noted by physicians throughout her treatment however Petitioner's cervical injuries and shoulder were never connected to her fall. Dr. Parker diagnosed Petitioner with cervical spine arthritis and degenerative disc disease. Dr. Parker did not opine that the arthritis or the degenerative disc disease were related to, or aggravated by, Petitioner's fall. Petitioner's primary care PA, Laura Law, did not opine that Petitioner's symptoms were caused by or aggravated by Petitioner's fall. Laura Law declined to write Petitioner an off work slip. Laura Law's notes indicate Petitioner was off work, because Petitioner reported that she could not work due to pain; however, Laura Law never took Petitioner off work.

Petitioner's treating physician, Dr. Arguelles, was deposed on July 25, 2018. Dr. Arguelles opined that he did not have enough information to determine if Petitioner's job duties were a cause of Petitioner's pain. All of the questions of Dr. Arguelles were related to Petitioner's accident date of July 23, 2012. Dr. Arguelles was not asked any questions about Petitioner's current condition of ill-being as it relates to the claim at bar.

Conclusions of Law:

An employee bears the burden of proof to establish the elements of the right to compensation. *Board of Trustees of University of Illinois v. Industrial Comm'n,* 44 Ill.2d 207, 214 (1969).

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

Proving an accident occurred that arose out of employment is a Petitioner's burden of proof and is necessary for finding an accident compensable. *Baggett v. Industrial Comm'n, 201 Ill.2d 187, 266 Ill.Dec. 836, 755 N.E.2d 908 (2002).* It is well settled law in Illinois that for an accident to "arise out of" one's employment, an injury "must (1) have an origin in some risk connected with or incidental to the employment; or (2) be caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment." *Wal-Mart Stores, Inc. v. Industrial Comm'n, 206 Ill.Dec. 585, 590, 326 Ill.App.3d 438, 434-44 (2001), citing Dodson v. Industrial Comm'n, 308 Ill.App.3d 572, 575-76, 241 Ill.Dec. 850, 720 N.E.2d 275, 278 (1999).*

When leaving after her shift, Petitioner fell in the parking lot when her shoe heel stuck in a hole in the sidewalk. The parking lot where she fell was open to the public and had several parking spots designated for visitors. Petitioner testified those public spots were located in the same lot where she was parked. Petitioner did not meet her burden of proof to establish that Respondent owned the parking lot as no evidence was presented in regards to ownership of the parking lot. Petitioner did not meet her burden of proof to establish that Respondent maintained the parking lot as no evidence was presented in regards to who was responsible for maintenance of the parking lot. Petitioner confirmed in her testimony that Respondent provided no instructions as to where Petitioner was to park, or which door Petitioner was required to use, or which route Petitioner was required to take to get to her vehicle. Petitioner failed to provide any evidence that Respondent owned, controlled, or maintained the parking lot or the building in which she worked.

Conclusion

Petitioner's claim for compensation is denied because Petitioner's fall did not arise out of and in the course of her employment with Respondent.

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

For all of the above reasons, Petitioner failed to offer any evidence regarding causation with regard to this instant accident claim. Therefore, the Arbitrator denies this claim for compensation.

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

RUTH ANN HEBERLEIN,

Petitioner,

v. NO: 02 WC 49523
02 WC 49524

HOMECARE MEDICAL EQUIPMENT,

Respondent.

20IWCC0127

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Adams County. The Circuit Court found that the bankruptcy filings initiated by Respondent did not discharge Petitioner's worker's compensation claims and remanded the matter to the Commission with specific instructions to address whether Travelers Property Casualty Company of America, f/k/a The Travelers Indemnity Company of Illinois ("Travelers") can be added as a party respondent at this stage in the proceeding. Additionally, the Circuit Court stated "With this remand, the court expresses no opinion regarding notices sent and what notices were received, whether the claimant timely pursued her claim or any of the other myriad reasons in defense that the employer has urged upon the Commission. All of these issues are ones which can and should be decided by the Commission." *Circuit Court Order, p. 14.*

Procedural History

Petitioner filed four Applications for Adjustment of Claim: 1) 95 WC 17687, D/A- 08/17/1994, Respondent- Quincy Medical Group ("QMG"); 2) 97 WC 35281, D/A- 09/11/1994, Respondent- QMG; 3) 02 WC 49523, D/A- 09/30/1999, Respondent- Homecare Medical Equipment ("HME"); and 4) 02 WC 49524, D/A- 10/01/1999, Respondent- HME. All four matters

were consolidated on September 1, 2004. On February 2, 2005, all four matters were dismissed. On June 1, 2005, the Arbitrator entered an order reinstating case numbers 02 WC 49523 and 02 WC 49524 and denying reinstatement for case numbers 95 WC 17687 and 97 WC 35281; this order was subsequently affirmed by the Illinois Workers' Compensation Commission ("the Commission").

On May 20, 2009, an *ex parte* hearing was conducted regarding case numbers 02 WC 49523 and 02 WC 49524. On June 11, 2009, the Arbitrator issued a decision finding Petitioner permanently totally disabled as of April 1, 2005 and awarding penalties and fees. On October 29, 2012, Petitioner's attorney directed correspondence via certified mail to HME providing a copy of the decision and demanding payment of the award.

On September 23, 2014, Petitioner filed a Petition for Penalties and Fees premised on HME's failure to pay the award. On May 13, 2015, HME filed a Motion to Vacate the Award. Hearings were conducted on August 6, 2015; October 15, 2015; and December 21, 2015. On March 4, 2016, the Commission entered an order denying HME's Motion premised on its lack of jurisdiction due to HME's prior bankruptcy filings as well as finding it lacked jurisdiction to rule on Petitioner's Petition for Penalties and Fees.

Thereafter, a timely appeal was filed to the Circuit Court of Adams County. On April 28, 2017, the circuit court entered an order finding HME's bankruptcy filings did not discharge its liability for the award entered on June 11, 2009 and further remanding the matter to the Commission to determine if Travelers can be named as a party to the action and for ruling on all other issues pending before the Commission.

On November 29, 2017, Petitioner filed two Amended Applications for Adjustment of Claim for 02 WC 49523 and 02 WC 49524 naming Travelers as a party respondent along with HME. On April 11, 2018, Commissioner Coppoletti dismissed the Amended Applications of Adjustment of Claim emphasizing no ruling was yet made by the Commission as to the propriety of naming Travelers as a party respondent and finding Petitioner's actions an improper attempt to usurp the Commission's authority.

All Motions and Petitions, specifically including Travelers' Motion to Dismiss; HME's Motion to Vacate the Award; and Petitioner's Petition for Penalties and Fees were fully briefed and argued on April 11, 2018 before Commissioner Coppoletti in Springfield, Illinois.

Statement of Facts

August 6, 2015 Hearing Date

On August 6, 2015, the parties appeared before former Commissioner Basurto for a joint hearing on Respondent's Motion to Vacate Arbitration Decision and Petitioner's Motion for

Penalties and Fees to Enforce Arbitration Decision. As Petitioner was medically unable to appear, the hearing proceeded solely on Respondent's motion. Prior to the taking of testimony, a copy of Respondent's motion and the seven exhibits attached thereto was admitted into evidence as Respondent's Exhibit 1. 8/6/2015 Trans., p. 8.

Suzette Martin (hereinafter referred to as "Martin") was called to testify on Respondent's behalf. Martin is a location manager for Homecare Medical Equipment (hereinafter referred to as "HME"), a position she has held since July 1, 2003. 8/6/2015 Trans., p. 9-10, 18. Martin began working for HME on April 16, 1998. 8/6/2015 Trans., p. 9. Martin testified that from 1998 through November 1, 2004, HME was located at 1026 Maine Street in Quincy; since November 1, 2004, HME has been located at 2439 Broadway in Quincy. 8/6/2015 Trans., p. 9-10. She explained that when HME moved from 1026 Maine Street to 2439 Broadway Street, the United States Postal Service forwarded HME's mail to the new location for a short time, possibly six months. 8/6/2015 Trans., p. 37.

Martin testified she opens all the mail received at HME. 8/6/2015 Trans., p. 13. She also stated she makes copies of the mail. 8/6/2015 Trans., p. 14. When asked if she had an opportunity to review the records she has maintained since 2003 regarding workers' compensation claims against HME in the Quincy location, Martin responded she "reviewed all the ones that I have," and the first notification she received regarding Petitioner's claims was a hearing notice in 2014. 8/6/2015 Trans., p. 14. Presented with Petitioner's Counsel's October 29, 2012 letter to HME and attached Certified Mailing return receipt, Martin identified her signature on the green card. 8/6/2015 Trans., p. 15. Martin testified she remembered receiving the letter and signing for it, but she did not have a copy of it in her records. 8/6/2015 Trans., p. 15-16.

On cross-examination, Martin explained that Russell Shuck was location manager at the Quincy HME from 1999 to March 2003; thereafter, from March 2003 through June 30, 2003, Michelle James was location manager. 8/6/2015 Trans., p. 21. Martin testified that Shuck still worked for HME as a customer service representative. 8/6/2015 Trans., p. 24. She had no knowledge of what Shuck did with any mail regarding workers' compensation claims when he was location manager, nor did she know what was done with any letters or notices regarding workers' compensation claims prior to when she became location manager on July 1, 2003. 8/6/2015 Trans., p. 26, 37.

Martin explained, when she receives mail regarding a workers' compensation claim, she forwards it to the corporate legal office in Orlando; the current process is to scan and email the document but prior to 2012, she would send it via UPS. 8/6/2015 Trans., p. 27-29. She did not maintain a record of the workers' compensation documents she sent UPS. 8/6/2015 Trans., p. 31. Martin testified she did not have a record of emailing the October 29, 2012 letter, so it was sent UPS. 8/6/2015 Trans., p. 32.

Respondent next called Lorraine McClarty (hereinafter referred to as "McClarty") to testify. McClarty is Unit Manager at Traveler's. 8/6/2015 Trans., p. 49. She testified as to Traveler's general claim reporting procedures.

McClarty stated her research showed HME was a Traveler's insured in 1999. 8/6/2015 Trans., p. 52. As to information regarding Petitioner's claims, McClarty explained, "What I did was I looked up the injured party's name and I saw this current claim that appears to have been reported to us January 22nd of [2015]." 8/6/2015 Trans., p. 54.

On cross-examination, McClarty testified her job title in 1999 was claim professional. 8/6/2015 Trans., p. 55. She agreed in 1999, if an employee reported an injury to a Traveler's insured employer, the employer was to contact Traveler's. 8/6/2015 Trans., p. 55-56. This was done via phoning the call reporting center or occasionally submitting the information via mail. 8/6/2015 Trans., p. 56. McClarty testified neither HME nor any corporate entity related to HME reported Petitioner's claims to Traveler's until January 22, 2015. 8/6/2015 Trans., p. 63. She then explained what would be done if an injury is reported where the employer and insured's name differ:

> If you were to call me and ask if I have a claim for your injured worker and you gave me the name of an insured whether it be Homecare or Integrated, we would take down the information and report a claim, and then we would investigate it to determine if we do have a policy. So we still set up a claim. 8/6/2015 Trans., p. 66.

McClarty further stated Traveler's is able to cross index corporate subsidiaries: "There is a part of the system that we can type in a name; if it's the corporate name we can find the entity or subsidiary within the corporate name." 8/6/2015 Trans., p. 67-68.

Steven Burres (hereinafter referred to as "Burres") was next called to testify on Respondent's behalf. Burres is assistant general counsel at Rotech Healthcare. 8/6/2015 Trans., p. 69. Burres testified Homecare Medical Equipment is a "doing business as" of Responsive Home Healthcare, Inc. 8/6/2015 Trans., p. 70. The entity is a subsidiary of Rotech. 8/6/2015 Trans., p. 70. Burres explained Integrated Health Services purchased Rotech around 1999, resulting in Rotech inheriting Integrated's debt; Rotech filed for bankruptcy in 2000 and again in 2013. 8/6/2015 Trans., p. 70-72.

Burres confirmed he heard Martin's testimony regarding forwarding workers' compensation documents to the corporate legal office in Orlando. 8/6/2015 Trans., p. 73. He further confirmed he works in the corporate legal office and has access to the workers' compensation records maintained there. 8/6/2015 Trans., p. 73. Burres testified he searched those records for a claim by Petitioner "and there never was one"; the only documentation he located was the 2012 letter signed for by Martin and a 2014 hearing notice sent to that office. 8/6/2015

Trans., p. 74. He reiterated no documentation of Petitioner's claim was received prior to 2012. 8/6/2015 Trans., p. 75.

On cross-examination, Burres explained the proper procedure for reporting injuries is the manager files an incident report which is forwarded to the insurance company. 8/6/2015 Trans., p. 81. In Petitioner's case, he has no documentation of that happening. 8/6/2015 Trans., p. 81. Burres reiterated he reviewed the legal department's file and testified it does not contain the October 29, 2012 letter that Martin stated she forwarded via UPS. 8/6/2015 Trans., p. 83. Burres then stated there was no file: "We actually didn't have a file on Ruth Ann Heberlein because there was never a worker's compensation claim, so there was never any benefits paid out to Ruth. I believe she went on FMLA when she was apparently injured, so there would be no records." 8/6/2015 Trans., p. 83. He then explained his basis for stating Petitioner was on FMLA:

> When I initially got the E-mail from Ms. Martin I asked our risk management person oh, we have a hearing coming up, you need to forward it to our insurance company so they can be present. And they came out and said we have no record of this claim, and I said - - that's what started this whole investigation. And so what happens is I did an investigation to find out what was going on because the claim was one, very very old; and two, no one had any record of anything. So it led me to – part of my investigation lead me to uncover that when there was apparently an injury that she never filed a workers' compensation claim and she was out on FMLA per our Human Resources Department. And she came back to work in, I believe in January of 2000 and she worked until 2002 when she, I believe was terminated or was - - had quit on her own volition. And that's the record on Ruth Ann Heberlein.... 8/6/2015 Trans., p. 84-85.

Burres' investigation showed HME had workers' compensation insurance through Traveler's on Petitioner's dates of accident. 8/6/2015 Trans., p. 86.

The matter was then continued to October 15, 2015.

<u>October 15, 2015 Hearing Date</u>

When the hearing reconvened on October 15, 2015, Petitioner, Ruth Ann Heberlein, testified on her own behalf. Petitioner testified there were occasions when she was the person accepting the mail delivery at HME. 10/15/15 Trans., p. 6. She explained this occurred if Sue Martin or the front desk receptionist were away from their desks; on those occasions, Petitioner would get the mail then put it in Rusty's office. 10/15/15 Trans., p. 6-7. She estimated the store received an average of five to ten pieces of mail per day. 10/15/15 Trans., p. 7.

Petitioner testified she was friendly toward Martin but Martin did not like her. 10/15/15 Trans., p. 8. She detailed an instance where Martin purportedly threatened Petitioner would be fired if she left work for a family medical emergency. 10/15/15 Trans., p. 8-10. Petitioner further described an occasion where she observed Martin signing a doctor's signature on a document; Petitioner reported it to Rusty and testified she was thereafter afraid of retribution from Martin. 10/15/15 Trans., p. 12-13.

On cross-examination, Petitioner stated she was hired at HME as a customer service representative in January 1999. 10/15/15 Trans., p. 14. She remained in that position until her back injury in October 1999; when she returned to work in January 2000, her new position was patient care coordinator. 10/15/15 Trans., p. 14.

Petitioner confirmed Martin is one of her Facebook friends. 10/15/15 Trans., p. 14. She believed Martin held a grudge against her when they worked together but was unsure if that was still the case. 10/15/15 Trans., p. 15.

Petitioner testified she stopped working for HME in June 2002. 10/15/15 Trans., p. 19. She agreed she would thereafter occasionally drive past the 1026 Maine Street address as her physician's office was across the street. 10/15/15 Trans., p. 19-20. Petitioner stated she did not discover HME had moved by driving by the building; she was not sure but believed she learned that from the internet or possibly the building's owner mentioned it. 10/15/15 Trans., p. 20. She then explained her physician's office has two entrances and she habitually used the rear entrance to access the second floor directly and "very rarely did I ever drive by in front and park in front." 10/15/15 Trans., p. 21. Petitioner then referenced an email she authored to her attorney which details when she discovered Respondent had relocated:

> Saturday June 8, 2013 I sent Mr. Lichten an email and I - - in the middle of the email I have the address for my former employer is different than when I worked there, the address is as follows, and I got this information from the internet. Responsive Home Healthcare, Inc., 2439 Broadway Street and then I also gave him the insurance carrier number which I got from the state website for their workers' compensation insurance that they had as of that date. 10/15/15 Trans., p. 22-23.

Petitioner denied she only began searching for that information in 2013 and explained she had been trying to obtain the insurance information for several years:

> I didn't wait that long, we continually tried to find out. I called RoTech [SIC], which I have a phone bill here, I emailed RoTech [SIC] three different times, I even sent an email to Sue, which she

> didn't reply, and I also mailed a letter to RoTech [SIC] and I had a green card for it and I could not find that anywhere but I know I mailed it the same time as I mailed a letter to the Illinois Attorney General's Office, Lisa Madigan, regarding this workmen's comp case and insurance and basically I put in here I didn't know if I needed to contact Better Business or what I needed to do. I was going all avenues trying to help him and he was trying to help me to find out who the insurance carrier was and nobody wanted to say anything. 10/15/15 Trans., p. 23-24.

Petitioner testified she sent letters as well as emails to Rotech's corporate office in Florida, with her first email to corporate being sent November 14, 2011. 10/15/15 Trans., p. 24-25. This was done after speaking to someone at the Quincy HME store:

> ...I called the local store and I spoke with a girl, I don't remember who it was, and she said she didn't know anything about it and suggested that I call corporate in Florida...[The call] to the local store would have been somewhere before or maybe even on January 6, 2011 because after I was told that, that was when I called RoTech [SIC] and the lady I spoke with at corporate, her name was Liz and she was in human resources and she told me that she would have to give it to the human resource director. I think she said head, I don't know, director or head and I never heard anything back and Mr. Lichten and I were talking to each other via email, phone calls back and forth trying to get things and then that's when I went and emailed in November, three separate emails, and the one person that I actually got ahold of, his name was Juan Lacarno, Information Management Specialist in the RoTech [SIC] Healthcare, Inc. Compliance Department and he told me that he would make sure that the email got to human resources and I sent him an email back thanking him for his help and then I sent him another email stating that I never did hear back from RoTech [SIC] and - - ... First email to RoTech [SIC] corporate was November 14, 2011 and the second was...November 17, 2011 and November 30, 2011 and that was the last I heard, he never replied back. 10/15/15 Trans., p. 26-28.

Petitioner later clarified she was seeking insurance information when she contacted Rotech:

> I said I was a former employee of RoTech [SIC] and that I needed to find out an insurance carrier that they had in 1999 and the lady I spoke to, Liz, said she could not answer that question, that she would

> give the message on to the department head or director or whatever she said. 10/15/15 Trans., p. 32.

Respondent recalled Sue Martin to testify in rebuttal. Martin stated she and Petitioner were not friend friends but instead were work friends/acquaintances. 10/15/15 Trans., p. 36. She testified she did not recall an incident where Petitioner received a phone call at work notifying her of a family medical emergency, nor did she recall an incident where Petitioner confronted her about signing a doctor's name on a document. 10/15/15 Trans., p. 37-38. Martin confirmed she and Petitioner are Facebook friends and stated she sent the friend request to Petitioner. 10/15/15 Trans., p. 39.

Martin denied Petitioner sent her an email asking about insurance coverage and testified she instead received a Facebook message from Petitioner. 10/15/15 Trans., p. 39. Martin did not respond to Petitioner's message. 10/15/15 Trans., p. 40.

Respondent then presented the testimony of Russell Shuck (hereinafter referred to as "Shuck"). Shuck testified he has worked for HME since 1997 and his job title is customer service rep; in 2000 and 2002, he was location manager. 10/15/15 Trans., p. 44.

Shuck did not recall being notified by Petitioner that Martin had signed a physician's name on a document. 10/15/15 Trans., p. 44.

Shuck was not questioned as to whether he received any notices or correspondence regarding Petitioner's workers' compensation claim when he was location manager.

The matter was then continued to December 21, 2015.

<u>December 21, 2015 Hearing Date</u>

When the hearing resumed, James Gentry (hereinafter referred to as "Gentry") was called to testify by Petitioner. Gentry is the supervisor of the data entry department, central file department, and mail room at the Illinois Workers' Compensation Commission. 12/21/15 Trans., p. 4. Presented with Petitioner's Exhibit 5, the affidavit he executed on October 13, 2015, Gentry confirmed each of the statements therein was accurate. 12/21/15 Trans., p. 5-11. Pertinent to the issue before us, the affidavit included the following assertions:

4. Within 48 hours of the filing of a claim, Rule 9020.60 directs the IWCC to mail a computer-generated "initial status" notice to the parties. This notice is sent to the employer's address as noted in the claim, and it informs the employer of the date, time, and location of the first arbitration status call for the claim.

5. If the employer address noted in the claim is not valid, the initial status notice will be returned to the IWCC. The IWCC will undertake additional efforts to provide the employer with the required notice.

10. Claims 02 WC 49523 and 02 WC 49524 (against Homecare Medical Equipment) were filed with the IWCC on 9/24/2002.

11. The claims listed the employer address as: 1026 Maine Street, Quincy, Illinois 62301.

12. On 9/26/2002, IWCC records reflect that it sent the employer the initial status notice for both claims at the address listed above.

13. The IWCC sent notice of further status hearings on 11/5/2004 and 7/6/2005 to the employer at the address listed above.

14. IWCC records do not reflect any of these notices being returned due to an invalid employer address. PX5.

On cross-examination, Gentry testified he became supervisor of the Commission's central file department and mail room in 2008, and of the data entry department in 2013. 12/21/15 Trans., p. 13. He confirmed the statements in his affidavit were based on his review of the department records. 12/21/15 Trans., p. 13. Gentry agreed the records show the arbitration decision was sent by certified mail to the employer, but there is no longer proof of actual delivery as the Commission does not have the return receipt. 12/21/15 Trans., p. 14. Gentry further testified there is no indication in the records that the address the Commission had for the employer was invalid and stated the Commission did not receive any return mail showing the address was wrong. 12/21/15 Trans., p. 15.

Conclusions of Law

Naming of Travelers as Party Respondent

The circuit court's mandate tasked the Commission with determining if Travelers may be added as a party respondent at this time. The Dissenting opinion would deny the Petitioner this option because it would violate Section 6(d) of the Act; the statute of limitations. The Petitioner has argued that the statute of limitations does not prevent her from adding the insurance company under Section 4(g) of the Act.

Section 4(g) of the Act provides, in part:

> In the event the employer does not pay the compensation for which he or she is liable, then an insurance company, association or insurer

> which may have insured such employer against such liability shall become primarily liable to pay to the employee, his or her personal representative or beneficiary the compensation required by the provisions of this Act to be paid by such employer. The insurance carrier may be made a party to the proceedings in which the employer is a party and an award may be entered jointly against the employer and the insurance carrier.

In *QBE Ins. Co. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120336WC, the appellate court noted:

> [T]he plain language of the statute provides that if the employer does not pay the compensation for which it is liable, then an insurance company which may have insured such employer against such liability shall become primarily liable to pay the employee. The statute provides a claimant the right to proceed directly against the insurer in the event the employer does not pay the award. 'The proceeding should be brought before the *** Commission, and it is contemplated by this section that a proceeding has already been brought against the employer insured and his liability established and that the employer has refused or does not pay the compensation for which he is held liable.' *Equitable Casualty Underwriters v. Industrial Comm'n*, 322 Ill. 462, 468, 153 N.E. 685, 687 (1926). The Act does not mandate that the insurance carrier be made a party to the proceedings. The statute merely provides that the insurance carrier 'may be made a party to the proceedings' in the event the employer does not pay the award.

The statute provides a claimant the right to proceed directly against the insurer in the event the employer does not pay the award. As stated in *QBE*, the Act does not mandate that the insurance carrier be made a party to the proceedings; rather, the statute merely provides that the insurance carrier *may* be made a party to the proceedings in the event the employer does not pay the award.

Section 6(d) of the Act requires that unless an Application for Adjustment of Claim is filed within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred. *820 ILCS 305/6(d).*

In these cases, the accidents allegedly occurred in 1999. The Petitioner filed applications for adjustment of claim in a timely manner in 2002. She then had multiple issues locating and serving the Respondent as are outlined above. Eventually the claims were arbitrated in 2009,

producing decisions issued on June 11 of that year. It was only after those decisions that the Respondent failed to pay benefits as ordered by the arbitrator.

If the statute of limitations applied to actions under Section 4(g), then the Petitioner would have had to add Travelers Insurance prior to October 1, 2002, which is three years after the second alleged accident. The Commission does not believe the intent behind Section 4(g) would be served by narrowing its scope in that manner.

One must look at the historical rationale behind statutes of limitations. Basic fairness requires that respondents or defendants be made aware of actions for which they are claimed to be liable in a timely fashion. They need to have the ability to investigate and defend against such claims before evidence becomes lost, witnesses disappear and memories fade.

A good example of such an instance is shown by the Court's interpretation of Section 1(a)4 of the Act, which deals with liability for borrowing and loaning employers. In an unpublished opinion under Rule 23, the Appellate Court ruled that claims against employers alleged to have that status must be brought in accordance with Section 6(d). See *Norton v. Ill. Workers' Comp. Comm'n*, 2011 IL App (3d) 100288WC-U. Either the loaning or borrowing employer can be held primarily liable. Therefore, it is important that they be allowed to defend the claim and produce evidence to show that the relationship did not exist at the time of the alleged accident.

There is no rationale to support imposing the Statute of Limitation in the instant cases. Travelers is not prejudiced by being added late as it has no right of defending the claim by the employee as it applies to liability. Under Section 4(g), their liability would derive from that established against the employer.

The Commission has ruled on several occasions that Section 6(d) does not apply to another statute which holds a party responsible in such a fashion. In *Fusco v. Play N Trade and Ill. State Treasurer*, 16 IWCC 569, the Commission explained why the Injured Workers Benefit Fund could be added as a respondent pursuant to Section 4(d) of the Act after the statute of limitations had expired. The Commission first noted the legislative intent behind enacting Section 4(d) was to protect injured workers whose employers failed to provide adequate coverage under the Act. The Commission then pointed out that the Fund's liability was clearly derivative of the respondent-employer's liability.

It is submitted that respondents added to claims under either section 4(d) or (g) have no right to defend against the underlying claim of liability. They are simply added to the claim to pay when the primary party, the employer, does not. As such, the fairness concerns for which statutes of limitations have historically been enacted are not relevant.

The Commission thus allows the Petitioner to add Travelers Insurance company to these actions brought under Section 4(g) of the Act.

The dissenting opinion cites the *McAnally* opinion in support of its position that Section 6 (d) should apply. *McAnally* deals with enforcement actions under Section 19(g) of the Act and is not relevant to this discussion.

HME's Motion to Vacate Award

Pursuant to Section 19 of the Act, the Commission is precluded from entering a decision in violation of due process. *Interstate Contractors v. Indus. Comm'n*, 81 Ill. 2d 434 (1980). Moreover, "both the Industrial Commission and the circuit court are vested with the power to examine the validity of the decisions entered in the proceedings below and empowered to determine whether they are void for lack of jurisdiction over the parties." *Id.* at 438.

On September 24, 2002, Petitioner filed two Applications for Adjustment of Claim against HME which Petitioner's attorney mailed to 1026 Maine St., Quincy, IL 62301. The Commission's records indicate Notices of Hearing were sent on September 26, 2002 to HME at the Maine St. address. On November 1, 2004 HME relocated to 2439 Broadway, Quincy, IL 62301. Between November 2, 2004 and February 18, 2009, numerous Notices by the Commission and several Petitions by the Petitioner were sent to HME all to the defunct address.

On February 18, 2009, Arbitrator Tobin entered an order setting the matters for a trial date certain of May 20, 2009. The order further mandated Petitioner's attorney to provide a copy of the order to HME. Of significant note, the order is a hand-written Notice of Motion and Order which failed to provide a date, time, or place for the Motion or any indication notice was provided to HME. On May 14, 2009, six days before the pre-set trial date, Petitioner's attorney directed correspondence to the defunct address advising HME of the May 20, 2009 trial date.

On May 20, 2009, Petitioner and her attorney appeared for trial whereas HME did not. An *ex parte* hearing was conducted. The following exchange occurred between the Arbitrator and Petitioner's attorney:

> Petitioner's Counsel: The petitioner has never received any response of any kind from the respondent after the filing of these claims, and as Your Honor is aware, you had set these for a trial date certain for today, so I did send a letter to the respondent to notify them of that and got no response. Some time ago - -
>
> Arbitrator: When did you send that letter to them notifying them of a date certain?
>
> Petitioner's Counsel: That was sent on May 14th, 2009 to Homecare Medical Equipment...

Arbitrator: And the date of the date certain Order was February 18th, 2009 I believe, is that correct?

Petitioner's Counsel: That sounds right to me, Your Honor.

Arbitrator: Okay. And as you said, that was sent to the respondent's last known address a few weeks ago this May, is that correct, a copy of that Order?

Petitioner's Counsel: Yes.

On June 11, 2009, the Arbitrator issued his decision, and for more than three years, no action was taken until October 29, 2012, when a certified letter was sent to HME at its current location. Ms. Suzette Martin, manager for HME, testified the first notice she received regarding any filings before the Commission was the certified letter dated October 29, 2012.

There is no evidence HME actually received notice of a filing at the Commission prior to November 2, 2012. The evidence shows both Petitioner's attorney and the Commission sent information to HME in 2002 regarding the filings of the Applications for Adjustment of Claim, but there is no evidence such notices were received. Inexplicably, the cases were set for trial by an order dated February 18, 2009. There is no evidence HME was provided any notice that a trial date would be requested on February 18, 2009. Even assuming the request for a trial date in February of 2009 comported with the notice requirements, Petitioner was provided three months to notify HME of the trial date of May 20, 2009, yet Petitioner took no steps to provide notice during this period instead waiting until six days prior to trial to send notice to a defunct address.

Petitioner's reliance on *Preston v. Bell Trucking*, 295 Ill. App. 3d 659 (1998), in support of her argument regarding notice is misplaced. In *Preston*, claimant was represented by two separate attorneys, and the Commission mistakenly recorded one of those addresses as that of respondent's attorney. The respondent's attorney failed to file its Appearance at the Commission despite being advised on two occasions by Petitioner's attorney to do so and despite participating in the arbitration hearing. The arbitrator's decision thusly was sent to an inaccurate address. Therefore, the respondent filed its Petition for Review outside the jurisdictional 30 days, and claimant filed its Petition pursuant to Section 19(g) in circuit court. The respondent paid the award with interest but appealed the circuit court's award of fees and costs.

In affirming the circuit court's award, the Court applied Section 19(i) of the Act noting "that a party 'upon taking any proceedings or steps *whatsoever*' before the Commission *shall* file his name and address, or the name and address of an agent upon whom all notices shall be served." (Emphasis in the original). *Preston*, 295 Ill. App. 3d 659, 379 (1998). The Court went on to hold pursuant to Section 19(i), if a party fails to provide its address when taking such actions before the Commission, service of notice "'may be had by filing such notice with the Commission.' *820 ILCS 305/19(i)* (West 1996)." *Id.*

Section 19(i) of the Act mandates that once parties appear and act before the Commission, they must provide the Commission with a current name and address for service of notice. If the party fails to do so, then notice may be had by filing before the Commission. To be clear, Section 19(i) does not provide a blanket provision for notice at any time for any entity. Such a broad reading of the section would potentially implicate a party's due process rights.

In the current matter, as HME failed to receive notice of any proceeding before the Commission until 2012, it follows the requirements of Section 19(i) would not be applicable until actual notice was received. Given the above, the Commission finds HME failed to receive the required notice of trial, therefore, the arbitrator lacked jurisdiction over HME. The arbitrator's decision entered on June 11, 2009 is void.

Petitioner's Petition for Penalties and Fees

As the arbitrator's decision of June 11, 2009 is void, Petitioner's Petition for Penalties and Fees is moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that Travelers can be named as a party to the proceedings pursuant to Section 4(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the June 11, 2009 Arbitrator's Decision is void and hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter is remanded to the Arbitrator for a new trial on the merits.

DATED: FEB 25 2020

LEC
D: 2/28/18
043

D. Douglas McCarthy

Stephen Mathis

DISSENT/SPECIAL CONCURRENCE

I respectfully dissent as to the decision of the Commission allowing Travelers to be named as a party. I concur with the decision of the Commission in all other respects.

The circuit court's mandate tasked the Commission with determining if Travelers may be added as a party respondent. A resolution of this issue requires the Commission to examine two provisions of the Illinois Workers' Compensation Act ("the Act") specifically Section 4(g) and Section 6(d). Section 4(g) states, in part,

> In the event the employer does not pay the compensation for which he or she is liable, then an insurance company, association or insurer which may have insured such employer against such liability shall become primarily liable to pay to the employee, his or her personal representative or beneficiary the compensation required by the provisions of this Act to be paid by such employer. The insurance carrier may be made a party to the proceedings in which the employer is a party and an award may be entered jointly against the employer and the insurance carrier. *820 ILCS 305/4(g)* (West 2013).

This section speaks to liability and which entity may be responsible for payment of an award and in what priority. Further, it grants an employee the right to proceed directly against the insurance company either prior to or after an employer's liability has been established. See *Equitable Casualty Underwriters v. Industrial Commission*, 322 Ill. 462 (1926).

> Section 6(d) states, in part,
>
> In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred. *820 ILCS 305/6(d)* (West 2013).

This section speaks to the time period of filing a cause of action which has accrued and acts as a statute of limitations.

> Thusly, we must employ the rules of statutory construction which are well-established. Our primary goal, to which all other rules are subordinate, is to ascertain and give effect to the intention of the legislature. [citation omitted]. We determine this intent by reading the statute as a whole and considering all relevant parts. [citation

> omitted]. We must construe the statute so that each word, clause, and sentence, if possible, is given a reasonable meaning and not rendered superfluous [citation omitted], avoiding an interpretation which would render any portion of the statute meaningless or void [citation omitted]. We also presume that the General Assembly did not intend absurdity, inconvenience, or injustice. [citation omitted]. The Workers' Compensation Act is to be interpreted liberally [citation omitted], to effectuate its main purpose-providing financial protection for interruption or termination of a worker's earning power. [citation omitted]. *Sylvester v. Indus. Comm'n*, 197 Ill. 2d 225, 232 (2001).

In assessing legislative intent "the court should consider, in addition to the statutory language, the reason for the law, the problems to be remedied, and the objects and purposes sought. [citation omitted]." *People v. Donoho*, 204 Ill. 2d 159, 172 (2003).

The legislature in enacting Section 6(d) created a defined period of time in which a cause of action can be filed against an entity which falls under the purview of the Act. Section 6(d) makes no distinction as to which type of entity *i.e.* employer or insurance carrier but merely provides that a cause of action must be filed within three years of the date of accident where no compensation is paid or two years where compensation is paid, whichever is later, otherwise the cause of action is barred.

The legislature in enacting Section 4(g) granted an employee additional rights to proceed directly against an insurance company 1) in the first instance as a named party respondent, and/or 2) when an employer fails to satisfy its obligation to pay an award.

In construing the language of Section 6(d) in context with Section 4(g), I see no reason why the limitations period would not apply if an employee so chooses to proceed directly against an insurance company. Section 4(g) allows for both an employer and its insurance carrier to be named as party respondents: "The insurance carrier may be made a party to the proceedings in which the employer is a party and an award may be entered jointly against the employer and the insurance carrier." *820 ILCS 305/4(g)* (West 2013). Section 6(d) defines when such cause of action must commence. If Section 4(g) is interpreted to allow for a limitless addition of an insurance company, it would render Section 6(d) meaningless.

The matter of *McAnally v. Butzinger Builders*, 263 Ill. App. 3d 504 (1994), is instructive. In *McAnally*, the employee successfully prosecuted his workers' compensation claim against his employer, Butzinger Builders. His employer tendered what it calculated as full payment of the award which the employee rejected. Pursuant to Section 19(g) of the Act, the employee filed a cause of action in the circuit court requesting the Commission's award be reduced to judgment

naming Butzinger Builders and for the first time, its insurer, State Farm. State Farm filed its Motion to Dismiss which was granted.

In affirming the dismissal, the Court noted State Farm was not named as a party respondent at the arbitration proceedings and only at the enforcement proceedings. The employee argued Section 4(g) allowed for State Farm to be named as a party for enforcement of the award. In rejecting this argument, the Court noted the employee could have chosen to name State Farm at the onset during the arbitration proceedings but chose not to do so. Section 4(g) did not confer an ongoing right to name the insurer. The Court went on to state "where the workers' compensation claimant foregoes naming the insurance carrier at the outset, the claimant may not enforce the workers' compensation award against the carrier without filing a separate action." *Id.* at 510.

As Section 4(g) states and as noted by the Court in *McAnally*, if an employee chooses not to proceed directly against the insurance company at the onset, she can proceed directly against the insurance company to collect an award previously entered in favor of an employer so insured. See *QBE Ins. Co. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120336WC, ¶ 22 ("The statute provides a claimant the right to proceed directly against the insurer in the event the employer does not pay the award"). Generally, Illinois public policy does not allow for direct actions against an insurer, but the Act carves out an exception to this policy with Section 4(g). Such is consistent with the Act's purpose of "providing financial protection for interruption or termination of a worker's earning power." *Sylvester v. Indus. Comm'n*, 197 Ill. 2d 225, 232 (2001). Moreover, the Act was designed to provide an injured employee with a defined amount of compensation through an efficient remedy. *O'Brien v. Chicago C. R. Co.*, 305 Ill. 244 (1922); *820 ILCS 305/16* (West 2013).

Therefore, consistent with the rules of statutory construction and the purposes of the Act, the statute of limitations period applies to both employers and its insurers as it relates to the naming of parties prior to hearing. (Generally, a statute of limitations is raised as an affirmative defense, but as the circuit court mandated this Commission to determine initially the propriety of naming Travelers as a party respondent, we have done so). I find Petitioner is barred from naming Travelers as a party respondent pursuant to Section 6(d) of the Act. As such, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMMY A. TAYLOR,

Petitioner,

20IWCC0128

vs. NO: 10 WC 3519

JACK COOPER TRANSPORT COMPANY, INC.,

Respondent.

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 causation, medical expenses, temporary total disability, permanent partial disability, Section 5(b) Third Party lien and Denial of Petitioner's Motion to Reopen Proofs, and being advised of the facts and law, remands this case to the Arbitrator for further proceedings.

The Arbitrator denied Petitioner's Motion to Reopen Proofs to allow in to evidence the Federal Court settlement documents which would purportedly show the allocation of the settlement amongst Petitioner's multiple accidents. The Arbitrator then declined to rule on the issue of the 5(b) credit on the grounds that there was insufficient evidence before the Commission to render a ruling.

The Commission remands this matter to the Arbitrator to reopen proofs for the limited purpose of the admission into evidence of the Federal Court Settlement documents and to address the 5(b) credit issue.

IT IS THEREFORE ORDERED BY THE COMMISSION that this matter is remanded back to the Arbitrator for further proceedings.

20IWCC0128

No bond is required as this decision is interlocutory and no review may be taken.

DATED: FEB 25 2020

Maria E. Portela

Kathryn A. Doerries

Marc Parker

MEP/dmm
O: 012120
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAYLOR, TIMMY
Employee/Petitioner

Case# **10WC003519**

JACK COOPER TRANSPORT COMPANY INC
Employer/Respondent

20IWCC0128

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:

5542 WENDLER LAW PC
BRIAN WENDLER
900 HILLSBORO SUITE 10
EDWARDSVILLE, IL 62025

4866 KNELL O'CONNOR DANIELEWICZ
MICHAEL DANIELEWICZ
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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

Timmy Taylor
Employee/Petitioner
v.
Jack Cooper Transport Company, Inc.
Employer/Respondent

Case # **10** WC **3519**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Geneva, IL, on October 13, 2016 and January 24, 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. ☒ PTD, accrued unpaid TTD, unpaid medical bills, Section 5 third-party settlement set off, Section 5 third-party reimbursement

FINDINGS

On **January 12, 2010,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the 52 weeks preceding the injury, Petitioner earned **$74,984.00.** The average weekly wage was **$1,442.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$62,444.48** for TTD, **$0** for TPD, **$0** for maintenance, and $0 for other benefits under Section 8(j) of the Act, for a total TTD credit of **$62,444.48.**

Respondent shall be given a credit of **$42,387.77** 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.

ORDER

TTD
Respondent is ordered to pay Petitioner 256 weeks of accrued unpaid TTD at the rate of $961.33 weekly for benefits commencing March 25, 2011, through February 17, 2016. As noted above, Respondent shall be given a credit of $62,444.48 for TTD under Section 8(j) of the Act.

Medical Bills
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for medical services and treatment, contained in Petitioner's Exhibit 14, as provided in Sections 8(a) and 8.2 of the Act. As noted above, Respondent shall be given a credit of $42,387.77 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.

Nature & Extent of Petitioner's Injury
Respondent shall pay Petitioner permanent partial disability benefits of $ 664.72 /week for 150 weeks, because the injuries sustained caused the 30% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Third Party Lien under Section 5 of the Act
No ruling on this issue.

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

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

Jessica A. Hegarty
Signature of Arbitrator

2-26-18
Date

MAR 1 - 2018

BEFORE THE WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

TIMMY TAYLOR, Petitioner,	)	
	)	
VS.	)	NO. 10 WC 3519
	)	
JACK COOPER TRANSPORT, INC. Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter commenced on October 13, 2016 and was continued until January 24, 2017, at which time proofs were closed (Ax. 1). Thereafter, Petitioner filed a motion to re-open proofs to allow for additional evidence

Petitioner's Testimony

Petitioner testified he worked as a driver, hauling cars for Respondent, since 1997. (Tr. 11) Prior to the accident at issue, Petitioner was injured while working for Respondent on October 1, 1997, in a slip and fall accident in which he sustained cervical and shoulder injuries. (Tr. 12, 17). Sometime following surgeries to his shoulder and neck, Petitioner returned to full time work for Respondent until the date of injury involving the case at bar. (T. 17-18).

As a driver/hauler for Respondent, Petitioner was required to load and unload vehicles onto a trailer, pull and push heavy ramps from beneath the truck, and tighten chains, which requires a driver to lift up to 80 lbs. and exert a pushing force of up to 100 lbs. per Respondent's written job description. (PX. 24) Drivers, like Petitioner, are also required to sit for long periods of time, hauling vehicles over long distances, and must be able to perform tie down procedures in confined spaces, work outside in excessive heat, cold, and inclement weather, and have the agility to climb trucks to access vehicles and balance on narrow rails which are high off the ground while performing their work. (Id.).

Petitioner testified that on January 12, 2010, he was at a car dealership in Illinois where he had finished unloading 4-5 cars. As he climbed up the side of his truck to unload the last vehicle, he "went to swing" himself over, lost his balance and fell approximately 12 feet to the ground. (Tr. 18). Petitioner did not remember how he landed on the ground but did recall he was lying on his back when a man walked up to him and carried him inside the car dealership after which he was transported to a hospital via ambulance. (Tr. 23). Petitioner testified his neck, back, and shoulders hurt when he was at the hospital. (Tr. 24). After being hospitalized for three days, Petitioner was transported by ambulance to the airport after which he flew home to Oklahoma. (Id.). After his arrival home, he treated with Dr. Odor and Dr. Olsen with whom he previously treated for his prior work-related injuries. (Tr. 25).

Petitioner testified that following this accident he walked in a hunched over fashion and was unable to stand up straight. (Id. 29-30). He further testified that Dr. Odor performed surgery nearly two years after the accident

consisting of an anterior triple fusion at L3 through S1 with instrumentation including 3 implants, 18 screws and six pieces of steel. (Id. 30-31).

Petitioner testified that rather than authorize the above surgery, Respondent flew him to Chicago twice to be examined by Dr. Ghanayem. (Id., 32). Following that appointment, Dr. Ghanayem concluded Petitioner could return to work full duty after which, Respondent instructed Petitioner to report to work in Arlington, Texas. (Id. 34). Petitioner testified that a friend drove him to Arlington, Texas as Petitioner was taking Hydrocodone and muscle relaxers at the time. (Id. 35, 38). Petitioner further testified that once he reported to work, he was instructed to report for a DOT physical exam (required for all interstate truck drivers) and drug screen. (Id. 34-35).

The records indicate that Petitioner presented on 4/4/11 for a Commercial Driver Fitness Determination exam. (PX. 11). Petitioner testified and the records confirm that once the examining doctor determined that Petitioner was taking certain medications, he was deemed unfit to perform commercial driving duties. (Tr. 37; PX. 11).

Petitioner testified that after failing the DOT physical, Respondent did not offer him any light duty work. (Tr. 38).

Petitioner testified he underwent a posterior triple lumbar fusion on 9/11/12. Following that surgery, he used a walker but did not undergo any physical therapy or rehabilitation because Respondent would not authorize such treatment. (Id. 39-40).

Pursuant to his testimony, he is now able to walk using a straighter posture as opposed to his pre-surgical walking style where he was hunched over forward. (Id. 29-30).

Petitioner testified he saw his surgeon, Dr. Odor about one week before he testified at this hearing on October 13, 2016 at which time Dr. Odor made his restrictions permanent. (Id. 41). Petitioner testified he can now sit for 15-30 minutes and can stand for 15-25 minutes. (Id. 41). Petitioner testified he is taking medication for pain, sleeping and depression as well as muscle relaxers. (Id. 46). Petitioner testified he can walk 50-75 yards without resting. (Id. 46).

Petitioner testified he worked as a limousine driver after his back surgery which did not require any lifting. (Id. 75). Petitioner testified the job involved sitting for 20-minute periods as he was driving short distances. (Id. 75).

Petitioner further testified he was injured (prior to the accident at issue) at work on October 1, 2007 resulting in neck and shoulder surgeries. (Id. 17).

On cross-examination, Petitioner would not admit that he had low back complaints in 2009. (Id. 49). Petitioner was asked whether his back pain was so bad that he stopped working in 2008, Petitioner answered he had a doctor's appointment and went back to work after that. (Tr. 50). Petitioner did not recall attempting to return to work in June of 2009. (Id. 50). Petitioner testified he more than likely underwent a lumbar epidural injection in 2009. (Id. 50-51). Then, Petitioner testified he did not know if he was having low back pain in 2009. (Id. 51). Petitioner testified he could not remember low back pain in 2009. (Id. 50). Petitioner was asked whether he was treating with Dr. Odor for low back pain prior to the January 12, 2010 accident, but Petitioner answered he was "released to go to work." (Id. 51). For a second time, Petitioner was asked whether he was treating with Dr. Odor for low back pain prior to the January 12, 2010 accident, and Petitioner testified "I'm lost." (Tr. 51). For a third time, Petitioner was asked whether he was treating with Dr. Odor for low back pain prior to the January 12, 2010 accident, and specifically June of 2009. (Id. 51-52). Petitioner testified "[p]robably so because I went

back to work the next month. (Id. 52). Petitioner was asked a fourth time, whether he was treating with Dr. Odor for low back pain prior to the January 12, 2010 accident, and Petitioner testified "I don't understand what you're trying to say." (Id. 52).
At this point, the Arbitrator stated, "You can go back to work and still be treated by a doctor at the same time." (Id. 52-53). The Arbitrator asked Petitioner, "When you went back to work, were you still going to visit Doctor Odor?" Petitioner testified "I don't recall." (Id. 53).

Petitioner testified he likely told Dr. Bartlow that he always worked in some form of driving since age 21. (Id. 53). Petitioner testified he has a valid commercial chauffeur's license and has worked for a limousine company, Paris Limousine, prior to 2015. (Id. 53-54). Petitioner testified that if Paris Limousine would give him work, then Petitioner would work. (Id. 57). Petitioner then testified he told Dr. Bartlow about his previous work as a limousine driver and that Petitioner would like to continue working as a limousine driver. (Id. 58). However, other than driving for Paris Limousine, Petitioner testified he has not attempted to look for work anywhere else in the years 2015 or 2016. (Id. 58-59). Petitioner testified he did not produce any job logs identifying his efforts of looking for work. (Id. 59). Petitioner testified he did not look for any work in the year 2013 or 2014, other than Paris Limousine. (Id. 60). Petitioner testified he did not look for work with any other employer in 2015 and he does not have any job logs that show he looked for work in 2015. (Id. 61). Petitioner testified he did not work for any employer in the year 2016, nor did he attempt to look for work. (Id. 62).

Petitioner testified he was recently a plaintiff in a third-party case in the United States District Court for the Eastern District of Missouri. (Id.). Petitioner testified he received a settlement pursuant to that case but does not recall the amount of that settlement. (Id.). The Arbitrator asked Petitioner, "No clue?" (Id.). Petitioner testified he had "no clue." (Id. 64). Petitioner testified that the third-party case had settled at least five or six weeks ago. (Id.). Petitioner testified he knew the settlement amount had been deposited into his Chase Bank accounts but did not know how much was deposited. (Id. 65). Petitioner's attorney stated on the record that the settlement agreement amongst the parties allocated zero percent of the settlement to [the 1/12/10] injury. (Id. 66).

Injury and Treatment Summary
Following Petitioner's work-related accident of January 12, 2010

Records from the Aurora Fire Department dated 1/12/2010 note Petitioner's report that he fell off his truck at a Honda dealership in Aurora, Illinois. He said someone helped him up. When the EMTs arrived, they found Petitioner sitting in a chair in an office inside the Valley Honda. (Px. 1).

1/12/10 records from Rush Copley Medical Center note Petitioner presented to Dr. Muna Salman with a history of "attempting to empty his truck and he fell off and he landed on his back." Petitioner denied any loss of consciousness. Dr. Salman noted, "He apparently fell about 8 to 10 feet". Petitioner's complaints of back and left hip pain were noted. He denied any leg pain, tingling or numbness. Dr. Salman noted the hip exam was "pretty benign." (Id.).

CT of Petitioner's cervical, thoracic and lumbar spine showed no evidence of fracture or deformity and no post traumatic subluxation. Mild central canal stenosis at L3-4 and L4-L5, and moderate bilateral neural foraminal narrowing at L5-S1 and at L4-L5 were noted. Degenerative changes at multiple levels throughout the thoracic/lumbar spine, including disc space narrowing, endplate sclerotic changes, osteophyte formation, facet joint hypertrophy and vacuum disc phenomenon at L4-L5 were noted. (Id.).

On 1/15/2010, Petitioner presented to Southwest Oklahoma MRI for lumbar and cervical spine MRI. The findings from that exam are contained in a letter to Dr. Odor noting a small circumferential disc bulge at L4-L5

had caused mild indentation of the anterior thecal sac and mild bilateral foraminal stenosis. A transitional vertebral body was noted at L5. At L3-4, a small circumferential disc bulge had caused mild narrowing of the right intervertebral foramen. MRI of Petitioner's cervical spine showed an anterior interbody fusion of C4, C5, and C6 with anterior plate, screws and spaces in position. At C6-7, a small midline disc bulge had resulted in partial effacement of the ventral subarachnoid space was noted. At C3-4, a tiny midline disc protrusion had partially effaced the ventral subarachnoid space. (Id.).

On 1/28/2010, Petitioner presented to Dr. James Odor for examination. Dr. Odor noted he had treated Petitioner's neck and lower back related to prior injuries sustained on 10-1-07. The doctor noted Petitioner's prior low back treatment was conservative in nature, including physical therapy and injections. Dr. Odor noted the "[Petitioner] had gotten a lot better and states just prior to this new injury he was feeling well." After reviewing the CT scans, X-rays, and Petitioner's MRIs, Dr. Odor's impressions noted Petitioner's previous ACDF C-4-5 & C5-6 remained solid. The doctor further noted Petitioner's previous cervical lumbar symptoms, due to an injury of 10-01-07 were improving to the point of maximal medical benefit prior to this injury. The doctor noted new injuries to the cervical, thoracic and lumbar spine with cervical disc protrusions at C-3-4 and C6-7, lumbar disc protrusion L3-4 and L-4-5 with new onset of lumbar radicular symptoms, related to injury as above and thoracic pain of uncertain etiology;

Pursuant to Dr. Odor's recommendation, a thoracic MRI was performed on 2/8/10 which noted a small disc protrusion in the left paramedian effaced the ventral subarachnoid space at T7-8. At T8-9, T9-10, and T10-11, small circumferential disc bulges had partially effaced the ventral subarachnoid space at each level. (Id.).

On 2/25/10, Dr. Odor recommended Petitioner receive bilateral transforaminal epidural steroid injections at L4-L5 along with physical therapy. (Id.).

On 3/02/2010, Dr. James Odor noted Petitioner's complaints of bilateral shoulder pain. Petitioner was referred to a shoulder specialist. (Id.).

On 3/26/2010, Dr. Odor noted a pre-procedure diagnosis of bilateral lumbar radiculopathy. Dr. Odor administered epidurography and epidural steroid injection ("ESI") at L4-5 on the right and left. (Id.).

On 4/08/2010, Todd Olsen, D.O., noted Petitioner presented with bilateral shoulder complaints. Dr. Olsen recommended physical therapy and follow-up appointments every 4 weeks. (Id.).

On 4/12/2010, Dr. Odor reviewed MRI scans of the lumbar spine from 11-24-2008 and 1-15-2010 noting bilateral foraminal stenosis at L4-5 on the 1-15-2010 MRI scan. Regarding the 11-24-08 scan, the doctor noted mild narrowing of the left L4-5 foramina. Dr. Odor further noted Petitioner's symptoms changed following his newer injury of 1-12-10, indicating that Petitioner's current need for treatment was causally related to his injury of 1-12-2010. (Id.).

5/07/2010 records from Oklahoma Spine Hospital note Petitioner received multiple transforaminal ESIs and multiple epidurography injections. (Px. 1).

On 5/20/2010, Dr. Odor noted the injections were not helping. The doctor recommended lumbar discography. (Px. 1).

On 5/27/2010, Todd Olsen, D.O., noted Petitioner's report that his right and left shoulder status had not changed since his last examination. (Px. 2).

On 6/03/2010, Petitioner presented to Dr. Alexander Ghanayem for an Independent Medical Examination pursuant to Respondent's Section 12 request. (Rx. 1, p. 8).
On 7/06/2010, Todd Olsen, D.O., noted a diagnosis of bilateral right shoulder pain, strain and contusion. (Px. 2).

On 12/3/2010, Dr. Odor administered injections for discography, radiologic supervision and interpretation at L2-3, L3-4, L4-5, L5-S1. Summary of findings noted positive discography at L3-4, L4-5. Petitioner was sent for a CT scan for further structural diagnostic evaluation. Impression of the radiology report noted narrowing of the disc spaces at L3-4 and L4-5, annular fissures at L3-4 and L4-5 and mild to moderate foraminal stenosis bilaterally at L4-5. (Px. 1).

On 12/9/2010, Dr. Odor issued an addendum to his 12/3/2010 report stating that Petitioner should have the option of a two-level anterior posterior lumbar fusion at L3-4 and L4-5 with stabilization and anterior reconstruction to restore sagittal height and alignment. (Px. 1).

On 1/11/11, Dr. Ghanayem reviewed pre- and post-accident MRI scans of Petitioner's lumbar spine, confirming that Petitioner had reached maximum medical improvement and that Petitioner could return back to work at regular duty with no need for further medical care. (Rx. 1)

On 3/2/2011, Petitioner presented for another independent medical examination with Dr. Ghanayem who noted that Petitioner exhibited "nothing short of willful malingering" based on his examination and findings. The doctor noted again that Petitioner required no further medical care, and should have been able to return back to regular work activities no later than three months post injury. (Id.).

On 5/5/2011, Dr. Odor noted Petitioner's complaints of severe low back pain with bilateral radiation into his hips and legs with associated weakness and numbness with walking. The doctor noted an impression of severe lumbar radicular pain syndrome related to lumbar stenosis and lumbar central disc herniation L4-5 with retrolisthesis at L4-5 and multiple reasons for pain with two level positive discography L3-4 and L4-5 with updated MRI. (Px. 1).

On 4/19/2012, Dr. Odor noted Petitioner's complaints of continued pain in his neck, arms, back and legs. Dr. Odor's impression was lumbar radicular syndrome with known L3-4 and L4-5 lumbar instability, and lumbar stenosis with radiculopathy. Petitioner's ongoing cervical radicular pain were noted status post two level ACDF C4-5 and C5-6, which Dr. Odor noted was solid. It was recommended that Petitioner receive another MRI of the lumbar spine. (Id.).

On 4/24/2012, MRI of Petitioner's lumbar spine demonstrated moderate right neural foraminal stenosis at L3-4 from a right foraminal protrusion, mild bilateral neural foraminal narrowing at L4-5 from a mild disc bulge, a small posterior protrusion at T11-12 minimally effacing the thecal sac and mild disc dehydration. (Id.).

On 4/30/2012, Dr. Odor noted Petitioner's the most recent lumbar MRI showed significant disc disruption. Dr. Odor noted his continued recommendation for a two-level lumbar decompression, restoration of sagittal alignment, interbody reconstruction and two-level fusion L3-4 and L-4-5 with decompression. (Id.).

On 9/11/2012, Dr. Michael Riggs and Dr. Odor performed surgery at Oklahoma Spine Hospital. Dr. Riggs operative report noted a preoperative diagnosis of degenerative lumbar disc disease at L3-4, L4-5, and L5-S1 with lumbar instability and spondylolisthesis. Dr. Odor's preoperative diagnosis noted lumbar stenosis, lumbar

instability, lumbar spondylolisthesis, lumbar radiculopathy and lumbosacral instability. Petitioner underwent an anterior lumbar interbody fusion at L3-4, L4-5 and L5-S1, with discectomy and anterior instrumentation at L3-4, L4-5 and L5-S1. (Px. 9).
On 10/11/2012, Dr. Odor noted Petitioner returned for a one-month post-operative visit status three level lumbar decompression, fusion and instrumentation. The doctor noted Petitioner was doing well and was walking erect for the first time in almost three years. (Px. 1).

Petitioner continued to follow-up with Dr. Odor who noted on 6/14/2013 that Petitioner had increased his walking to 3 times a day while x-ray showed continuing consolidation. (Id.).

On 9/11/2013, Dr. Odor noted Petitioner was one year postop following a three-level lumbar fusion and stabilization. Petitioner reported feeling much better than he did before his surgery. X-rays showed the fusion appeared to be consolidating nicely with no evidence of screw loosening or instability. (Id.).

On 12/12/2013, Petitioner returned to Dr. odor reporting some flare up due to the cold weather and some pain over his hardware, especially over the L-5 and S-1 screws. Petitioner was advised of the possibility of hardware removal in the future. (Id.).

Petitioner continued to follow-up with Dr. Odor on 2/13/2014 when the doctor noted Petitioner demonstrated a normal gait and was neurologically intact. On 4/17/2014, Dr. Odor noted Petitioner was 1.5 years post-op from his fusion surgery. X-rays showed that his fusion appeared to be consolidating nicely with no evidence of screw loosening or instability. (Id.).

On 9/18/2014, Dr. Odor noted Petitioner reported having had some good days and bad days but overall was much improved. X-rays showed his fusion continued to consolidate. (Id.).

On 11/20/2014, Dr. Odor noted radiographs demonstrated a solid fusion. Petitioner continued to take medication for pain management. Dr. Odor recommended a follow up in 4 months. (Id.).

On 3/19/2015, Dr. Odor noted Petitioner continued to limit his activities within his restrictions. For now, Petitioner was to continue with medication and was to be seen in 4 months. (Id.).

On 8/26/2015, Dr. Odor noted Petitioner may still need more injections, ongoing pain management, and posterior hardware removal. (Id.).

On 2/17/16, Petitioner presented to Dr. Odor reporting new pains over the last several months in his hips and SI joints. Dr. Odor issued temporary restrictions not to exceed lifting of 10 lbs., push/pull 15 lbs. Petitioner was also restricted from "walking, standing, and sitting," but doctor Odor did not elaborate on the duration of the limitation. Petitioner was also restricted from bending, twisting, climbing, and crawling. Petitioner was to follow up in 2 months. (Id.).

On 4/20/16, Petitioner returned to Dr. Odor reporting his pain has been stable and controlled, other than a recent flare up due to rainy weather. Dr. Odor continued the same temporary restrictions as 2/17/16 and added that Petitioner could not operate machinery. Petitioner was to follow up in 3 months. (Id.).

On 7/7/16, Petitioner presented to Dr. Odor reporting weakness in his legs after standing for very long or walking for more than 15-20 minutes. Dr. Odor noted a new lumbar MRI might be needed at some point and

continued the same temporary restrictions as 2/17/16. Dr. Odor issued a prescription for more medication and instructed Petitioner to follow up in 3 months. (Id.).

On 10/6/2016, Petitioner presented to Dr. Odor noting a diagnosis of post laminectomy syndrome, chronic pain syndrome, and bilateral sacroiliitis. Dr. Odor issued permanent restrictions of maximum lifting of 10 lbs., push/pull 15 lbs. Petitioner was also restricted from bending, twisting, climbing, crawling, and from reaching overhead and away from the body. He recommended ongoing medication and follow-up in 2 months. (Id.).

On 12/8/16, Dr. Odor noted permanent restrictions not to exceed lifting of 10 lbs., push/pull 15 lbs. Petitioner was further restricted from operating machinery and "walking, standing, and sitting". Petitioner was also restricted from bending, twisting, climbing, and crawling. Petitioner was to continue his medications and home exercise program and follow-up in 3 months. (Id.).

Lower Back Injury and Treatment Summary Prior to January 12, 2010

On 8/18/2008, Petitioner presented to Dr. James Odor of Spine Surgery, Inc., reporting he injured his lower back. Dr. Odor noted he would see Petitioner for lower back issue if authorized. (Px. 1).

10/18/2008 records from Oklahoma Physical Therapy note Petitioner "displays negativity towards progression with exercises." Petitioner's "progression with exercise and range of motion, at this point in time, is self-limiting. He shows very little motivation to return to work at this time."

11/24/2008 records from Olsen Orthopedics note Petitioner is status post left shoulder arthroscopy with labral debridement and subacromial decompression. Petitioner stated, "he went back to work on a work trial but had to cut it short because of the development of significant lower back pain." Petitioner agreed to "proceed with an MRI of the lumbar spine and request for a timely evaluation from Dr. Odor." (Rx. 5).

Records from Oklahoma MRI dated 11/24/2008 noted a lumbar spine MRI showed L5 is a transitional vertebral body. At L3-4, a small circumferential disc bulge that mildly indented the anterior thecal sac and mildly narrowed the left intervertebral foramen was noted. At L3-4, a small right foraminal disc protrusion, superimposed on a small circumferential disc bulge, causing moderate narrowing of the right intervertebral foramen was documented. (Id.).

On 12/19/2008, Petitioner presented to Dr. James Odor who noted complaints of lower back pain with radiation at times into the left buttock and leg with associated numbness and tingling. On exam, Petitioner displayed limited lumbar motion with significant spasms of the lumbar spine. On review of the 11/24/08 lumbar MRI, Dr. Odor noted a disk bulge at L3-4 and mild narrowing of the foramen at L3-4. There were no significant findings with regard to L4-5 or L5-S1 (in contrast to the MRI's and operative notes following the January 12, 2010, injury). The clinical impression was lumbar radicular pain syndrome likely arising from the L3-4 level. Dr. Odor advised Petitioner to begin a trial of physical therapy, epidural steroid injections, and medications were prescribed.

On 4/03/2009, Petitioner presented to Dr. Odor who noted a diagnosis of lumbar radiculopathy at L3-4. Petitioner received an ESI and epidurography at L3-4 on the left. (Id.).

On 4/24/2009, Dr. James Odor noted a diagnosis of lumbar radiculopathy at L3-4 on the right and lumbar facet joint syndrome at L3-4 on the left. Petitioner received an ESI and epidurography at left L3-4, left lumbar facet joint injection and fluoroscopy at L3-4. (Id.).

On 5/22/2009 Petitioner received an ESI, epidurography, fluoroscopy and lumbar facet joint injection at L3-4 on the left. (Id.).
On 6/10/2009, Dr. Odor administered an ESI and facet injection at L3-L4 on the left. Petitioner asserted that he felt much better and could go back to work. Dr. Odor believed Petitioner could return to work in 6 weeks. (Id.).

On 9/04/2009, Petitioner presented to Dr. James Odor reporting that he had returned to work. Petitioner noted he had a flare up and did not think he reached MMI. Petitioner noted he did benefit from his most recent injections. (Id.).

On 11/6/2009, Dr. Odor noted Petitioner's report of continued low back pain with radiation down his left buttock and leg, sometimes in the right as well. Petitioner was still performing the same activities at work, chaining down trucks. Petitioner requested injections. (Id.).

On 12/11/2009, Dr. Odor administered an ESI and epidurography at L3-4 on the left with moderate conscious sedation. (Id.).

On 12/18/2009, Petitioner presented to Dr. Odor who noted Petitioner's report that his "right side now hurts." His current pain level was noted as 7-8 on the right, and 5-6 on the left. Dr. Odor recommended TFESI at L3 - 4 on the right and an injection at L3 - 4 on the right. (Id.).

On 12/21/2009, Dr. Odor's office sought authorization for this right-side epidural injection and left a message for adjuster Michelle Price. (Rx. 5). On 12/28/2009: Dr. Odor's office made additional efforts to contact Michelle Price noting she was out of office. (Id.).

On 1/6/2010, Dr. Odor's office contacted the new adjuster. (Id.).

Dr. Alexander Ghanayem's Independent Medical Evaluations and Deposition Testimony

June 3, 2010 Evaluation

Petitioner presented to Dr. Alexander Ghanayem for an independent medical evaluation on June 3, 2010 pursuant to Respondent's Section 12 request. Dr. Ghanayem noted an accident history consistent with Petitioner's testimony at the arbitration hearing. Petitioner reported low back pain radiating to the front of his thighs and down to his knees. He denied any prior low back problems. On examination, Petitioner stood with normal posture and walked with a slight forward pitch. The exam of the lumbar spine showed tenderness throughout the entire lumbar region. Tensions signs were negative for radicular pain and back pain. (Rx. 1, deposition exhibit 2, pg. 1).

Upon review of Petitioner's prior medical records, Dr. Ghanayem noted "significant low back problems that predate" Petitioner's work injury "despite his history to me denying any prior low back problems". Dr. Ghanayem noted Petitioner's lumbar problems required treatment including injections up until the month before Petitioner's work injury in January of 2010. Further, the cervicothoracic and lumbar CTs scan performed in January 2010 showed no fractures and some degenerative arthritis. (Id.)

With respect to Petitioner's cervical spine, the doctor opined Petitioner "has some muscular discomfort consistent with a cervical strain".

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Regarding Petitioner's lumbar spine, the doctor opined that Petitioner has "non-organic physical findings on today's exam consistent with symptom magnification". (Id.). Dr. Ghanayem noted he found "nothing objective on today's examination." (Id.). Further, Dr. Ghanayem noted, "Clinically, this patient represents contraindication to discography with the multiple nonorganic physical findings consistent with symptom magnification. While he did sustain injury when he fell, it would appear that this injury was only soft tissue in nature. (Id.)

Dr. Ghanayem requested the lumbar MRI scans from January 15, 2010 and November 24, 2008 be forwarded to his attention for further review. (Id.).

January 11, 2011 Addendum

On January 11, 2011, after reviewing the two lumbar MRI scans from 2008 and 2010, Dr. Ghanayem found "nothing structural causing neurologic compression." The doctor noted that any narrowing exhibited in the scans was not significant, and even "if the narrowing was significant it would not cause the subjective complaints that the patients noted at the June 3, 2010 examination." Dr. Ghanayem opined, based on the mechanism of injury, that Petitioner sustained a back sprain and had reached MMI. Dr. Ghanayem further testified that lumbar discectomy was not indicated. In his opinion, Petitioner could return back to regular duty and no further medical care was required. (Id.)

March 2, 2011 Evaluation

Dr. Ghanayem re-evaluated on Petitioner March 2, 2011 noting on exam that Petitioner "essentially threw himself forward," after which, Dr. Ghanayem caught him. The doctor noted, "It was very clear in feeling the tone in his musculature that he was essentially acting." The doctor concluded Petitioner exhibited "nothing short of willful malingering" based on his examination and findings.

Despite positive findings on discography, the doctor found Petitioner's subjective complaints and physical exam findings did not warrant any surgical intervention. Dr. Ghanayem noted Petitioner's lumbar MRI scans simply showed degenerative changes. The foraminal narrowing present on MRI would not cause significant neurological compression that would explain Petitioner's complaints of generalized lower extremity weakness. Dr. Ghanayem confirmed that no further medical care was required, noting Petitioner should have been able to return to regular work activities no later than three months post injury. Dr. Ghanayem noted physical therapy would have been reasonable for Petitioner's injury. (Id.)

Dr. Todd Olsen's Deposition Testimony

Dr. Todd Olsen, D.O., testified that Petitioner presented for initial consult on October 17, 2007 with complaints of left shoulder and radicular arm pain. (Id., Pg. 10). Subsequently, MRI of Petitioner's cervical spine showed a C5-C6 disc protrusion, resulting in lateral stenosis. (Id., Pg. 11). Dr. Olson further testified that Petitioner reported low back complaints prior to his January 12, 2010 accident. (Id., Pg. 23). Petitioner's low back complaints were significant enough that Dr. Olsen ordered a lumbar MRI on November 24, 2008. Petitioner was in excruciating pain and couldn't stand up straight. (Id., Pg. 39-40). It was Dr. Olsen's opinion that Petitioner could have had back problems as early as 2007. (Id., Pg. 45). During the entire time that Dr. Olsen treated Petitioner, for 18 visits altogether, Petitioner gait was always normal, heel to toe. (Px. 3, Pg. 45-46). Dr. Olsen testified Petitioner had a normal gait after his January 2010 accident. (Id., Pg. 47). Dr. Olsen also knew

that Petitioner smoked one or two packs each day and confirmed that smoking can affect the healing process. (Id., Pg. 49).

Cary Bartlow, Ph. D. Deposition Testimony

Cary Bartlow, Ph.D. opined the sedentary restrictions placed on Petitioner by his treating physician are too profound and too limiting to enable any type of driving work. (Px. 4, Pg. 16). Dr. Bartlow did not perform a job market analysis because he didn't believe Petitioner is capable of working. (Px. 4, Pg. 20). He did look at the Dr. Odor's recommendations for permanent physical limitations. (Px. 4, Pg. 25). Cary Bartow confirmed his job is to determine the need for and practicality of vocational rehabilitation services and to place people in rehabilitation training or job placement when determined appropriate. (Px. 4, Pg. 34).

Of note, Petitioner drove approximately 30 minutes to the appointment with Dr. Barlow. (Px. 4, Pg. 40)

He opined that Petitioner is 100% vocationally disabled, but acknowledged Petitioner had engaged in part-time work following the accident at issue. (Px. 4, Pg. 54).

Labor Market Survey of Charline M. McGrath, M.S. C.R.C

Charlene McGrath reviewed the opinions of Dr. Ghanayem and Petitioner's vocational rehabilitation consultant. (Rx. 2, p Pg. 1). Ms. McGrath noted Petitioner's report of brief employment as a part-time limo driver in 2015 and that he received his Commercial Chauffer's License at age 21 and had been engaged in commercial driving since 1994 at Jack Cooper. (Rx. 2, pg. 2).

Ms. McGrath performed a Labor Market Survey that identified job targets focused on alternative "driving" and related positions. (Rx. 2, Pg. 8). These job targets are consistent with Petitioner's expressed job interests per Dr. Bartlow's evaluation. (Rx. 2, Pg. 8). Ms. McGrath noted that if accommodations were necessary for Petitioner to return to full duty employment, all employers in her Survey would consider modification and/or accommodation requests for individuals with disabilities. (Rx. 2, Pg. 8).

CONCLUSIONS OF LAW

F: Is Petitioner's Current Condition Causally Related to the Injury?
J: Responsibility for Medical Treatment Pursuant to Section 8(a)

There is no dispute that Petitioner sustained a work-related injury on January 12, 2010, while in the course of his employment with Respondent when he fell eight to twelve feet off the top of his trailer and landed flat on his back onto the pavement below. Without anything more, it would not be surprising if a serious injury resulted from such a fall or an aggravation of a pre-existing condition.

The evidence *prior* to the January 12, 2010 accident indicates that Petitioner engaged in a conservative course of treatment for lumbar radicular pain arising from the L3-L4 level on the left with no significant findings or treatment relative to L4-L5:

- Petitioner presented for lumbar MRI on 11/24/2008 which indicated at L3-4, a small circumferential disc bulge that mildly indented the anterior thecal sac and mildly narrowed the left intervertebral foramen. No significant findings regarding L4-5 or L5-S1 were noted (in contrast to the 1/15/10 lumbar MRI).

Petitioner's treating surgeon, Dr. Odor, noted a clinical impression of lumbar radicular pain syndrome likely arising from the L3-4 level. Dr. Odor advised Petitioner to begin a trial of physical therapy, epidural steroid injections, and medications.

- On 4/03/2009, an ESI and epidurography at left L3-4 left were administered. (Id.). On 4/24 and 5/22/09, Petitioner received an ESI, epidurography, and lumbar facet joint injection at left L3-4. On 6/10/2009, Petitioner returned to Dr. Odor for facet injection and ESI at L3-L4 on the left. Petitioner asserted that he felt much better and could go back to work. Dr. Odor believed Petitioner could return to work in 6 weeks.

- On 9/04/2009, Petitioner presented to Dr. Odor reporting he had returned to work. Reportedly, Petitioner had a flare up and did not think he reached MMI. Petitioner noted he did benefit from his most recent injections. Dr. Odor noted Petitioner was to continue various treatment modalities. (Id.).

- On 11/6/2009, Dr. Odor noted Petitioner's report of continued low back pain with radiation down his left buttock and leg, sometimes in the right as well. Petitioner was still performing the same activities at work, chaining down trucks. Petitioner requested injections. (Id.).

- On 12/11/2009, Dr. Odor administered an ESI and epidurography with moderate conscious sedation at L3-4 on the left. (Id.).

- On 12/18/2009, Petitioner presented to Dr. Odor reporting that his "right side now hurts." His current pain level was noted as 7-8 on the right, and 5-6 on the left. Dr. Odor recommended TFESI at L3 - 4 on the right and an injection at L3 - 4 on the right. (Id.).

The medical evidence indicates that *after* the uncontested January 12, 2012 injury, Petitioner presented with a new onset of lumbar radicular symptoms that clinically correlate to new objective findings (notable at L4-L5) which required significant medical intervention:

- On 1/15/10, lumbar MRI noted at L4-L5, a small circumferential disc bulge at L4-L5 had caused mild indentation of the anterior thecal sac and mild bilateral foraminal stenosis with a transitional vertebral body at L5. At L3-4, a small circumferential disc bulge had caused mild narrowing of the right intervertebral foramen.

- On 4/12/2010, Dr. Odor reviewed MRI scans of Petitioner's lumbar spine from 11-24-2008 and 1-15-2010. Regarding the 2010 scan, the doctor noted bilateral foraminal stenosis at L4-5 while the 2008 scan revealed mild narrowing of the left L4-5 foramina. Dr. Odor further noted Petitioner's symptoms changed following his newer injury of 1-12-10, indicating that Petitioner's current need for treatment was causally related to his injury of 1-10-10. (Id.).

- On 12/3/2010, Dr. Odor administered injections for lumbar discography at L2-3, L3-4, L4-5, L5-S1. Summary of findings noted a two-level positive lumbar discography at L3-4, L4-5 with normal disc L2-3 and L5-S1. Petitioner was sent for a CT scan for further structural diagnostic evaluation. Impression of the radiology report noted narrowing of the disc spaces at L3-4 and L4-5. There were annular fissures at L3-4 and L4-5. Mild to moderate foraminal stenosis bilaterally at L4-5 was noted.

- On 12/9/2010, Dr. Odor issued an addendum to his 12/3/2010 report stating that Petitioner should have the option of a two-level anterior posterior lumbar fusion at L3-4 and L4-5 with stabilization and anterior reconstruction to restore sagittal height and alignment. (Px. 1).

- On 4/24/2012, MRI of Petitioner's lumbar spine demonstrated moderate right neural foraminal stenosis at L3-4 from a right foraminal protrusion. At L4-5, mild bilateral neural foraminal narrowing from a mild disc bulge was noted. A small posterior protrusion at T11-12 minimally effaced the thecal sac. There was mild disc dehydration. (Id.).

- On 4/30/2012, Dr. Odor noted Petitioner's most recent lumbar MRI showed significant disc disruption. The doctor's continued recommendation for a two-level lumbar decompression, restoration of sagittal alignment, interbody reconstruction and two-level fusion L3-4 and L-4-5 with decompression of the spinal canal was noted. (Id.).

- On 9/11/2012, Dr. Michael Riggs and Dr. Odor performed surgery at Oklahoma Spine Hospital. Dr. Riggs operative report noted a preoperative diagnosis of degenerative lumbar disc disease at L3-4, L4-5, and L5-S1 with lumbar instability and spondylolisthesis. Dr. Odor's preoperative diagnosis noted lumbar stenosis, lumbar instability, lumbar spondylolisthesis, lumbar radiculopathy and lumbosacral instability. Petitioner underwent an anterior lumbar interbody fusion, L3-4, L4-5 and L5-S1, with discectomy and anterior instrumentation at L3-4, L4-5 and L5-S1. (Px. 9).

In his deposition on February 24, 2016, Dr. James Odor testified:

A: [On January 28, 2010,] I discussed the fact that he had new injuries to his cervical, thoracic, and lumbar spine, cervical disc protrusions at C3-4 and C6-7 surrounding his fusion construct, thoracic pain of uncertain etiology, and a lumbar disc protrusion at L3-4 and L4-5 with new onset of lumbar radicular symptoms that, in my opinion, were related to his injury of . . . 1/12/10.

Q. So just so we're clear, the conditions and the problems that you've just diagnosed and described in your opinion are related to the injury sustained on January 12, 2010; correct?

A. Correct. (PX #1, p. 23).

In part, Dr. Odor based his opinion upon a comparison between a prior MRI scan and an MRI taken after the 2010 accident.

A. . . . I reviewed MRI scans of the lumbar spine, the first being dated 11/24/08, and the second dated January 15th of 2010. Also reviewed my record and noted the difference on the two scans with bilateral foraminal stenosis at L4-5 being present on the January 15th, 2010, MRI. And on the 11/24/08 scan only showing mild narrowing of the left L4-5 foramen.

Q. And then what did you conclude based on that?

A. I stated the patient's symptom changed following his newer injury of 1/12/10. Also indicates the patient has a current need for treatment, major cause to be related to his injury of January 12, 2010. (PX #1, p. 25-6).

Dr. Odor opined that the need for the lumbar surgery was caused by the injury of January 12, 2010:

A. I recommended that the patient have the option of an anterior/posterior lumbar fusion. At that time, I mentioned L3-4 and L4-5, two-level with stabilization and anterior reconstruction to restore sagittal height and alignment.

Q. Okay. Was that, in your opinion, to correct the injury sustained in the January 12, 2010, incident?

A. Yes. (PX #1, p. 33).

Prior to the surgery, Dr. Odor evaluated Petitioner's gait and posture:

Q. Okay. Would you explain to the arbitrator what you observed when you saw Mr. Taylor walking before the surgery?

A. Well, he had to take very short steps and he was flexed forward at the lumbar spine and held himself in a -- in a hip-flexed position, which then, in order to kind of offset that disturbance in his center of gravity, required him to bring his neck back up. I mean, it almost looked kind of like a -- oh, almost kind of like a bird walk. It was just an odd -- it was an odd walk that I've only seen when patients are in such dire pain that they're just doing what they can to walk and not exacerbate their pain. (PX #1, p. 34).

Having treated Petitioner for both the workplace injuries sustained in 2007 and 2010 (PX #1), Dr. Odor was in a position to differentiate between the effects of each injury. At the January 28, 2010, examination, Dr. Odor noted that Petitioner "had gotten a lot better" and "just prior to this new injury he was feeling well" (PX #1, Ex. 3). Dr. Odor further noted, "He had only minimal residual symptoms, which he was able to tolerate and in fact, was scheduled to see me today to be released." However, due to the recent injury, instead of being released from Dr. Odor's care, Petitioner now complained of new neck, low back, and mid-back thoracic area pain. Dr. Odor noted that Petitioner "gets about the room very slowly." Dr. Odor testified that Petitioner had new injuries to his cervical, thoracic, and lumbar spine, cervical disc protrusions at C3-4 and C6-7 surrounding his fusion construct, thoracic pain of uncertain etiology, and a lumbar radicular symptoms that were related to his injury of 1/12/10 (PX #1, p. 23). Dr. Odor also noted that Petitioner did not walk with his unique and guarded gait until after the 2010 injury (PX #1, p. 30). Dr. Odor testified that the medical treatment and care, including charges, provided for Petitioner from January 12, 2010, to present (date of deposition: February 24, 2016) were related to the January 12, 2010, injury (PX #1, p. 59-60).

With respect to Petitioner's surgery Dr. Odor testified Petitioner was scheduled for a two-level fusion at 3-4 and 4-5 although:

> [A]fter getting in there and also reviewing all the imaging studies concomitantly in the OR, I decided to do L5-S1 because it was asymmetrically tilted in the coronal plane throwing him into a slight scoliosis. And so it wouldn't have been proper to stop 3 at just 3-4 and 4-5 without connecting it to 4 the -- to the base of the spine. So he underwent a three-level, anterior and posterior lumbar decompression and fusion with stabilization.

Dr. Odor further testified to his intraoperative impressions:

Q. Okay. Doctor, after getting into Mr. Taylor's lumbar spine and seeing what the condition was in the surgical process, was there any doubt in your mind whatsoever that Mr. Taylor was faking or malingering any of his complaints, symptoms, or altered gait?

A. No. And, in fact, it further confirmed. Actually looked worse than, you know, what the scans had indicated, especially with that L5-S1 level as well. It was also in what we call restrolisthesis position and asymmetrically tilted. And so, you know, I went - I was very comfortable with being there after seeing the findings, knowing that we were doing the right thing. (PX #1, p. 45-7).

Furthermore, Dr. Odor examined and observed Petitioner after the surgery, including Petitioner's first post-operation visit on October 11, 2012. Dr. Ghanayem did not have the benefit of this or any other post-op follow up visit:

Q. How was Mr. Taylor's gait that day?

A. It was good. He was walking erect. First time I'd seen him walk in that normal gait position for almost three years.

Q. Do you recall how his spirits were?

A. He was smiling. He was happy. He was doing very well. He was -- he was really a pleased patient.

Q. Okay. And, Doctor, after having performed the surgery and seeing the end results, do you have an opinion within a reasonable degree of medical certainty as to whether the end results verified the need for the surgery, or validated the need for the surgery, I should say?

A. Well, it always helps. When you see such a striking difference between pre and post op, it helps confirm the right decisions were made. (PX #1, p. 48-9).

Regarding Petitioner's shoulder pain, Dr. Olsen testified that shortly before Petitioner's 2010 injury, Petitioner had gone back to full activity with no particular complaints until he suffered another work injury in January 2010. (PX #3, p. 24). Dr. Olsen further testified that the symptoms he treated Petitioner for in 2010 were not related to the injuries sustained in 2007 (PX #3, p. 24-5). As a result of the 2010 injury, Dr. Olsen ultimately diagnosed Petitioner with left and right shoulder pain with mild mechanical symptoms of his right shoulder. (PX #3, p. 34).

Regarding medical evidence to the contrary, on June 3, 2010, Dr. Ghanayem performed an examination pursuant to Section 12 of the Act. Notably, Dr. Ghanayem advised that he had no opinion on issues of causation and treatment with respect to Petitioner's shoulders. (RX #1, p. 8). Regarding Petitioner's lumbar spine, the doctor opined that Petitioner has "non-organic physical findings on today's exam consistent with symptom magnification". (Id.). Dr. Ghanayem noted he found "nothing objective on today's examination." Dr. Ghanayem acknowledged Petitioner did sustain injury when he fell, he believed such was only soft tissue in nature. The Arbitrator notes the doctor had not reviewed the lumbar MRI scans from January 15, 2010 and November 24, 2008 on this date.

When Dr. Ghanayem had the opportunity to review Petitioner's 2008 and 2010 MRI comparison scans, he did find that "there was [were] some differences in foraminal stenosis being bilateral on the latter scan and unilateral on the older scan" (RX #1, p. 11). Ultimately, Dr. Ghanayem concluded that Petitioner suffered a "soft tissue injury of the back," and he "felt that he [Petitioner] needed nothing further and should move on" (RX #1, p. 18). Dr. Ghanayem stated the belief that Petitioner's condition was the result of "malingering" and symptom exaggeration, based upon his examination and observations, but, in his reports and testimony, Dr. Ghanayem never provided a detailed analysis of the medical treatment record to support his theory.

Regarding the proposed surgery, Dr. Ghanayem concluded there was no objective basis that required spine surgery (RX #1, p. 48, 55). Dr. Ghanayem last examined Petitioner in 2011 and last reviewed Petitioner's medical records on September 12, 2012 (RX #1, p. 44). Therefore, he had no access to the additional MRIs, operative report, or four years of additional medical treatment records.

Based on careful review of the evidence contained in the record, the Arbitrator finds the preponderance of the evidence supports a finding that Petitioner's current condition of ill being is causally connected to his work-related accident of January 12, 2010, necessitating all of the medical treatment of record (PX #14) provided to Petitioner since that date.

Regarding Issue "K," whether temporary total disability (TTD) benefits are due, the Arbitrator finds the following:

Following Dr. Ghanayem's first Section 12 examination, the Respondent terminated temporary total disability benefits. There is no stipulation regarding the precise stipulated date of the onset of Respondent's payment of TTD or termination date. However, there is a stipulation between the parties that the Respondent is entitled to receive credit for having paid a total of $62,444.78 in TTD. Accordingly, the Arbitrator finds that Respondent has paid TTD from the date of accident through March 24, 2011. Therefore, at issue is Petitioner's entitlement for additional TTD commencing on March 25, 2011, and when that obligation would end. Petitioner claims that he is entitled to TTD through the date of February 17, 2016, which coincides with an office visit and examination by Dr. Odor.

The medical records in evidence show that from the date of accident until the date of maximum medical improvement, Petitioner was under the continuous care of his treating physicians for the purposes of curing and alleviating the injurious effects of his accidental injury until the date of MMI. Dr. Odor had either excused Petitioner from work altogether or to the extent that Dr. Odor released Petitioner to return to work with restrictions pending MMI. Respondent elected not to take Petitioner back to work in a position accommodating his restrictions in a non-DOT capacity (PX #1, Ex. 3). Respondent never challenged the examining DOT physician's determination that Petitioner was medically unfit to perform his duties as a commercial driver.

Consistent with well recognized Illinois law on this issue, it is the holding of the Arbitrator that pending MMI during a period of temporary total disability and if the employer is unable to accommodate the injured employee's medical restrictions governing a return to work, the employer is obligated to continue TTD payments until the worker has attained maximum medical improvement. Petitioner's having reported to the Texas facility to return to work, after being informed by Dr. Ghanayem that he was medically fit to do so and despite whatever misgivings or concerns Petitioner may have had, shifted the burden to Respondent to either provide work he was capable of performing or pay TTD through MMI.

Accordingly, Respondent is ordered to pay Petitioner 256 weeks of accrued unpaid TTD at the rate of $961.33 weekly for benefits commencing March 25, 2011, through February 17, 2016.

Regarding Issue "L," the nature and extent of Petitioner's injury, the Arbitrator finds the following:

The Arbitrator does not agree that Petitioner is permanently and totally disabled as a result of his work accident. "An employee is totally and permanently disabled for the purpose of workmen's compensation benefits when he is unable to make some contribution to industry sufficient to justify payment to him of wages." *A. M. T. C. of Illinois, Inc., v. Indus. Comm'n*, 77 Ill. 2d 482, 487 (1979). However, this does not require that the injured party be reduced to a state of total physical or mental incapacity or helplessness. *Id.* A person is totally disabled when he cannot perform services except those that are so limited in quantity, dependability or quality that there is no reasonably stable market for them. *Id.* Therefore, if an employee can take up some form of employment without seriously endangering his health or life he is not entitled to total and permanent disability compensation. *Id.* at 488.

At the very least, the "medical reports admitted into evidence must state that he is permanently and totally disabled." *Id.* On the other hand, the claimant can also testify that he is permanently and totally disabled." *Id.* at 489. "However, the inability to do very strenuous manual labor does not necessarily make one permanently and totally disabled." *Id.* 'Disability is not tested by any particular occupation." *Id.* "[E]ven a skilled craftsman who can no longer perform his craft due to an industrial injury may not be deemed totally disabled if there is regular unskilled work that is continuously available to him." *Id.* Therefore, just because the claimant cannot perform very strenuous physical labor does not, by itself, entitle him to an award as permanently and totally disabled. *Id.*

"In arriving at a determination of an award for permanent and total disability, the Commission should consider the extent of the claimant's injury, the nature of his employment, his age, experience, training and capabilities." *Id.*

"If a claimant's physical disability is limited in nature so that he is not obviously unemployable, then it is not unreasonable that the burden be upon him to establish the unavailability of work to a person in his circumstances." *Id.* at 490. "This burden can be met by showing that reasonable efforts were made to secure suitable employment the kind of employment that can be performed by a person in his circumstances." *Id.* In *A. M. T. C. of Illinois, Inc.*, the petitioner "did not attempt to seek other employment, nor did he testify that he cannot perform work other than heavy moving due to physical inability or lack of training and skills." *Id.* Similarly, in this case, Petitioner testified he can work as a limousine driver, and that he would work as a dispatcher if he was offered such a position. Accordingly, Petitioner is not so obviously unemployable. Petitioner testified he does not have any job logs showing confirming that he looked for work in the years between his date of loss January 12, 2010 and the date of this hearing October 13, 2016. Petitioner confirmed during trial he did not look for any work in any of these years. It is also noted Petitioner never demanded vocational rehabilitation services from Respondent.

Petitioner never underwent a Functional Capacity Evaluation to objectively test his work restrictions.

The Arbitrator is not persuaded by the opinions of Petitioner's vocational rehabilitation counselor that Petitioner is not employable. Petitioner himself testified he can and did work as a limousine driver after his back surgery and that he still has a limousine Chauffer's driving license. Petitioner further testified that he would work as a dispatcher if he was offered such a position. Dr. Odor noted that Petitioner could go back to a job that is within his restrictions. When asked if he expects Petitioner to go back to work in some capacity, Dr. Odor answered "sure."

Based on a careful review of the evidence contained in the record, the Arbitrator finds that Petitioner has failed to prove he is permanently and totally disabled.

Based on a careful examination of the evidence contained in the record, the Arbitrator finds that Petitioner is entitled to an award of permanent partial disability to the extent of 30% loss of use of the person as a whole pursuant under Section 8(d)(2) of the Act, or 150 weeks at a PPD rate of $664.72.

Regarding Issue "O," whether Respondent is entitled to Section 5(b) credit, the Arbitrator finds the following:

The Arbitrator does not have enough evidence to rule on this issue.

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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HOWARD COCKRELL,

Petitioner,

20IWCC0129

vs.

NO: 16 WC 38838

MACY'S CORP. SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability and medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but corrects several scrivener's errors as explained below.

On Page 1 of 6, in the last sentence of the first paragraph, we correct the phrase "her average weekly wage" to "his average weekly wage." Similarly, the end of issue "1." should state, "his employment" instead of "her employment."

On Page 2 of 6, we correct the first sentence of the first full paragraph to state that Petitioner loaded "couches" instead of "coaches." The last sentence of the seventh paragraph should state "that Petitioner advised he thought the man was Jamaican based upon his thick accent;" not "accident." The first sentence of the last paragraph on Page 2 should state "on behalf" instead of "in behalf."

On Page 4 of 6, the first paragraph should indicate, "His pain had worsened" instead of "hae" worsened.

20IWCC0129

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2018, is hereby affirmed and adopted with the correction of scrivener's errors.

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

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

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

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

DATED: FEB 25 2020

Maria E. Portela

Kathryn A. Doerries

Marc Parker

MP/se
O: 1/21/20
49

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

COCKRELL, HOWARD
Employee/Petitioner

Case# **16WC038838**

MACY'S CORP SERVICES
Employer/Respondent

20IWCC0129

On 7/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.10% 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:

1691 RICHARD O. GREENFIELD
415 N LASALLE ST
SUITE 203
CHICAGO, IL 60654

5001 GAIDO & FINTZEN
GAIL M BEMBNISTER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS
COUNTY OF LA SALLE)

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

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

Howard Cockrell
Employee/Petitioner

Case # 16 WC 38838

v.

Macy's Corp. 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 **Christine Ory**, Arbitrator of the Commission, in the city **Ottawa on December 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. **X** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. **X** Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident **April 11, 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 accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$18,833.10**; the average weekly wage was **$362.18.**

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

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

Respondent shall be given a credit of **$13,383.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,383.23.**

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

ORDER

Petitioner failed to prove he sustained accidental injuries that arose out of and in the course of his employment with respondent on April 11, 2016.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine M Ory
Signature of Arbitrator

July 13, 2018
Date

IC ArbDec19(b) p. 2

JUL 1 6 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Howard Cockrell	)
Petitioner,	)
vs.	) **No. 16 WC 38838**
Macy's Corp Services	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Ottawa on December 28, 2017. The parties agreed that on April 11, 2016, 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 petitioner gave notice of the alleged accident within the time limits stated in the Act. They agree petitioner's wage in the year predating the claimed accident was $18,833.10 and her average weekly wage, calculated pursuant to §10, was $362.18.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for medical expenses.
4. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner, Howard Cockrell, Testimony

Petitioner began initially working for respondent through a labor service for one year. As of March 6, 2016, petitioner became a direct employee of respondent as a material handler.

On April 11, 2016, petitioner was working at respondent's dock area in Minooka. He clocked in at 7 AM. Thereafter he huddled with his supervisor, Barry for five to ten minutes in Barry's office. After the meeting, a black man at the computer, directed petitioner where he was to work.

He was told to unload broken pieces from a truck. There were three ladies on one side and a man on the other side, who inspected the pieces to determine if they should be fixed or discarded. He was told by the ladies where the pieces go by the color and type of product. He used a two-wheeler to unload the truck and to take the merchandise where it was to go. He scanned the pieces as they were unloaded.

Petitioner testified there was a call on the radio by an unknown person; who advised him that Barry wanted him to go up front. On his way up to the front, petitioner noticed Barry was in his office. Up front, he was instructed by a short dark Jamaican man to load trucks. Petitioner was given a new scanner by the Jamaican man and received instructions on operating the new scanner,

who also helped him put his code into the gun. He was advised by the Jamaican man to go to the "Detroit" truck. When petitioner opened the truck, he noted the floor was wet. He was told by the Jamaican man it was okay to put cardboard down in the truck. He had to come out and find the floor supervisor to assist him with the scanning gun. The scan was to show where the furniture was loaded inside the truck.

Petitioner testified he first loaded coaches and sofa beds; then loaded all sorts of other products on top, including ottomans and chairs. This took about an hour and a half. During this time, petitioner noticed the Jamaican man passed by him twice; saying nothing. Petitioner understood the Jamaican's job was to insure the trucks were properly loaded. Petitioner testified as he loaded the third of four sectional chairs, he twisted his ankle and heard a pop. He yelled for help. A nurse came with a wheel chair. There were no witnesses to the accident.

He was taken to Physicians Immediate Care in Joliet. He was given an ice pack or heat pack and prescribed physical therapy. He also went on his own to see Dr. Krevitz.

He was examined by Dr. Holmes in accordance with §12 of the Act.

On cross-examination, petitioner confirmed he was hired directly by respondent on a part-time basis as of March, 2016.

Petitioner testified, that on the morning of the claimed occurrence, the meeting with Barry lasted five to ten minutes; the first meeting with the Jamaican man lasted five to ten minutes and he unloaded the miscellaneous pieces for about thirty minutes. The meeting with the Jamaican man regarding loading the truck lasted five to ten minutes. It took him ten to fifteen minutes to learn how to use the scanner.

He also stated there was water in the front of the truck.

Prior to April 11, 2016, petitioner had spoken with the Jamaican man on a daily basis. Petitioner could not identify the Jamaican man by name as he is not good with names. The Jamaican man was a supervisor on the floor; who normally sat behind a computer. When petitioner was present for the hearing that was to take place in Kankakee, he said he thought the Jamaican man was name Matt or Michael or Carl David. Petitioner testified that when Carl David appeared for the hearing in Kankakee, he decided Carl David was not the Jamaican man. It was not until late November or December, 2017 that petitioner advised he thought the man was Jamaican based upon his thick accident.

Despite the positive urine test on April 11, 2016 for cocaine and codeine opiates, petitioner denied he ever used illegal drugs. Specifically, he denied ever using cocaine, opioids or any illegal drugs.

On redirect, petitioner testified he had been referred for dental work to an oral surgeon and given a pain killer prescription. He had been taking a prescription not prescribed for him but for his significant other. The prescriptions he was taking was Norco and Tylenol 3.

Petitioner testified his normal supervisor was Steve, who was not working that day. Petitioner testified his friend told him that the Jamaican no longer worked for respondent.

Petitioner testified he advised Ashley Harris, who took the first report of injury, that he was taking Norco and Tylenol 3 at time of the accident.

Barry Mason Testimony

Barry Mason, was called upon to testify in behalf of respondent. Mason, who last worked for respondent on July 9, 2017, had been the operations manager for four years at respondent's operations in Minooka. Mason knew petitioner and had dealt with him on a daily basis.

Mason specifically recalled April 11, 2016, as the Minooka location had gone over 600 days without a lost-time accident. Mason started the day at 6:15 A.M. Petitioner started at 7:00 A.M. Mason discussed with petitioner the areas to be covered, volume and the what was to be done in the next couple of days. This meeting lasted about 10 to 15 minutes. During this interaction, Mason did not find petitioner exhibited any evidence of intoxication. Mason instructed petitioner to sweep out trailers prior to loading the trailers.

Mason left the "Big Ticket Area", which is where petitioner was working, for about ten to twelve minutes, to go to receiving. Petitioner was sweeping out trailers when he left. When Mason returned to the "Big Ticket Area", petitioner was in a wheelchair. Other crew members told Mason what occurred. Mason went into the truck where petitioner was working. Mason found the floor was not wet, there was no cardboard and there was no furniture. Mason was advised by crew members there were no witnesses and petitioner came out of the truck limping. This occurred at about 7:20 to 7:25 A.M.

Mason testified petitioner had not yet been trained on the use of scanners. Mason was not aware of anyone working in a supervisory capacity at the facility with a Jamaican accent. The only short black man who worked in a supervisory capacity was Carl David. The other two black supervisors were Jason Moore and Ron Ellerson. Jason is 6'2" tall and was stock leader; he would not have given instructions to Mason's employees. Ron was out on medical leave on April 11, 2016.

Mason testified that if the trailer was wet, it would have been taken out of service. He also testified respondent used to put down cardboard, but no longer do so as it was too expensive.

Northwestern Medical Group/Dr. Curt S. Krevitz Bill (PX.1)

$219.00 for services rendered on March 20, 2017

Employer's First Report of Injury (PX.2)

The employer's first report of injury was completed by Ashley Harris, Claims Analyst, on April 14, 2018. According to this report, petitioner was loading an armchair into a trailer by himself. As he lifted the armchair to shoulder height he twisted his foot outward and felt pain in his [left] foot. The accident reportedly occurred at 8:00 A.M.

Hinsdale Orthopaedics Work Status Report (PX.3)

The work status report, completed by Dr. Brian J. Burgess, D.P.M. on May 24, 2016, authorized petitioner off work for four weeks.

Physicians Immediate Care Physical Therapy Records (PX.4)

The history given at the April 28, 2016 physical therapy evaluation was that he was lifting chair and foot slipped on cardboard in truck.

Physicians Immediate Care Records (PX.5)

History provided at the time of petitioner's initial visit on April 11, 2016 was: "Patient was putting a chair in a high position with the chair held in front of him and as he lifted and went forward the lateral side of hid (sic) ankle went laterally."

Petitioner reported he was already taking Aleve and Tylenol-Codeine 3. X-rays were taken, walking boot and crutches were prescribed for the diagnosed ankle sprain. He was also prescribed Tylenol-Codeine 3 and all-day pain relief. He was released to sedentary work only.

Petitioner returned on April 19, 2016. His pain hae worsened. He was given a Toradol shot and physical therapy was prescribed. He was to discontinue use of Tylenol-Codeine 3. He was released to sit-down work only.

At the May 3, 2016 visit, an MRI was ordered. He was released to sit-down work only.

An MRI of May 11, 2016, showed a peroneus longus tendon tear by the inferolateral aspect of the calcaneocuboid joint in the midfoot; severe tendinopathy of the peroneus longus proximal to the tear which extends to approximately 3 cm above the tip of the fibula. Another high grade tear is questionable approximately 2.3 cm superior to the tip of the fibula. Lisfranc ligament was intact with no evidence of bone contusion or occult fracture.

On May 13, 2016, petitioner was referred to Hinsdale Orthopaedics and kept on sit-down work only.

He was seen again on May 27, 2016, and kept on sit-down work restrictions. He was to see Dr. Burgess on June 21, 2016.

Northwestern Medical Foundation (PX.6)

Petitioner was seen by Dr. Curt S. Krevitz, DPM on April 14, 2016; but no information was provided regarding this visit.

On August 22, 2016 petitioner was seen by Dr. Scott Dresdan for the left ankle injury. He was looking for pain medication; having no new opiates since May. He was given four Tylenol with codeine to tide him over until his orthopedist appointment that week.

On August 24, 2016, petitioner was seen by Dr. Krevitz. The history was that he was loading truck when his left ankle gave out/slipped, heard a loud pop and had severe pain immediately, swelled, turned black and blue.

The August 27, 2016 MRI showed moderate retromalleolar and inframalleolar peroneus longus tendinosis with areas of partial-thickness tearing and mild inframalleolar peroneus brevis tendinosis without high-grade tear. No full-thickness tear or tendon displacement was identified. There was mild peroneal tenosynovitis.

Petitioner was seen again on September 8, 2016, but no notes were included with this encounter.

On September 19, 2016, petitioner reported he missed his last appointment as he was hit by offender with a baseball bat on September 1, 2016; delayed going to doctor until the following Thursday when he went to Mr. Sinai Hospital. Dr. Krevitz injected petitioner's ankle with lidocaine into left peroneal tendon. Surgery was discussed.

On September 28, 2016 there were no entries for this visit.

On October 3, 2016 petitioner reported no improvement with the injection. He was not ready to schedule surgery.

There was no information recorded for the October 8, 2016 visit.

Petitioner returned to Dr. Krevitz on March 20, 2017, after exam by Dr. George Holmes. Dr. Krevitz reported Dr. Holmes advised petitioner he did not need the CAM boot. Dr. Holmes did not believe the pain was due to peroneal tendon tear despite the MRI findings. Dr. Homes recommended an EMG.

There was no entry for the May 19, 2017 encounter.

Midwest Orthopaedics at Rush/Dr. George Holmes January 11, 2017 Report (PX.7)

Petitioner was examined by Dr. George Holmes on January 11, 2017. Dr. Holmes reviewed medical records. Dr. Holmes diagnosis was possible neuritis involving the superficial

peroneal nerve and possibly even the sural nerve of the left ankle. Dr. Holmes found petitioner's condition was caused by the claimed accident.

Dr. Holmes found the treatment to date had been appropriate; although Dr. Holmes believed cortisone injection of a tendon injury was contraindicated. He did not recommend surgery. He recommended an EMG. Dr. Holmes did not believe petitioner was capable of working full duty.

First Advantage Controlled Substance Report (RX.1)

The laboratory report from Quest Diagnostics reported petitioner's specimen from April 11, 2016 tested positive for cocaine metabolites and Codeine.

TTD Payments to Petitioner (RX.2)

The shows payment of temporary total disability from April 12, 2016 through May 5, 2017 at the rate of $241.45 for a total of $13,383.23.

Medical Payments (RX.3)

This shows respondent paid $7,145.08 for direct medical services.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

Petitioner has a serious credibility problem. The reported use of cocaine was not so much the problem, but rather the fact he lied about using cocaine, which was refuted by Respondent's Exhibit 1. The timing of the accident, as well as the elaborate story regarding the Jamaican man, added to petitioner's credibility issues.

Contrary to the petitioner, the Arbitrator finds Barry Mason to be credible. As he no longer works for respondent, he has nothing to gain by fabricating or embellishing what occurred.

The only thing that occurred on April 11, 2016 that petitioner and his supervisor, Barry Mason, agreed on was that petitioner arrived at work at 7 AM. After that, their testimony is diametrically opposed.

Even if petitioner's testimony is taken as true, and he performed all of the activities he claimed he was performing before and at the time he was injured, the accident would have occurred well after the 8 A.M., the time petitioner reported the accident occurred. Furthermore, Mason testified petitioner was in a wheel chair by 7:30 A.M. at the latest.

The story petitioner told regarding the "black Jamaican supervisor", even without the testimony of Mason, holds no water. The Arbitrator noted petitioner testified he initially advised respondent he thought the man's name was Michael or Matt, and then settled on Carl David. However, when Carl David showed up for the hearing that was to take place in Kankakee, petitioner decided it was not Carl David. Furthermore, it was not until November or December [2017], that petitioner added the fact that he thought the man was Jamaican. Conveniently, petitioner learned from a friend, who was still working for respondent, that this Jamaican man was no longer employed by respondent.

Petitioner's testimony that he was told to go up front by an unknown person at the direction of Barry Mason, and yet saw Barry Mason in his office, makes no sense.

Petitioner testified he twisted his ankle when lifting an armchair overhead. This was also what was reported at the time of his initial visit to Physician's Immediate Care (PX.5) and on the First Report of Injury (PX.2). And yet, on April 28, 2016, he reported he slipped on cardboard when lifting a chair. According to Mason, they no longer use cardboard as it is too expensive. Furthermore, according to Mason, if the trailer was wet, it would have been taken out of commission, rather than putting down cardboard.

Additionally, Mason testified that he inspected the trailer where petitioner was purportedly working when he twisted his ankle; he found it was empty and was without water, cardboard or furniture. This debunks petitioner's claim that he twisted his ankle when lifting furniture and/or slipping on cardboard. Therefore, even if petitioner rolled his ankle while inside the trailer, there is no evidence petitioner suffered a work accident by rolling his ankle.

Petitioner testified that after twisting his ankle, he yelled for help. The nurse came out, talked to petitioner, and then went and for a wheel chair. This is contrary to what Mason learned from the crew members, which was that petitioner came out of the trailer limping.

For the foregoing reasons, the Arbitrator finds petitioner failed to prove by a preponderance of the evidence that he suffered an injury to his left ankle as a result of a work accident that arose out of his employment with respondent on April 11, 2016. The Arbitrator, having found that petitioner failed to prove by a preponderance of the evidence that he suffered a work accident by merely rolling his ankle, does not address the issue of whether petitioner's claim should be barred under §11 of the Act due to his apparent use of cocaine.

As the Arbitrator determined petitioner failed to prove he was injured in an accident that arose out of his employment with respondent, the claim is denied and all other issues are moot.

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

Sonya Morgan,

Petitioner,

20IWCC0130

vs.

NO: 17 WC 032823

Walmart, 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, causation, medical expenses and prospective medical, notice, temporary total disability, oral amendment of dated application and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2019 is hereby affirmed and adopted.

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

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

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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: FEB 25 2020
o020420
MEP/ypv
049

Maria E. Portela

Kathryn Doerries

Marc Parker

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

MORGAN, SONYA Case# **17WC032823**
Employee/Petitioner

WALMART INC **20IWCC0130**
Employer/Respondent

On 8/9/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.95% 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:

4888 SHORT AND DAUGHTERTY PC
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

5074 QUINTAIROS PRIETO WOOD & BOYER
JULIE M SCHUM
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

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STATE OF ILLINOIS)
)SS.
COUNTY OF **Williamson**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sonya Morgan,
Employee/Petitioner

v.

WalMart Inc. ,
Employer/Respondent

Case # **17** WC **32823**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Herrin**, on **6/12/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **10/04/17**, Respondent ***was*** operating under and subject 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 $**14,690.30**; the average weekly wage was $**282.51**.

On the date of alleged 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent on October 4, 2017 or on any other date. Petitioner's claim for compensation is therefore denied.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

August 8, 2019
Date

AUG 9 - 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sonya Morgan,	)	
	)	
Petitioner,	)	
v.	)	
	)	Case No. 17 WC 32823
WalMart Neighborhood Market	)	
	)	
Respondent.	)	
	)	

MEMORANDUM OF DECISION OF ARBITRATOR

I. Procedural History

This matter proceeded pursuant to Petitioner's Motion under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") by Sonya Morgan (hereinafter "Petitioner") who sought relief from Walmart Inc. (hereinafter "Respondent"). Petitioner filed an Application for Adjustment of Claim on November 7, 2017. This matter was heard on June 12, 2019, in Herrin, Illinois before Arbitrator Robert M. Harris (hereinafter "Arbitrator Harris"). Arbitrator Harris has examined the Transcript of Proceedings on Arbitration and the submitted records and renders the following Decision.

II. Findings of Fact

On October 4, 2017, Petitioner was employed by Respondent as a cashier. (T.20). She had been working for Respondent in that capacity since September 2017. (T.19). Prior to her employment with Respondent, Petitioner was in a car accident in December 2016 as well as in 2008. (T. 46-47).

Also prior to the alleged incident, Dr. Gebauer's records reflect that on March 5, 2015, Petitioner treated for upper back and neck ongoing for the past six months. (RX.3). She noted upper back, neck, and middle back pain at that time. (*Id.*). Petitioner denied making those reports. (T. 50).

Subsequent to the December 2016 motor vehicle accident, Petitioner treated for pain in her right shoulder, neck, thoracic and lumbar spine. (PX. 1 and 2). She underwent epidural steroid injections for the same and a MRI on January 4, 2017. (*Id.*).

Petitioner also saw Dr. Fast on January 16, 2017 for increased pain in the neck and shoulder after a slip and fall on ice. (T. 51).

At trial, Petitioner testified that on October 4, 2017, a Wednesday, she was injured. (T.21-22). She testified that she was moving a case of beer off the conveyor belt and reached with her right arm to grab the handle. (T.22-23). She then lifted it just enough to get her left hand under. (T.23). As she lifted it with her right hand, she testified that she felt a pop in her neck and pain down her right arm. (T.24). She did not report it at that time. She testified that she went to customer service but did not report it to a manager at that time. (T.27-28). She testified that the following day she was off work. (T. 28). She came back on Friday and reported the incident to the HR Manager and Heather, the assistant store manager. (T.28). She testified that this occurred two days after the event. (T.28). She further testified that at that point, she had pain in the right side of her neck and by the time she reported the incident two days later, both arms had already started going numb. (T.29).

Petitioner visited Anderson Hospital Emergency Department on October 6, 2017. (Rx. 4.). Petitioner's Chief Complaint was "Nausea" that began two weeks ago. "Associated Symptoms" was "Headache." (RX.4). There was no mention of any work accident. There was no mention of any neck, shoulder or arm pain or symptoms. A physical examination was performed; Musculoskeletal exam showed "Full ROM, normal strength" and Spine/Back exam showed "Normal ROM".

Petitioner testified she first sought treatment regarding accident on October 19, 2017 (T. 30-31). Petitioner was seen on October 19, 2017 at HSHS St. Elizabeth's Hospital Emergency Department (PX. 4). At that time, Petitioner reported a history as follows: "This is a 30-year-old Caucasian female past history cervical disc bulging with radicular pain to right shoulder following MVA in December 2016 who presents to ER with complaints of right shoulder pain and right neck pain which flared up again on or about September 9, 2017. She reports pain worsened after started working as a cashier for Walmart. She had thought the problem with the bulging disc and right shoulder pain was fixed after she had steroid injections in early 2017." The diagnosis/impression was "cervical radiculopathy, chronic." No specific history of a work accident is indicated. On

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October 19, cervical X-rays were taken. The "Clinical history" was "History of trauma. MVA several months prior." No specific history of a work accident is indicated.

While this record entry indicates Petitioner gave a history of a pain flare-up again on or about September 9, 2017, Petitioner testified she believed a mistake occurred regarding this date as the hospital staff asked her when she started working and she said September 9, 2017. (T. 31). Petitioner testified that she began working on September 1, 2017. (T. 19).

On October 23, 2017, Petitioner was seen at St. Elizabeth's emergency room again. The Chief Complaint was "Lower Extremity Complaint", "right foot pain." At that time, Petitioner reported a history as follows: "patient here in the right foot and right ankle pain over the past week she reports she twisted it last week no loss of function no other physical complaints. Past medical history noncontributory." (PX 4). No specific history of a work accident is indicated. Those records show no indication of any complaints of neck or shoulder pain at that time. (*Id.*). A physical examination was performed and there were no symptoms reported other than her foot.

Petitioner was seen by primary care provider Dr. Kyle Ashland on October 25, 2017 with a Chief Complaint of "right shoulder pain." (PX.5). The HPI was "Has r shoulder pain after suffering neck injury in MVA that was improved after neck injection until she attempted to lift a 30 pack of beer at work 3 weeks ago. She felt a pop in the based of her neck with shooting pain down her R arm. "

On October 30, 2017 - within the same month of the alleged incident date - Petitioner obtained an attorney. (T. 44). Petitioner completed an Application for Adjustment of Claim with "his assistant" at that time. (*Id.*). Petitioner testified that the Application indicated an accident date of October 4, 2017 and that she was aware that by signing the Application she was putting forth the information on it as being accurate. (T. 45-46). When asked if the accident paperwork she filled out could have indicated that she reported the alleged incident occurred on October 11 or October 13, 2017, Petitioner did not deny the possibility and said she was "confused" about the date but remembered the days of the week. (T. 56).

Petitioner did not treat again until she went to see Dr. Raskas on January 19, 2018. (T. 34). At that visit, Petitioner complained of neck pain with bilateral numbness that began after a motor vehicle accident in December 2016. (PX. 2). Petitioner reported to Dr. Raskas she had a work-related injury that occurred on October 2, 2017 when lifting a heavy item and scanning it (*Id.*).

A cervical MRI was performed on February 3, 2018. (PX. 3). The radiologist's impression was "C6-7 has a central disc herniation. This extends more towards the left than the right. There is impression upon the dura and extends to the cord. There is no abnormal cord signal, though there may be minimal cord flattening, as suggested on axial image #22 of 28. The disc does not have a definite foraminal component. The disc does extend more towards the left than the right but without definite extension into or beyond the foramina." All other discs were normal.

Dr. Raskas was deposed on August 6, 2018. (PX. 1). Dr. Raskas testified that his understand was that Petitioner was able to work and function until a work injury on October 2, 2017. (PX. 1, p. 7). He opined that Petitioner needed a C6-7 total disc arthroplasty for spinal cord compression. (*Id.* at 14). He opined that the only intervening event from the car accident that he was aware of was the work injury of October 2, 2017 and so he felt it was at least a cause of her current condition. (*Id.* at 16). Dr. Raskas opined that based on the records injections had helped her previous complaints of neck pain after the motor vehicle accident. (*Id.* at 19). Dr. Raskas also opined that she had not undergone injections after the alleged work injury. (*Id.* at 31).

Petitioner was evaluated by Dr. Chabot pursuant to Section 12 on May 31, 2018. (RX. 2). Dr. Chabot was deposed on January 11, 2019. (RX. 2). Dr. Chabot indicated that when he asked Petitioner to relate her alleged work injury, she reported to him that on October 4, 2017, she was injured at work. (*Id.* at 10). Dr. Chabot testified he reviewed the records from Anderson Hospital, Memorial Pain Clinic, Dr. Raskas, and Belleville Family Practice. (*Id.* at 11). Dr. Chabot reviewed both sets of MRI films and opined that the 2018 MRI actually showed a reduction of the disc lesion at C7. (*Id.* at 17). Petitioner complained of only diffuse pain at the time of his exam and had a number of non-organic complaints that Dr. Chabot opined were a strong psychosocial overlay to his complaints. (*Id.*). Dr. Chabot opined Petitioner suffered a strain for which she had reached MMI by the time of his IME and that any work restrictions were related to her general obesity. (*Id.* at 21-22). Dr. Chabot also testified that his opinions were all given to a reasonable degree of medical certainty. (*Id.* at 8).

Respondent presented the testimony of Jessie Baer, an operations manager for Respondent. (T. 62). Pursuant to store policy, when Petitioner made him aware of an incident on October 27, 2017, Baer testified that he collected statements. (T. 65-67). Baer testified consistently with his own statement that Petitioner reported three separate potential dates of accident to him. (T. 67-68 and

RX 6). Per Baer's contemporaneous statement, those dates included October 4, October 11, and October 13, 2017. (RX. 6).

Four other witness statements were also presented into evidence from Alice Geminn, Lori Kovar, Valencia Bee, and Heather Miller. (RX. 7-8). In the statement of Lori Kovar, it was indicated that on October 18, 2017, Petitioner reported incredible pain in her arm since the week prior. (*Id.*). No mention is made of any accident at work. (*Id.*).

Geminn testified consistently with her report that Petitioner advised her that her arm was sore due to her car accident from the beginning of this year. (*Rx. 7*).

Store Surveillance video was submitted from October 11 and 13, 2017. (RX 11). Of note, during the course of the video footage, Petitioner walks around to scan a large case of beverage rather than lifting it seven times. (*Id.*). On October 11, 2017 at 8:53am, she reaches out with her right arm with no apparently difficulty. (*Id.*). Again on October 13, 2017, at the 9:23am time stamp, she puts both arms on top of her head in a stretch with no apparent pain or difficulty. (*Id.*). On the same date, at 2:38pm, she is seen holding her arm out and behind her with no sign of pain or difficulty.

Surveillance from G4 Investigations was also submitted into evidence. (RX. 12). On April 2, 2018, Petitioner is seen driving and walking with no issues or evident pain. (*Id.*). Petitioner also is seen leaning into and out of her car with no apparent pain or difficulty. (*Id.*). On May 30, 2018, at the 5:50 mark, she is seen carrying two bags and getting into her car to drive. (*Id.*). At the 9 minute mark, Petitioner is seen clearly lifting both bags out of the back truck bed with no apparent pain or difficulty. (*Id.*). Throughout both videos, she is seen walking with normal arm and head movement with no indications of pain or difficulty. (*Id.*).

Time cards and punch clock registers were also submitted into evidence. (RX. 9-10). Based upon those documents, Petitioner did not work on either October 4, 2017 or October 5, 2017. (*Id.*).

At the conclusion of testimony, Petitioner made a motion to amend the accident date to October 3, 2017. (T. 113-114). Respondent objected to the same. (*Id.*). The Arbitrator denied the motion based upon Rule 9020.20: "Applications may be amended prior to a hearing on the merits by filing an Amended Application for Adjustment of Claim under the letter and number given the original Application."

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III. Conclusions of Law

The aforementioned Statement of Facts is hereby incorporated into each section of the follwing Conclusions of Law.

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 or her claim (*O'Dette v. Industrial Commission*, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1989). Decisions of an Arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

a. **With Regards to disputed issues "C" and "D", did Petitioner sustain an accident arising out of and in the course of her employment with Respondent, and on what date did that alleged accident occur, the Arbitrator finds and concludes as follows:**

The Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained an accident arising out of and in the course of her employment with Respondent on October 4, 2017 or on any other date. In making this finding, the Arbitrator notes the numerous inconsistencies in the records, Petitioner's own reports and her less then credible trial testimony.

The Arbitrator notes Petitioner filed her Application for Adjustment of Claim alleging a specific injury occurring on October 4, 2017 – and acknowledged by her own testimony that by signing that Application she was presenting it as accurate. Further, that Application was completed on October 30, 2017 – the very same month as the alleged injury occurred. It goes to follow that the date of accident should have still bene fresh in Petitioner's mind on that date, but apparently it was not. Petitioner's own testimony at trial had numerous inconsistencies regarding the date as well. Petitioner testified at trial that she was unsure of the date but was sure of the day of the week – a Wednesday per her testimony. October 4, 2017 was a Wednesday but the time cards are very clear October 4 was not a day on which she worked. Petitioner then testified that the next day she was off but then the following day returned to work and reported it. Petitioner confirmed that was

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on the sixth. This would be inconsistent with the date she requested the accident be changed to – October 3, 2017. Petitioner also testified "...I'm pretty sure it was the first week of October." (T. 21).

The Arbitrator also notes that there are numerous other dates present throughout the reports and medical records. These varying dates adversely impact Petitioner's credibility.

The first medical record of treatment for the alleged injury reflects an accident date of September 9, 2017. Petitioner testified that this is when she told them she started working but earlier in her testimony, she testified that she started working around September 1 – which comports with the wages submitted into evidence showing a full week worked from September 2 through September 8, 2017. Later, Petitioner tells Dr. Raskas the alleged injury happened on October 2, 2017 (and Dr. Raskas relied on that date when offering his opinions). Then to Dr. Chabot Petitioner reports October 4, 2017. When she reports to Mr. Baer, she reports **three dates** on which her alleged accident could have occurred – October 4, October 11, and October 13, 2017. Again, the Arbitrator notes this claim is **not** based on a repetitive trauma theory of recovery.

The Arbitrator emphasizes that nowhere in any of the medical records or incident reports does Petitioner indicate an alleged accident date of October 3, 2017.

In addition to the alleged multiple dates of accident the medical records themselves cast doubt upon Petitioner's credibility with regards to the existence of a work injury on either October 3 or October 4, 2017. Petitioner testified at trial that by October 6, 2017, her neck was hurting and both arms were numb. Yet at the emergency room that same night, she makes no mention of any of those symptoms. When she is seen at the emergency room on October 19, 2017 – a mere two weeks after she is alleging the incident occurs – the records reflect she reported an injury in September. At Petitioner's October 23, 2017 visit, she again makes no mention of any neck or shoulder complaints or any work injury.

Case law has consistently held that the first histories given to physicians nearest to the date of accident tend to be the most accurate and reliable. *Shell Oil v. Indus. Comm'm.*, 2 Ill.2d 590 (1954). The Arbitrator in this matter finds it significant that at the very first medical visit after the alleged incident, there is no mention of any work incident at all, nor in other dates in October.

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Given all of the above, the Arbitrator finds and concludes Petitioner failed to prove by a preponderance of the credible evidence that she sustained an **accident** arising out of and in the course of her employment with Respondent on October 4, 2017 or on any other date.

b. With regards to disputed issue "E", did Petitioner give appropriate notice of a work-related injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes that based upon the evidence and testimony presented, **Petitioner failed to prove she provided Respondent timely and appropriate notice of an October 3, 2017 work place injury, the date Petitioner alleged is the date of accident as of the date of hearing.** The Arbitrator does find and conclude Petitioner did provide Respondent timely notice of a claimed October 4, 2017 date of accident, based, at the very least, on the November 7, 2017 filing of the Application of Adjustment of Claim.

In fact, regarding the newly claimed October 3, 2017 date of accident, the evidence clearly indicates Petitioner provided Respondent **no notice** **at all of a claimed October 3, 2017 accident - not "defective notice", but no notice**. It was not until the date of hearing, on June 12, 2019, almost two years after the claimed date of accident, that Respondent was made aware of any claim of an October 3, 2017 claimed date of accident.

The Arbitrator confirms his prior ruling denying Petitioner's oral motion to amend the Application. Petitioner has offered no argument that the Arbitrator abused his discretion.

Petitioner sought to orally amend the date of accident on the Application only near the near the end of the hearing, after all witnesses testified but just before proofs were closed. Petitioner's counsel orally moved to amend the Application to reflect the change of date from October 4 to October 3. (T.113-118) Respondent's counsel objected. Arguments were held and the Arbitrator, referencing and citing from the Administrative Code, Rule 9020.20(e), specifically noted that, "Applications may be amended prior to a hearing on the merits by filing an Amended Application for Adjustment of Claim…" The Arbitrator noted, "Had this issue been raised prior to the hearing, I would have been inclined to allow that." (T. 116). Based thereon, Petitioner's motion was denied. The Arbitrator further noted that the parties were totally free to fully argue their cases and their claims based on the evidence in the record, notwithstanding this ruling. 116-118).

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Petitioner agrees "that the fact of the denial of Petitioner motion is not fatal to Petitioner's case." The Arbitrator stated as much on the record. Further, the Arbitrator agrees that, "An analysis of the case law, the Act and full consideration of Administrative Code 9020.20 confirms the Commission is empowered to allow the date of accident to be amended at any time before the close of proofs." **But this power is discretionary**. Rule 9020.20(e), specifically states, "Applications **may** be amended prior to a hearing on the merits by **filing** an Amended Application for Adjustment of Claim…It shall be within the **discretion** of the Commission whether to allow any amendments to the Application **after** the commencement of a hearing on the merits." There is no doubt a Petitioner can amend an Application at any time prior to hearing, even without leave of the Commission. But after the trial has begun, amendments are allowed only at the discretion of the Commission. Petitioner wants the Arbitrator, post-hearing, to reverse his ruling, yet **Petitioner does not argue the Arbitrator abused his discretion when denying his motion.**

Petitioner argues that the Appellate court in *Freeman United Coal v. Industrial Commission*, 232 Ill. Dec. 192, (1998) held that the Commission may allow amendment of the Application at any time and may *sua sponte* amend the date of accident on the Application to conform to the evidence. The Court cited *McLean Trucking Co. v. Industrial Comm'n*, 96 Ill.2d 213, 70 Ill. Dec. 485, 449 N.E.2d 832 (1983), where the Commission allowed claimant to amend his application for adjustment of claim to conform to the evidence adduced at hearing. *McLean Trucking*, 96 Ill.2d at 218-19, 70 Ill. Dec. 485, 449 N.E.2d at 834-35. The *Freeman* Court continued by saying, "McLean stands for the proposition that the Commission can permit the application for adjustment of claim to be liberally amended to conform to the proofs contained in the record before the Commission, as well as the proposition that the date of the accident can be changed to conform to those same proofs." **This case does not change the fact that the Arbitrator/Commission has discretion to amend the Application; further, the evidence adduced at hearing herein does <u>not</u> credibly reflect or indicate an October 3, 3017 date of accident.**

Petitioner further argues that in *Duguid v Olin Brass*, 10 IWCC 1253, Petitioner, after sustaining a traumatic injury, alleged a date of injury as June 20, 2006. Later information confirmed the injury occurred on June 21, 2006. The Commission allowed the Petitioner to amend his Application citing *McLean* and *Freeman United* and reiterated that Respondent must show that it was somehow prejudiced by the amendment. Prejudice can be shown by an inability to

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investigate timely, or to locate witnesses or preserve evidence. Petitioner argues "none of that occurred in the instant case." **The Arbitrator disagrees. Because Respondent had no reason to suspect an October 3, 2017 accident claim, based on the dates (plural) it had and that Petitioner never made such a claim, Respondent had no reason to investigate that date.** The Arbitrator draws the inference that is why Respondent did not obtain and provide video of Petitioner working on October 3; **it had no reason to do so.** Petitioner nonetheless argues Respondent "intentionally omitted video of October 3d." There is no evidence in the record of any such "intent." Respondent therefore had a reasonable defense as to both accident and notice. Again, Petitioner never claimed she was injured on October 3, but offered instead several specific and non-specific alternative accident dates. Respondent, accordingly, could not have been – and was not – provided timely notice of an October 3, 2017 accident date **when it was never made aware of that specific date. Again, Respondent never received any notice of an October 3, 2017 alleged accident date.**

It is undisputed the Arbitrator/Commission **may** amend the Application at any time to conform to the evidence. **However, October 3, 2017 does not conform to the evidence.** The evidence is that Petitioner claims - and has provided - inconsistent histories of several potential accident dates. **This is a significant obstacle to her proving her claim.** 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). **Petitioner has not proven, by a preponderance of the credible evidence, <u>any</u> accident date, and specifically not October 3, 3017.**

In that regard, Petitioner also argues, "Whether the injury was October 4 that she believes, or October 3, is not relevant to the compensability of this claim." **To the contrary, if Petitioner cannot allege and <u>prove</u> a <u>specific</u> date of accident, she therefore cannot meet her burden to prove every element of her claim, including "accident."** Petitioner admittedly was confused regarding her dates. But nonetheless it is and remains Petitioner's burden to prove her date of accident. Further indicating Petitioner could not even offer a specific date of accident in her trial testimony, Petitioner testified **"...I'm pretty sure it was the first week of October." (T. 21).** Again, since **Petitioner cannot allege and <u>prove</u> a <u>specific</u> date of accident, she therefore cannot meet her burden to prove every element of her claim.**

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Petitioner further argues: "Respondent was aware that Petitioner did not work on October 4 and had ample reason to expect Petitioner's counsel would amend the application back to October 3." Why would Respondent have any reason, let alone "ample" reason? No evidence in the record was offered to support that conclusion.

Petitioner further argues, "Respondent could have presented video of Petitioner's work activities on October 3 to support their contention that petitioner was not injured during her employment. They provided work videos for other days, but omitted October 3d." **That is correct; but that is because Respondent again had no reason to defend or even investigate against an October 3, 2017 accident date, as that date was never claimed or mentioned until the hearing, but other dates were. It is inexplicable that Petitioner was unable to testify to a specific accident date.**

An analysis of the records – both the time cards and medical records – fail to support that a finding that any injury occurred on October 4, 2017. The records equally also fail to support that a finding that any injury occurred on October 3, 2017, or on any other specific date.

However, even had such injury occurred on October 3, 2017, in the nearly two-year history of the case, that specific date was **never** mentioned or brought to Respondent's attention as a possible accident date and therefore, Respondent could not have had any notice that an alleged work place accident occurred on that date. As shown by the Respondent's procurement of surveillance video from October 11 and October 13, 2017 – which was presented at trial and were the only two dates Petitioner worked of the three potential accident days she alleged to Respondent – had Respondent been made aware of an additional potential accident date earlier in the case, further investigatory measure could have been undertaken. As Respondent was not made aware, Petitioner's failure to provide any specific or even consistent date of accident was a failure of notice and was prejudicial to Respondent.

Therefore, the Arbitrator finds and concludes Petitioner failed to meet her burden of proof with regards to providing Respondent notice of a claimed date of accident of October 3, 2017.

c. **With regards to "F", is Petitioner's current condition causally related to the alleged incident, the Arbitrator finds as follows:**

The Arbitrator finds and concludes Petitioner's current condition of ill-being (including her claimed need for cervical surgery) is not causally related to the alleged work incident. In making

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this conclusion, the Arbitrator notes Petitioner's inconsistent initial reports to her providers and ultimately finds the opinions of Dr. Chabot to be more credible and are afforded more weight over those of Dr. Raskas.

As noted previously, case law is consistent in holding that the first or earliest histories given to physicians nearest to the date of accident tend to be the most accurate and reliable. *Shell Oil v. Indus. Comm'm.*, 2 Ill.2d 590 (1954). Petitioner testified that by October 6, 2017, her neck was hurting and both arms were numb. Yet at the emergency room that same night, she makes no mention of any of those symptoms. When she is seen at the emergency room on October 19, 2017 – a mere two weeks after she is alleging the incident occurs – the records reflect she reported an injury in September. At her October 23, 2017 visit, she again makes no mention of any neck or shoulder complaints or any work injury.

Dr. Raskas specifically testified that his opinions (in Petitioner's favor) were made predicated on Petitioner's report to Dr. Raskas that her only "intervening incident" was her **October 2, 2017** work incident. (PX 2, p. 16). **Even Petitioner's own treating expert – who offered deposition testimony because he produced a hearsay narrative opinion report in furtherance of litigation - was not aware of the claimed date of injury. Petitioner's attorney did not correct or question this date during the deposition.** Petitioner's treating medical records do not comport with that assumption. The Arbitrator concludes that Dr. Raskas lacked sufficient – or correct - credible information to form his opinions, which opinions therefore lacked adequate foundation. The Commission relies upon evidence-based medicine and expert "testimony need not be based on absolute certainty, but only a reasonable degree of medical and scientific certainty." *Nowicki v. Union Starch & Refining Co.,* 1 Ill.App.3d 92, 272 N.E.2d 674 (1971).

The Arbitrator ultimately finds the testimony of Dr. Chabot to be more credible. Dr. Chabot testified Petitioner suffered at most a strain and had reached MMI before his IME.

It is the Petitioner's burden of proof to prove that her condition is causally related to the alleged work incident. The liability cannot rest upon imagination, speculation, or conjecture, but must be based upon facts established by a preponderance of the evidence. This, in conjunction with the inconsistent medical records and multiple visits in October 2017 with no mention of neck or shoulder pain leads the Arbitrator to the conclusion that Petitioner failed to meet her burden of proof with regards to causal connection.

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d. With regards to "J", should medical expenses be awarded to Petitioner, the Arbitrator concludes as follows:

Pursuant to the Arbitrator's findings with regards to accident, notice, and causal connection, no medical benefits are awarded.

e. With regards to "K", is Petitioner entitled to any prospective medical, the Arbitrator concludes as follows:

As noted above, the Arbitrator finds Petitioner failed to meet her burden of proof in regards to accident, notice, and causal connection and therefore prospective medical is denied. However, the Arbitrator further notes that he finds the opinion of Dr. Chabot to be more persuasive and concludes that Petitioner reached MMI by May 31, 2018 and she does not need the surgery Dr. Raskas recommends.

In making this finding, the Arbitrator ultimately finds the testimony of Dr. Chabot to be more credible and persuasive. Dr. Chabot opined that Petitioner suffered at most a strain and had reached MMI before his IME.

f. With regards to "L", is Petitioner entitled to any TTD benefits, the Arbitrator finds and concludes as follows:

Pursuant to the Arbitrator's findings with regards to accident, notice, and causal connection, no TTD benefits are awarded.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: August 8, 2019

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIDGETTE STUBER,

Petitioner,

20IWCC0131

vs.

NO: 15 WC 37745

MURRAY DEVELOPMENT CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

We affirm the Arbitrator's finding that Petitioner was involved in an undisputed accident on July 4, 2015, in which she sustained left shoulder and lumbar strains while lifting a mixing bowl. However, we modify the decision to find that, instead of merely a cervical strain, Petitioner sustained an aggravation of her previously asymptomatic degenerative cervical condition.

Respondent's first Section 12 physician, Dr. Hobbs, opined that Petitioner's continued left shoulder and upper extremity complaints were neurogenic and related to cervical radiculopathy. Petitioner's physician, Dr. Gornet, opined that the March 31, 2016 MRI revealed disc protrusions at C4-5 and C5-6, which were consistent with Petitioner's subjective complaints of pain and her physical examination. He testified that Petitioner's left shoulder symptoms were also associated with her cervical spine condition. Dr. Gornet disputed that Petitioner suffered a cervical strain because there were no "hyperintense bright" areas on the MRI. Dr. Chabot, Respondent's second Section 12 physician, opined that Petitioner only sustained a cervical strain in the work accident and that the bulges at C4-5 and C5-6 "most likely" predated the accident. However, we note that Dr. Chabot never disputed that these bulges could be a competent cause of Petitioner's continued symptoms, which had not completely resolved after more than three years.

We find the opinions of Dr. Gornet and Dr. Hobbs most persuasive on this issue and find that Petitioner's pre-existing cervical degenerative changes were aggravated by her work injury and caused them to become symptomatic. We also find Petitioner's residual shoulder complaints to be cervically related. However, although Petitioner testified that she is still having "pain down my left arm," she was not specific about how far "down" and the exact location. There is also a significant question, based on the medical records, of whether Petitioner may be suffering from an unrelated ulnar neuropathy. Therefore, the Commission finds that Petitioner failed to prove that any current symptoms in her forearm or hands are causally related to her work injury.

We affirm the Arbitrator's analysis of Section 8.1b(b) permanency factors (i) through (iv). For factor (v), evidence of disability corroborated by the treating medical records, we make the following findings for each body part separately:

Lumbar: Petitioner testified that her pain "goes in my lower back," *T.15*, but she has not had any significant treatment for her low back since her last visit with Dr. Kovalsky on October 29, 2015. *Px4.* After the November 23, 2015 lumbar MRI, Petitioner's treatment began focusing on her neck with Dr. Gornet. Dr. Gornet did not believe that this MRI showed any major change compared to an MRI Petitioner underwent in 2011. *Px13 at 8, 35.*

The Commission notes that Petitioner did not testify that her lumbar area had been symptom-free prior to her accident. On cross-examination, she testified that she had previously treated with Dr. Gornet for a lumbar strain. *T.23.*

We take judicial notice of a prior Commission decision in case 12 WC 2820, in which Petitioner alleged a work accident on April 28, 2011. The Arbitrator in that case awarded 3% person-as-a-whole for an "aggravation to degenerative disk disease." Petitioner had been treated with physical therapy and lumbar facet injections. She returned to work but had "occasional back pain, triggered by activity."

Since Petitioner never testified that her post-new-accident lumbar condition was any different or worse than it was previously as residual from her 2011 accident, we find that Petitioner's current lumbar condition is only minimally related to this new accident.

Furthermore, on the August 1, 2017 office questionnaire for her visit with Dr. Wagner who performed gastric sleeve surgery, Petitioner indicated that she exercised 6 hours per week "walking, lifting weights." *Px10.* This is not consistent with any significant residual lumbar problems. Also, at her February 1, 2018 visit with Dr. Wagner, it was noted that her "unspecified back disorder, surgery pending weight loss" was "improved." *Id.*

Based on the above, we give this factor some weight and find Petitioner is entitled to 2% loss of use of the person-as-a-whole for her lumbar strain.

Left shoulder: Having found that Petitioner's continuing left shoulder and arm symptoms are related to her cervical condition, and not specifically related to the shoulder, we give this factor little weight and find Petitioner is entitled to 1% loss of use of the person-as-a-whole for her left shoulder strain.

Cervical: Dr. Gornet's July 17, 2017 record indicates Petitioner still complained of neck pain, headaches, left trapezius, left shoulder, and left arm pain. *Px8.* However, we note that Petitioner never testified she currently has headaches. She testified that she was having pain

down her left arm "whenever I'm doing stuff at work, upper body." *T.16.* She takes two over-the-counter Tylenol twice a day and her left arm is not as strong as it used to be. *Id.* She testified that she has pain in her shoulder and neck. *T.19.* Petitioner is working full-duty and currently is not a surgical candidate. *T.15, 25.*

We give this factor significant weight and award 5% loss of the person-as-a-whole for the aggravation of her pre-existing degenerative cervical condition.

In summary, we find Petitioner is entitled to a total permanent partial disability award of 8% loss of use of the person-as-a-whole: 5% for the cervical aggravation plus 2% for the lumbar strain plus 1% for the left shoulder strain.

We also correct two scrivener's error in the Findings section of the decision. First, that Petitioner was 45 years of age (not 55) at the time of her accident, as stipulated by the parties. Second, to reflect that Petitioner's current condition of ill-being "is" causally related to the accident.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $523.76 per week for a period of 40 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 8% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical expenses listed in Petitioner's Exhibit 1, as provided in §8(a) of the Act subject to the fee schedule in §8.2 of the Act, directly to the providers.

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: FEB 25 2020

Maria E. Portela

Marc Parker

Kathryn A. Doerries

SE/
O: 2/4/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STUBER, BRIDGETTE
Employee/Petitioner

Case# **15WC037745**

MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

20IWCC0131

On 1/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J 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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 10 2019

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

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BRIDGETTE STUBER
Employee/Petitioner

Case # 15 WC 37745

v.

Consolidated cases: ____

MURRAY DEVELOPMENT 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 **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon** on **10/3/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Findings

On **7/4/15** 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**45,392.75**; the average weekly wage was $**872.94**

On the date of accident, Petitioner was **55** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

Order

The Arbitrator finds that Petitioner suffered a shoulder, lumbar and cervical strain as a result of the July 4, 2015 incident.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes no AMA report was submitted by the parties. No weight will be given 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 Support Service Worker at the time of the accident and that he was able to return to work in her prior capacity as a result of said injury. The Arbitrator notes Petitioner was able to return to her normal duties without restrictions. Therefore gives *little* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Because of Petitioner's age, the Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there was no evidence that Petitioner's earning capacity was affected by this injury. Because there was no evidence that Petitioner's earning capacity was affected by this injury, 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 treated with Dr. Matthew Gornet for for her cervical injury consisting of physical therapy and two injections. On September 28, 2017 Dr. Gornet last saw Petitioner. She was released at MMI with no restrictions. Therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **5% loss use of the Man as Whole** pursuant to §8(d)2 of the Act.

Respondent shall pay Petitioner the sum of **$523.76**/week for a further period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **5% loss use of the Man as a Whole.**

Respondent shall pay reasonable and necessary medical services as listed in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act directly to the providers. Respondent shall have a credit for all amounts previously paid.

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

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

Edward Lee | 1/1/19

Signature of Arbitrator | Date

JAN 10 2019

The Arbitrator finds the following facts:

The issue in this case is causation and nature and extent of the injury..

At the time of the injury, Petitioner was a 45 year old employee of the State of Illinois at Murray Development Center.

On July 4, 2015 Petitioner sustained an injury while lifting a bowl. (Rx. 1)

On July 6, 2015, Petitioner began treating with SSM Health St. Mary's in Centralia. (Px. 3) Petitioner had complaints of low back pain and shoulder apin. (Id.) Petitioner was diagnosed with a lumbar and shoulder sprain. (Id.) Petitioner was given an order for tramadol and told to follow up in two weeks. (Id.) Petitioner was placed on light duty.

Petitioner returned to SSM Health on July 13, 2014. (Id.) At this visit, Petitioner had complaints of low back and shoulder pain. (Id.) Petitioner was diagnosed as having a lumbar strain and shoulder strain. (Id.) Petitioner was continued on light duty. (Id.)

Petitioner was again seen by SSM Health on July 20, 2015. (Id.) Petitioner complained of left shoulder pain. (Id.) The physician noted that despite the shoulder complaints, Petitioner had a normal physical exam. (Id.) Petitioner was referred to Physical therapy for her left shoulder. (Id.)

Petitioner continued to see SSM Health on August 3rd, 17th and 31st. (Id.) She was seen for left shoulder and low back pain. (Id.) She was ultimately, referred to an orthopedist for her shoulder pain. (Id.)

On September 10, 2015 Petitioner began treating with Dr. Angela Freehill for her left shoulder complaints. (Px. 4) On the same date, Petitioner was seen for low back complaints by Dr. Kovalsky. (Id.) Dr. Kovalsky saw Petitioner again on October 29, 2015. (Id.) At this visit, a lumbar MRI was ordered and Petitioner told to return to the clinic. (Id.) Petitioner did not return.

On October 26, 2015 Petitioner began treating with Dr. Lyndo Gross. (Px. 5) Petitioner had complaints of left shoulder pain. (Id.) Dr. Gross diagnosed Petitioner as having left shoulder pain. (Id.) She was referred for injections and told to follow up in four weeks. (Id.) Petitioner did not return.

On January 21, 2016 Petitioner began treating with Dr. Matthew Gornet. (Px. 6) Petitioner was referred to Dr. Gornet by her attorney, Thomas C. Rich.

Petitioner reported that her main complaint is neck pain to the base of her neck. (Id.) Dr. Gornet ordered an MRI of the lumbar spine and cervical spine. (Id.) Petitioner continued to treat with Dr. Gornet. (Id.) Dr. Gornet found disc bulges at C5-6 and C4-5. (Id.) Dr. Gornet ordered steroid injections in the cervical spine. (Id.) Petitioner last saw

Dr. Gornet on September 28, 2017. (Id.) At this visit, Petitioner was placed at MMI and to follow up as needed. (Id.)

On May 29, 2016 Petitioner was examined by Dr. Micah Hobbs regarding her left shoulder. (Rx. 4) Dr. Hobbs diagnosed Petitioner as having osteoarthritis of the left shoulder. (Id.) Petitioner was placed at MMI as to the left shoulder. (Id.) On exam, Petitioner had full ROM and normal strength in the left shoulder. (Id.)

On February 3, 2017 Respondent had Petitioner examined by Dr. Michael Chabot pursuant to Section 12. (Rx. 5) Dr. Chabot opined that Petitioner suffered a left shoulder, cervical and lumbar strain as a result of the incident. (Id.) Dr. Chabot opined that Petitioner did not need additional treatment

Dr. Chabot reviewed the cervical MRI scan. (Id.) Dr. Chabot opined that there were not any disc bulges at C4-5 or C5-6. (Id.)

THEREFORE, THE ARBITRATOR FINDS that Petitioner suffered a left shoulder, cervical and lumbar strains as a result of this incident.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes no AMA report was submitted by the parties. No weight will be given 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 Support Service Worker at the time of the accident and that he was able to return to work in her prior capacity as a result of said injury. The Arbitrator notes Petitioner was able to return to her normal duties without restrictions. Therefore gives *little* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Because of Petitioner's age, the Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there was no evidence that Petitioner's earning capacity was affected by this injury. Because there was no evidence that Petitioner's earning capacity was affected by this injury, 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 treated with Dr. Matthew Gornet for for her cervical injury consisting of physical therapy and two injections. On September 28, 2017 Dr. Gornet last saw Petitioner. She was released at MMI with no restrictions. Therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **5% loss use of the Man as Whole** pursuant to §8(d)2 of the Act.

Respondent shall pay Petitioner the sum of $**523.76**/week for a further period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **5% loss use of the Man as a Whole.**

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MADISON)	☒ 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

STEPHEN SHAFER,

Petitioner,

20IWCC0132

vs. NO: 16 WC 9689

ALTON MENTAL HEALTH CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator's decision contains a scrivener's error in the last sentence under Section "F" of page 1 of the Arbitrator's decision. It states, "The causation of compression neuropathy via repetitive has been deemed to fall in the area requiring such expert testimony." We hereby insert the word "trauma" after the word "repetitive" in that sentence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 26, 2018, is hereby affirmed and adopted with the correction noted above.

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

DATED: FEB 25 2020

MEP/dmm
O:02042020
49

Maria E. Portela

Marc Parker

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHAFER, STEPHEN
Employee/Petitioner

Case# **16WC009689**

ALTON MENTAL HEALTH CENTER
Employer/Respondent

20IWCC0132

On 12/26/2018, 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 2.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0487 SMITH MENDENHALL SELBY & COLE
STEVE SELBY
PO BOX 518
ALTON, IL 62002

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

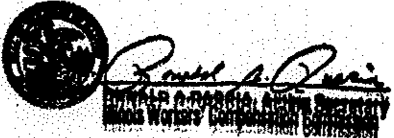
0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 28 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEPHEN SHAFER
Employee/Petitioner

v.

ALTON MENTAL HEALTH CENTER
Employer/Respondent

Case # **16** WC **9689**

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 **Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **9/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **2/29/16** Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**120,000.00**; the average weekly wage was $**2307.69**

On the date of accident, Petitioner was **55** 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 $ **if any** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $-.

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

The Petitioner has failed to prove that he sustained repetitive trauma injuries arising out of his work duties for Respondent.

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

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

Edward Lee
Signature of Arbitrator

12/18/18
Date

DEC 2 6 2018

The Arbitrator finds the following facts: **20IWCC0132**

This is a decision on a repetitive trauma claim. The issues in dispute are accident, notice, causation, medical expenses and TTD.

Petitioner is a 55 year old employee of the Alton Mental Health Center. Petitioner has been working for the State of Illinois for 33 years. Petitioner is a Public Service Administrator at Alton Mental Health. Petitioner job is Information Technology. Petitoner has been at Alton Mental Health Center since 2012.

On September 21, 2015 Petitioner saw his family physician, Dr. O'Neill, with complaints of pain upon awakening in both hands. (Id.) Petitioner returned on January 11, 2016. (Id.) At this visit, he was referred for an EMG. (Id.)

On January 14, 2016 Petitioner underwent a NCV/EMG at Alton Memorial Hospital. (Id.) The exam showed bilateral carpal tunnel syndrome at the wrists and left cubital tunnel syndrome.

Petitioner began treating with Dr. Aaron Omotola on February 29, 2016. (Px. 2) Dr. Omotala diagnosed Petitioner as having bilateral carpal tunnel syndrome and left cubital tunnel sydrom. (Id.) Petitioner underwent left carpal tunnel release and left ulnar nerve release on March 31, 2016. (Id.) Petitioner underwent left ulnar release revision on June 15, 2017. (Id.) On April 18, 2018 Petitioner underwent right carpal tunnel release. (Id.)

Dr. Omotola's records are devoid of any job descritption or work that Petitioner performed for Respondent. On cross examination, Dr. Omotola admitted that his sole knowledge of Petitioner's job duties came from the hypothetical posed by Petitioner's attorney. (Px. 2, pg. 15)

On March 17, 2017 Petitioner was examined by Dr. Patrick Stewart pursuant to Section 12. (Rx. 2, Rx. 3) Dr. Stewart testified via deposition. (Rx. 3) Dr. board certified in surgery and has the certificate of added qualification in hand surgery. (Id. at 5, ex. 1) Dr. Stewarts practice is limited to the treatment of upper extremity problems. (Id. at 5)

Dr. Stewart testified that Petitioner had bilateral carpal tunnel syndrome and left cubital tunnel syndrome. (Id. at 7) Dr. Stewart testified that Petitioner had comorbid conditions that could lead to the development of these conditions because Petitioner had uncontrolled diabetes and a BMI of more than 31. (Id. at 9) Additionally, Petitioner's age of 55 is another comorbid factor for the development of these conditions. (Id. at 10)

During the exam, Petitioner's explained his job duties to Dr. Stewart. (Id. at 12-13) Petitioner explained that he performed keyboarding at a computer. (Id. at 13)

Dr. Stewart testified that the current medical literature does not support a link between carpal tunnel syndrome and keyboarding. (Id. at 14)

Dr. Stewart stated that there was no connection between Petitioner's job duties and his carpal and cubital tunnel syndrome. (Id. at 15) Additionally, given Petitioner's age, obesity and uncontrolled diabetes, Petitioner would have developed this condition regardless of occupational activities.

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

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

A claimant must prove by the preponderance of credible evidence all elements of the claim in order to receive compensation under the Act. Orisini v. Industrial Commission, 117 Ill. 2d 38, 44-45, 509 N.E.2d 1005, 109 Ill. Dec. 166 (1987). In cases involving the repetitive trauma concept, the petitioner must show the injury arose out of and in the course of his employment and was not the result of a normal degenerative aging process. Peoria County Bellwood Nursing Home v. Industrial Commission, 115 Ill. 2d 524, 505 N.E.2d 1026, 106 Ill. Dec.235 (1987).

Simply performing work over a period of years is not legally sufficient to prove that work is repetitive enough to cause an increased to the petitioner. Id.

The Arbitrator also notes a claimant fails to prove a causal relationship through repetitive trauma where the medical opinion upon which they have relied is based upon incorrect or incomplete information about the claimant's job duties. See, e.g., Lon Dale Beasley v. Decatur Public School #61, 03 IIC 301; Jerry Wiser v. American Steel Foundries. 02 HC 310; Vicki Staley v. BroMenn Lind Medical Hills Internists, 99 IIC 539.

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.

Additionally, in cases involving a repetitive trauma theory, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood,* 115 Ill.2d 524 (1987); *Quaker Oats Co.* v. *Industrial Commission,* 414 Ill.2d 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission,* 157 Ill. App. 3d 470, 478 (4th Dist. 1987). The causation of compression neuropathy via repetitive has been

deemed to fall in the area requiring such expert testimony. *Johnson v. Industrial Commission*, 89 Ill. 2d 438 (1982).

The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill. 2d 24 (1977).

The Commission decision Clay v. Hill Correctional Center, 12 I.W.C.C. 0152, is instructive to this case. In Clay, the Commission noted that testimony of locking and unlocking hundreds of doors was unpersuasive testimony to show that those job duties aggravate carpal tunnel syndrome when there is no mention of the force required to do these activities. (Id.) Likewise, in this case there is no testimony about the force to perform any of the activities listed by Petitioner.

Further, the Commission has noted "[c]ould be a possible aggravating factor is not a definite medical opinion establishing causation." *Jeffrey Miller v. Menard Correctional Center*, 12 I.W.C.C. 1182.

The opinions of Dr. Stewart are more persuasive than those of Dr. Omotola. Dr. Omotola does not have a certificate of added qualification for hand surgery. Dr. Omotola did not know anything of Petitioner's job duties until the deposition.

Dr. Stewart has a certificate of added qualification in hand surgery. Dr. Stewart took a detailed history from Petitioner regarding his job duties.

THEREFORE, THE ARBITRATOR FINDS, no repetitive injury arising out of and in the course of the employment of Respondent on February 29, 2016 and that there is no casual connection between Petitioner's current condition and his work activities for Respondent.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF PEORIA	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Contreras,

Petitioner,

20IWCC0133

vs.

NO: 17 WC 003025

State of IL / IDOC,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 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.

20IWCC0133

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: FEB 25 2020
o020420
MEP/ypv
049

Maria E. Portela

Kathryn Doerries

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONTRERAS, TINA
Employee/Petitioner

Case# **17WC003025**

ST OF IL - DEPT OF CORRECTIONS
Employer/Respondent

20IWCC0133

On 11/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.43% 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:

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

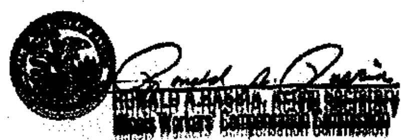
6140 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

NOV 5 - 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF **PEORIA**)

20IWCC0133

- ☐ 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

TINA CONTRERAS
Employee/Petitioner

Case # **17** WC **03025**

v.

Consolidated cases: ___

STATE OF ILLINOIS – DEPARTMENT OF CORRECTIONS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gerald Granada, Arbitrator of the Commission, in the city of **PEORIA**, on **9/24/2018**. 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

20IWCC0133

On **1/10/17**, Respondent ***was*** operating under and subject 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 **$76,284.00**; the average weekly wage was $**1,467.00**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **1** dependent children.

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

Respondent ***has 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

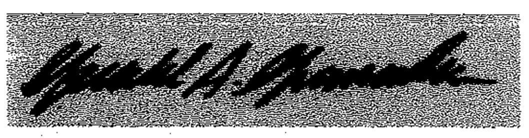
Respondent shall pay reasonable and necessary medical services totalling $34,504.25, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $978.00/week for 6-2/7 weeks, commencing 2/3/17 through 3/20/17, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $880.20/week for 41 weeks, because the injuries sustained caused the 10% loss of each hand, as provided in Section 8(e) of the Act.

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

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



Signature of Arbitrator Gerald Granada

10/31/18
Date

NOV 5 - 2018

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on January 10, 2017. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident; 2) notice; 3) causation; 4) medical expenses; 5) TTD; and 6) nature and extent.

Petitioner works for Respondent as a Senior Correctional Parole Officer. Petitioner testified that she was first employed by Respondent in 1997 as an office assistant. She was moved to the Department of Corrections in March of 1999 and started working as an office associate, before becoming a parole officer. She worked as a parole officer for approximately 1 year before she became a senior correctional parole officer in June of 2006. Petitioner testified that as part of her job duties she was responsible for managing adult and juvenile parolees. As a senior correctional parole officer Petitioner would cover 4 counties: Marshall, Putnam, Woodford and Peoria. Her job responsibilities further included: transporting the parolees and conducting home, office and field visits; monitoring the parolees and filling out various paperwork with regards to the parolees; making various phone calls with regards to the parolees. Petitioner testified that she worked approximately 8-/12 hours per day, during which she spend 5 to 6 hours driving a vehicle provided by Respondent. She described that the vehicles she drove for Respondent would vibrate at the steering wheel moreso than a regular sedan. Also, the driver's seat of her vehicle could not recline.

Petitioner testified that besides driving she would also spend approximately 2 to 3 hours a day typing at her workstation located within her vehicle. She used this workstation to type, write and make phone calls. Petitioner described her workstation not having any resting surface like a wrist pad or anything soft on which she could rest her hands while typing – which would require her to raise her arms and shoulders while typing. Petitioner testified that she has to bring the workstation tray toward her and rest her wrist on the edge of the keyboard while typing. Petitioner testified that she did not believe that her workstation was ergonomically correct, as she could not pull the stand closer to her body when typing. She asked Respondent to have her workstation computer stand fixed or replaced but was told they could not replace it. As she was typing, her computer would not stay in place, causing her to have to hold the laptop while trying to type. Petitioner would spend 3-4 hours per day on her computer typing up forms, reports, emailing, and looking up information.

Petitioner testified that during the performance of her job duties she started experiencing: numbness in her thumb, index and long fingers and weakness in both of her hands. She had problems with typing, writing and driving. Petitioner testified that when she first started experiencing these problems she did not know what was causing her problems and her problems became progressively worse to a point that she required medical treatment.

On December 15, 2016, Petitioner discussed with her primary care physician, Dr. Reich the problems she was experiencing with her hands. Dr. Reich's records note that Petitioner had bilateral wrist pain that has been present for a long time, and paresthesia. The records further mention that Petitioner does much typing at work and at times poor ergonomics due to circumstance. Petitioner testified that at that time she did not know her condition, did not know what was causing her condition, and that Dr. Reich then referred her for a nerve conduction study. Petitioner testified that after her visit with Dr. Reich, she notified her supervisor, Tim Lowe, about her condition. She testified that at that time she did not know what causing her condition but at the request of her employer she filled out CMS Workers' Compensation Notice of Injury and Accident Report.

On January 10, 2017, Petitioner underwent a nerve conduction study with Dr. Stedwell at Illinois Neurological Institute. During this visit and after speaking with Dr. Stedwell, Petitioner learned that she had bilateral carpal

tunnel syndrome. Petitioner testified that it was at this time that she first realized the association between her job duties and her condition of bilateral carpal tunnel. After she was diagnosed with bilateral carpal tunnel syndrome she once again notified her supervisor about her condition and the association between her condition and her job duties.

On January 23, 2017, Petitioner saw Dr. Williams at Midwest Orthopaedic Center - a medical practice group that Petitioner had seen on prior occasion due to unrelated health issues. Dr. Williams noted Petitioner's job description and her complaints - which were worse with typing, writing and while driving. Dr. Williams noted no history of diabetes or thyroid disease. After conducting a physical exam, reviewing the EMG results and Petitioner's history, he diagnosed Petitioner with bilateral carpal tunnel syndrome. Dr. Williams eventually performed surgeries on Petitioner: right carpal tunnel release on February 3, 2017 and left carpal tunnel release on February 21, 2017. Petitioner testified that from the day of the surgery on February 3, 2017 she was taken off of work until March 20, 2017. Petitioner testified that after March 20, 2017 she was on light duty per Dr. Williams and Respondent accommodated her light duty status. On April 3, 2017, Dr. Williams released Petitioner to return to work without restrictions. Dr. Williams testified via evidence deposition on January 11, 2018. Dr. Williams opined that Petitioner's bilateral carpal tunnel syndrome was at the very least aggravated by the ergonomics of her workstation, which lead to the worsening of her condition and the eventual need for surgery. Dr. Williams testified that he reviewed the pictures of Petitioner's workstation and described the Petitioner's workstation and work duties consistent with Petitioner's testimonial description of the same – indicating his belief that Petitioner's workstation was ergonomically incorrect. On cross-examination, Dr. Williams further testified that the vibration from Petitioner's steering wheel also aggravated Petitioner's condition.

On May 22, 2017 Dr. Lawrence Li conducted an Independent Medical Examination of Petitioner at Respondent's request. Dr. Li testified via evidence deposition on November 13, 2017. Dr. Li reviewed Petitioner's job description, her medical history, photos of Petitioner's work station, and had her demonstrate where her computer was positioned while she would be working by way of a keyboard Dr. Li had in his exam room. Dr. Li believed that Petitioner used proper ergonomics and opined that there was no relationship between Petitioner's job duties and her development of carpal tunnel syndrome.

Mark Schafer was called as a witness for the Respondent. Mr. Schafer works for Respondent as a Patrol Commander. He sat in during the testimony of Petitioner. Mr. Schafer testified that that he himself performed Petitioner's job for approximately 14 years, and that Petitioner testified consistently regarding her job duties in that same job position.

Petitioner testified that her night pain in her hands resolved post surgery. She still complains of weakness, pain, numbness and discomfort with typing, writing or driving but has no work restrictions.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible, unrebutted testimony and the preponderance of the medical evidence. The evidence shows that the Petitioner's job required her to repetitively type on a laptop in a non-ergonomic workstation in the vehicle provided by Respondent. The Arbitrator found persuasive Petitioner's testimony that she experienced complaints with her hands after having to type for 3 or 4 hours per day at a work station located in the passenger section of a vehicle provided by

Respondent, that did not allow her to bring the keyboard closer to her body and did not hold her laptop in place while she typed. Essentially, the Petitioner would be twisting her upper body toward her work computer and trying to hold the computer in place, without any hand or arm rests, while trying to type. Given the awkward workstation arrangement described by Petitioner, it is very foreseeable that Petitioner would experience problems with her hands while working. The Arbitrator finds it telling that Respondent's witness basically confirmed Petitioner's description of how she performed her job duties. Given these facts, the Arbitrator concludes that the Petitioner sustained an accident involving repetitive trauma that became manifest on January 10, 2017 – the date Petitioner was diagnosed with bilateral carpal tunnel syndrome, and the date she realized her diagnosis was related to her job activities.

2. Regarding the issue of notice, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible, unrebutted testimony that she told her supervisor about her problems and advised of her diagnosis on or about January 10, 2017. Petitioner filled out an accident report at the request of her supervisor. There was no evidence offered to rebut Petitioner on this issue. Accordingly, the Arbitrator concludes that the Petitioner provided Respondent proper notice of her accident in this case.

3. Consistent with the Arbitrator's conclusions above, the Arbitrator further finds that the Petitioner has met her burden of proof regarding the issue of causation. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the preponderance of the evidence. On this issue, the Arbitrator finds persuasive the testimony of Dr. Williams, who opined that the incorrect ergonomics of Petitioner's workstation and the vibration of Petitioner's steering wheel aggravated Petitioner's carpal tunnel syndrome, eventually leading to her need for surgery. Dr. Williams' opinions are bolstered by Petitioner's complaints and the description of her workstation, which required Petitioner to work in physically awkward positions on a regular basis. The Arbitrator further notes that Respondent's IME, Dr. Li agreed that the exposure to vibration could be a cause of carpal tunnel – a fact Petitioner testified to with regard to the vibration in the steering wheel of the vehicle provided by Respondent. Based on these facts, the Arbitrator concludes that the Petitioner's bilateral carpal tunnel syndrome is causally connected to her employment with Respondent.

4. On the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment relating to her carpal tunnel syndrome has been reasonable and necessary. As such, the Arbitrator awards the Petitioner the medical expenses set forth in Petitioner's Exhibit #14, subject to the Fee Schedule.

5. Based on the Arbitrator's conclusions above, the Arbitrator further finds that the Petitioner was temporarily totally disabled from February 3, 2017 through March 20, 2017. This finding is supported by Petitioner's unrebutted testimony and the medical evidence. Petitioner credibly testified that Dr. Williams took her off of work for this time period – as evidenced by the medical records. Therefore, the Arbitrator awards Petitioner TTD benefits for the period in question.

6. 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 impairment rating was provided and therefore the Arbitrator gives no weight to this factor.

(ii) Occupation. Petitioner was employed as a Senior Correctional Parole Officer at the time of the accident, and was medically able to return to work in this position following this injury. The Arbitrator gives considerable weight to this factor.

(iii) Age. Petitioner was 52 years old at the time of the incident. The Arbitrator gives some weight to this factor.

(iv) Future Earning Capacity. There was no evidence that Petitioner's future earning capacity has been impacted by this accident and therefore the Arbitrator therefore gives no weight to this factor.

(v) Evidence of Disability. There was evidence of disability corroborated by the medical records, which show that Petitioner suffered: bilateral carpal tunnel syndrome, which required Petitioner to undergo surgery to both her hands. Petitioner testified that following surgery, most of her complaints resolved, but she still complained of decreased grip strength, and some numbness and discomfort with typing. The Arbitrator gives significant weight to this factor.

Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner resulted in a 10% loss of use of each hand..

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Batey,

Petitioner,

20IWCC0134

vs. NO: 17 WC 019664

Heritage Enterprises, LLC.,

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

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

20IWCC0134

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 $17,000.00. 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: FEB 25 2020
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MEP/ypv
049

Maria E. Portela

Kathryn Doerries

Marc Parker

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

BATEY, JAMES
Employee/Petitioner

Case# **17WC019664**

20IWCC0134

HERITAGE ENTERPRISES, LLC
Employer/Respondent

On 10/30/2018, 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 2.43% 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:

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242 N KNOXVILLE AVE
PEORIA, IL 61614

4234 RIPES NELSON BAGGOT KALOBRATSO
PETER DONAHUE
650 E DEVON AVE SUITE 110
ITASCA, IL 60143

20IWCC0134

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Batey
Employee/Petitioner

Case # 17 WC 19664

v.

Consolidated cases: N/A

Heritage Enterprises, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **9/21/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [x] Is Respondent due any credit?

O. [ ] Other ___

FINDINGS

On the date of accident, 5/18/17, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $19,968.00; the average weekly wage was $384.00.

On the date of accident, Petitioner was 47 years of age, *married* with 0 dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $256/week for 63 weeks, commencing 7/6/17 through 9/21/18, as provided in Section 8(b) of the Act.

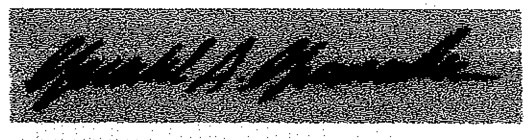
Respondent shall pay reasonable and necessary medical services of $784.69, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.

Respondent shall authorize and pay the prospective medical care recommended by Dr. Johnson, including the proposed right shoulder arthroscopic surgery.

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 Gerald Granada

10/29/18
Date

James Batey v. Heritage Enterprises, LLC, 17 WC 19664 - ICArbDec19(b)

OCT 3 0 2018

20IWCC0134

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on May 18, 2017. Respondent dispute Petitioner's claims and the issues in dispute are: 1) causation, 2) medical expenses, 3) prospective medical care, 4) TTD and 5) credit.

Petitioner is a Certified Nurse's Assistant (CNA) who has been employed by Respondent, a rehabilitation facility, for two separate periods. He initially worked for them in 2004 for one to two years. Later, on March 23rd, 2015, Petitioner returned to employment with Respondent, again as a CNA. Petitioner described the physical demands of this job as, "lifting, turning, walking residents" and being on your feet all day long.

Petitioner testified regarding a prior injury he sustained on November 16, 2016 wherein he injured his right shoulder while moving a resident in bed. He treated conservatively at IWIRC between November 16, 2016 and February 1, 2017 when he was released from care by IWIRC with a "resolved-right shoulder strain". (RX 6, p.6) An MRI on December 19, 2016 showed "supraspinatus tendinosis or partial tear". (PX 5) Petitioner was not referred to an orthopedic specialist during this time and had one shoulder injection, which spiked his blood sugar and put him in the hospital. This claim was filed as Case Number 17 WC 019663, and was settled prior to the Arbitration of the present case for 3.5% loss of the man as a whole. Petitioner testified that when he returned to work in January 2017, he felt achiness and had swelling in his shoulder. The first few weeks after returning, he iced his right shoulder during breaks. He never lost his range of motion in his right shoulder from his first accident. As of May 1, 2017, Petitioner testified that he no longer noticed, much, if any, right shoulder discomfort.

On May 18, 2017, Petitioner was transferring a left-side affected resident from his bed to a seated position when the resident pulled back against him and went rigid - pulling Petitioner's right arm and shoulder away from his body. Petitioner testified he had instant shoulder pain and numbness in his right hand. He completed an accident report that day (RX 3) and was again sent by Respondent to IWIRC. His recorded history on May 18, 2017 at IWIRC (PX 3, p.1) is, "Patient states that he was moving a partially paralyzed patient, and he felt a pulling sensation in his right shoulder and right scapular area". Petitioner was diagnosed with a shoulder strain, told to ice his shoulder, and was given light duty restrictions. (PX 3, pp.1-2)

Petitioner opted out of treatment at IWIRC, and instead chose to treat with his primary care physician, Dr. Schupbach. (PX 6) Dr. Schupbach's records from May 23, 2017 indicates, "47 year old with right shoulder pain he had previous injury and tearing of the rotator cuff, patient states he had a reinjury at work causing pain that was acute in the right shoulder which was on top of the chronic pain…is having decreased range of motion, difficulty sleeping at night, like to see orthotist…" (PX 6, p. B)

On May 26, 2017 Petitioner initially saw Dr. Brent Johnson with Midwest Orthopedic Center at the referral of Dr. Schupbach. (PX 2) Dr. Johnson's records include a history indicating "…shoulder pain began in December 2016…MRI revealed a partial tear…went through physical therapy where he notes his range of motion returned, but his strength was not back to baseline. He is a CNA and states he reinjured his shoulder on May 18, 2017 while helping a patient into bed. He states he felt a pop…he

notes pain is worse this time compared to the initial injury." (PX 2, p.10) An MRI of the right shoulder was performed on June 7, 2017 which showed an additional labral tear, labral fraying, rotator cuff tendinosis, and advanced AC joint arthritis . (PX 2, p.8, PX 4) On June 9, 2017, Dr. Johnson diagnosed Petitioner with a superior glenoid labrum lesion and localized primary osteoarthritis of the right shoulder AC joint, for which he recommended surgery in the form of an SAD (subacromial decompression) and DCE (distal clavicle excision) with possible biceps tenodesis. (PX 1, pp.6-7) Dr. Johnson saw Petitioner for a re-check on May 2, 2018 and noted that Petitioner reported worsened pain, numbness and tingling down his right arm. Dr. Johnson again recommended surgery. (PX 2, pp.3-4) Petitioner testified that the Respondent's workers compensation carrier has not approved the recommended surgery.

Dr. Johnson testified via evidence deposition on March 30, 2018. He is a board certified orthopedic surgeon with a sports medicine fellowship and specializes in treatment of knees and shoulders. Dr. Johnson testified that on Petitioner's initial May 26, 2017 visit, he suspected a rotator cuff tear and, "due to his new injury and increase in symptoms…recommended a new MRI scan". (PX 1, p.8) Dr. Johnson opined that the first MRI on December 19, 2016 demonstrated "tendinosis and partial tear of (the) supraspinatus tendon". (PX 1, p.10) The second MRI of June 7, 2017 showed "severe degenerative changes to the …AC joint with significant edema in the distal clavicle", and a probable SLAP tear. The partial tearing of the biceps tendon and the significant edema around the AC joint were new on the second MRI. (PX 1, p.11) Dr. Johnson further opined that the Petitioner's shoulder condition is more likely related to his May 18, 2017 accident than his previous injury because: Petitioner's complaints following the more recent incident were more severe; Petitioner was able to return to work without restrictions following the earlier incident; and the findings on the Petitioner's more recent MRI were different or worse than the findings from the prior MRI – noting specifically the increased edema around the AC joint and the bicep tendon changes. (PX 1, pp.15-16) Dr. Johnson testified that the surgery he is recommending is directed to Petitioner's biceps tendon and distal clavicle and AC joint. He noted that the abnormalities in the tendon are not present on the first MRI, and there were only mild degenerative changes of the clavicle which now has significant edema, as shown in the later MRI. Dr. Johnson further attributed the need for his proposed surgery to the later accident on May 17, 2017. (PX 1, pp.14-17)

Petitioner was evaluated at Respondent's request by two different Section 12 examiners. Dr. Bruce Sommerville evaluated Petitioner in reference to the May 17, 2017 accident date. Dr. Jason Young evaluated for Respondent as to the earlier accident date of November 16, 2016. Both doctors testified via evidence deposition. Dr. Summerville, testified on May 14, 2018. He is a board-certified orthopedic surgeon who examined Petitioner on November 1, 2017. The doctor felt that both of Petitioner's MRI's were largely negative and that neither showed evidence of a traumatic injury. (RX 1, pp.11-12) He opined that the degenerative changes noted on Petitioner's MRI were not consistent with the Petitioner's claimed mechanism of injury on May 18, 2017. Dr. Summerville's clinical exam on November 1, 2017 was normal. He stated that the Petitioner had pre-existing AC joint arthritis and rotator cuff tendinosis as evidenced by the 2016 MRI. He stated that no further treatment was necessary relating to the alleged work accident, though a course of physical therapy for four weeks and diagnostic injections into the sub-acromial space would be reasonable for the pre-existing arthritis. He stated that Petitioner's ongoing symptoms and MRI findings were not related to any specific organic pathology, and that the Petitioner was able to return to work without restrictions.

On July 27, 2018, Dr. Jason Young testified pursuant to deposition. He is a board certified orthopedic surgeon, specializing in shoulders, elbows and knees. Dr. Young performed an IME of Petitioner on October 11, 2017. (RX 2) He reviewed both MRI scan films. He diagnosed the Petitioner with severe right shoulder acromioclavicular joint arthropathy and right shoulder impingement with bursal-sided supraspinatus fraying. He believed that the Petitioner's condition was degenerative, with development of significant spurs, leading to impingement and bursal-sided fraying of the supraspinatus. He stated that the Petitioner's 2016 and 2017 accidents were not substantial causative factors in the degenerative pathology, but rather temporary exacerbations. He stated that the Petitioner's arthritic condition developed over time. He stated that injections, and possibly surgery, were reasonable to treat the arthritic shoulder, but unrelated to either accident.

Petitioner testified that he still has complaints of pain, tingling, swelling, headaches, swelling, decreased strength, which affect his sleep. He is seeking authorization for the surgery recommended by Dr. Johnson.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the records from Petitioner's treating physicians. The Arbitrator finds persuasive Dr. Johnson's opinions on this issue given the Petitioner's unrebutted testimony regarding the sequence of events following his undisputed May 18, 2017 accident. Petitioner's description of how his arm condition worsened after the May 18, 2017 accident is substantiated by the consistent history and findings in the records from his treating doctors. Although the IME doctors refer to Petitioner's arm conditions as pre-existing and describe the May 18, 2017 event as a temporary exacerbation of those conditions, Petitioner has made it clear that the exacerbation or aggravation of his arm condition continues to persist. The Arbitrator is further persuaded that the MRI findings following Petitioner's May 18, 2017 accident showed a change in his condition from what was contained in the prior MRI test results. There was no evidence presented regarding any intervening cause of Petitioner's current conditions and there was no indication Petitioner needed surgery prior to the May 18, 2017 event. Based on the facts presented, the Arbitrator concludes that the Petitioner's current condition of ill-being in his right arm are causally connected to his May 18, 2017 work accident.

2. Consistent with the above conclusion regarding the issue of causation, the Arbitrator further finds that the Petitioner's medical treatment for his right arm thus far has been reasonable and necessary in addressing his work-related injury. Accordingly, the Arbitrator awards the Petitioner the related medical expenses, subject to the fee schedule, as set forth in Petitioner's Exhibit 7 totaling $784.69.

3. Based on the Arbitrator's conclusions above, the Arbitrator further finds that the medical treatment proposed by Dr. Johnson, including the surgery to address the AC joint and possibly biceps tendon, is both reasonable and necessary to address Petitioner's work-related injuries. Accordingly, the Arbitrator awards Petitioner the prospective medical care recommended by Dr. Johnson. Respondent shall authorize and pay for said medical treatment.

4. Regarding the issue of TTD, the Arbitrator finds that the Petitioner was temporarily totally disabled from July 6, 2017 through September 21, 2018. The evidence shows that Petitioner was working light duty for Respondent following his undisputed May 18, 2017 work accident as recommended by his treating physicians. Respondent ordered Petitioner to return to work full duty as of July 5, 2017, which Petitioner could not do without violating the restrictions set forth by his treating physicians. The evidence shows that the Petitioner's restrictions as set forth by his treating physicians are still in effect. In accordance with the Arbitrator's findings above, the Arbitrator awards the Petitioner his TTD benefits for the time period in question.

5. With regard to the issue of credit, the Arbitrator finds that the Respondent is not entitled to the credit they are claiming for paying Petitioner's health insurance. In this case, the Respondent paid Petitioner's health insurance premiums after Petitioner left work in July, 2017. The Respondent is now seeking a credit for this voluntary payment of Petitioner's health insurance, against any TTD exposure. In denying Respondent's claim for credit, the Arbitrator relies on the Commission's decision in Cook v. Continental Tire North, 06 ILWC 45481 (2008) wherein the Commission affirmed the denial of such a credit, stating that the premiums do not entitle Respondent to a credit because the premium payments were not received by the Petitioner, and therefore aren't a "payment" to the Petitioner under the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie Salazar,

Petitioner,

20IWCC0135

vs. NO: 17 WC 7108

State of IL/Choate Mental Health,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 2019, is hereby affirmed and adopted.

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

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

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: FEB 2 6 2020
o2/6/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20 IWCC0135

SALAZAR, CONNIE Case# **17WC007108**
Employee/Petitioner

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

On 7/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

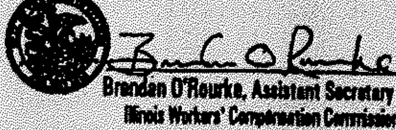
0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

JUL 17 2019



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

20IWCC0135

20IWCC0135

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Connie Salazar
Employee/Petitioner

Case # 17 WC 07108

v.

Consolidated cases: n/a

State of IL/Choate Mental Health
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on May 30, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [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 ______

20IWCC0135

FINDINGS

On the date of accident, November 30, 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 $37,257.93; the average weekly wage was $716.50.

On the date of accident, Petitioner was 47 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

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

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the left knee arthroscopic surgery recommended by Dr. Richard Lehman.

Respondent shall pay Petitioner temporary total disability benefits of $477.67 per week for 17 weeks commencing January 31, 2019, through May 30, 2019, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

July 11, 2019
Date

JUL 17 2019

20IWCC0135

Findings of Facts

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on November 30, 2016. According to the Application, Petitioner was running after an individual and sustained an injury to her left knee (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of 17 weeks, commencing January 31, 2019, through May 30, 2019 (date of trial). Respondent stipulated Petitioner sustained a work-related accident on November 30, 2016, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a mental health technician. On November 30, 2016, Petitioner was running after an uncooperative patient. When Petitioner attempted to get in front of the patient, she experienced a "pop" in her left knee and an immediate onset of pain. At trial, Petitioner testified the individual was running to a door and, while she was running, she had to twist and turn to get between the individual and the door. Petitioner reported the accident to Respondent on the day it occurred and various reports were prepared which were received into evidence at trial (Respondent's Exhibit 1).

Petitioner initially sought medical treatment at Convenient Care Clinic on November 30, 2016, and was evaluated by Russell Kinsey, a Physician Assistant. Petitioner advised PA Kinsey of the work-related accident and complained of left knee pain. PA Kinsey noted Petitioner had swelling on the medial side of the knee and pain across the tibial plateau. He directed Petitioner to rest, apply ice, elevate her knee and take ibuprofen for pain/swelling (Petitioner's Exhibit 3).

Petitioner continued to have left knee symptoms and was subsequently seen by PA Kinsey on December 3, and December 7, 2016. When PA Kinsey saw Petitioner on December 7, 2016, he recommended Petitioner have an MRI of the left knee performed (Petitioner's Exhibit 3).

At trial, Petitioner testified Respondent refused to authorize the MRI. Petitioner stated she continue to work even though she still had pain in her left knee.

On February 1, 2017, Petitioner sustained another accident at work which he was attacked by a patient. Petitioner was punched repeatedly in her face, was knocked unconscious and required a significant amount of medical treatment thereafter. Petitioner underwent surgery on her shoulder and jaw on June 19, 2017, and August 20, 2018, respectively. Because of the injuries Petitioner sustained as a result of the accident of February 1, 2017, Petitioner was off work for a period of time. When Petitioner returned to work, she was put in a light duty position in the dietary department, but continued to experience pain in her left knee.

At the direction of Respondent, Petitioner was examined by Dr. Joseph Ritchie, an orthopedic surgeon, on September 10, 2018. Petitioner advised Dr. Ritchie of the accident of November 30, 2016, that she had continued to work, but with left knee pain/discomfort and Respondent had refused to authorize an MRI scan. On examination, Dr. Ritchie noted Petitioner was morbidly

obese and noted medial sided joint line tenderness in the left knee. He ordered x-rays of the left knee which revealed medial compartment narrowing and evidence of arthritic changes. Dr. Ritchie opined the arthritic changes pre-existed the accident; however, he opined an MRI scan of the left knee should be performed (Respondent's Exhibit 4).

The MRI was performed on October 3, 2018. According to the radiologist, the MRI revealed mild osteoarthritic changes, tearing of the medial patellar retinaculum and joint effusion, but no evidence of a torn meniscus (Petitioner's Exhibit 4).

Dr. Ritchie subsequently reviewed the MRI scan and his interpretation of the scan was consistent with the radiologist. He opined that because the MRI eliminated meniscus pathology as a possibility, all of Petitioner's symptoms were due to an exacerbation of arthritis. He recommended Petitioner undergo a corticosteroid injection for the arthritis, but that Petitioner could work and would be at MMI either now or after she underwent the injection (Respondent's Exhibit 5).

Petitioner subsequently sought medical treatment from Dr. Richard Lehman, an orthopedic surgeon, on January 31, 2019. In connection with his examination of Petitioner, Dr. Lehman reviewed the reports of Dr. Ritchie and the MRI scan. Petitioner advised Dr. Lehman of the accident of November 30, 2016. On examination, Dr. Lehman noted medial popping and crepitus and a positive McMurray's. Dr. Lehman opined Petitioner had either an acute chondral fracture or meniscus tear that was missed by the MRI (Petitioner's Exhibit 5).

Dr. Lehman opined there was a causal relationship between Petitioner's symptoms and the accident of November 30, 2016. He recommended Petitioner undergo a series of hyaluronic acid injections, but if these did not resolve for symptoms, Petitioner should undergo arthroscopic surgery of her knee. Further, Dr. Lehman imposed work/activity restrictions of no bending, squatting, climbing or stairs. He noted Petitioner was limited to sedentary duty only (Petitioner's Exhibit 5).

Dr. Ritchie was deposed on March 4, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Ritchie's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Ritchie testified the MRI did not reveal a meniscus tear and that Petitioner sustained an exacerbation of arthritis which he characterized as a "flareup" (Respondent's Exhibit 6; pp 20-22).

On cross-examination, Dr. Ritchie agreed Petitioner sustained an injury which caused an aggravation of a pre-existing condition and the treatment which had been provided to Petitioner was reasonable and necessary. He also agreed that the accident was when Petitioner's "symptoms started" (Respondent's Exhibit 6; pp 29-31).

Dr. Lehman subsequently saw Petitioner on May 2, 2019. At that time, Dr. Lehman's findings on examination revealed a full range of motion with pain and mild/moderate crepitus. Dr. Lehman opined Petitioner would benefit from a Zilretta injection and he administered one at that time. Dr. Lehman renewed the work/activity restrictions he previously imposed (Petitioner's Exhibit 5).

Dr. Lehman was deposed on May 23, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Lehman's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Specifically, Dr. Lehman testified his findings on examination were consistent with a torn meniscus. He noted the MRI revealed effusion and swelling even though it was performed sometime after the accident. Even though the MRI did not show a meniscal tear, Dr. Lehman noted Petitioner's symptoms were consistent with a tear or something acute going on in her knee (Petitioner's Exhibit 6; pp 10-14).

When he was deposed, Dr. Lehman also reaffirmed his opinions regarding causality, treatment recommendations and the work/activity restrictions he imposed. Further, he did not note any signs of symptom magnification or malingering by Petitioner (Petitioner's Exhibit 6; pp 12, 14-17).

On cross-examination, Dr. Lehman agreed that if one ran in a straight line, such an activity would not cause a meniscus tear. However, if one decelerated, stopped, turned, etc., those were mechanics that could cause a torn meniscus. Dr. Lehman did agree that the only activity Petitioner described to him was that she was "running" down the hall (Petitioner's Exhibit 6; pp 26, 28-29).

Dr. Lehman also testified on cross-examination that because he had performed the Zilretta injection, he was no longer recommending the hyaluronic acid injections. Dr. Lehman wants to proceed with the arthroscopic procedure (Petitioner's Exhibit 6; p 33).

At trial, Petitioner testified she has not been able to work since the time she was first evaluated by Dr. Lehman. She wants to proceed with the treatment he has recommended.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being in regard to her left knee is causally related to the accident of November 30, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on November 30, 2016, in which she injured her left knee.

There was no evidence Petitioner had any left knee symptoms prior to the accident of November 30, 2016.

Petitioner credibly testified she has had persistent left knee symptoms since the accident of November 30, 2016. While there was a delay in Petitioner seeking treatment for her left knee condition, this was due, in part, to Respondent's initial refusal to authorize an MRI and the fact Petitioner sustained another work-related accident on February 1, 2017, following which Petitioner underwent surgeries on June 29, 2017, and August 20, 2018.

Petitioner had arthritis in her left knee which pre-existed the accident of November 30, 2016; however, it was asymptomatic up until that time.

Petitioner's primary treating physician, Dr. Lehman, opined Petitioner's current symptoms were related to the accident of November 30, 2016.

While Petitioner apparently only advised Dr. Lehman she was "running" at the time she sustained the accident, she testified at trial that to get in front of the patient she had to twist and turn.

Respondent's Section 12 examiner, Dr. Ritchie, opined Petitioner's current symptoms are due to pre-existing arthritis and the accident of November 30, 2016, exacerbated them. However, Dr. Ritchie agreed that Petitioner's left knee symptoms started on the day of the accident.

Given the preceding, the Arbitrator finds the opinion of Dr. Lehman to be more persuasive than that of Dr. Ritchie in regard to causality.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F), the Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

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

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the left knee arthroscopic surgery recommended by Dr. Lehman.

In support of this conclusion the Arbitrator notes the following:

As aforestated in disputed issue (F), the Arbitrator found the opinion of Dr. Lehman to be more persuasive than that of Dr. Ritchie in regard to causality.

While Dr. Lehman previously recommended Petitioner undergo a series of hyaluronic acid injections prior to considering arthroscopic surgery, he subsequently performed a Zilretta injection and now wants to proceed with arthroscopic surgery.

In spite of the fact the MRI was negative for a torn meniscus, Dr. Lehman's findings on examination were consistent with a torn meniscus and he opined Petitioner had sustained either an acute chondral fracture or torn meniscus.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 17 weeks commencing January 31, 2019, through May 30, 2019.

In support of this conclusion the Arbitrator notes the following:

When Dr. Lehman saw Petitioner on January 31, 2019, and May 3, 2019, he imposed work/activity restrictions of no bending, squatting, climbing or stairs and Petitioner was limited to sedentary duty only.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Williams,
Petitioner,

20IWCC0136

vs.

NO: 16 WC 33377

Caterpillar, Inc,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2019, is hereby affirmed and adopted.

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

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

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

DATED: FEB 2 6 2020
o2/6/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0136

WILLIAMS, JOHN
Employee/Petitioner

Case# **16WC033377**

CATERPILLAR INC
Employer/Respondent

On 8/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5354 STEPHEN P KELLY ATTY AT LAW
2701 N KNOXVILLE AVE
PEORIA, IL 61604

2851 CATERPILLAR INC
ELIZABETH Z LeBARON
PO BOX 348 A-11
AURORA, IL 60507

20IWCC0136

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

John Williams
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # **16** WC **33377**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Peoria**, on **April 24, 2019**. By stipulation, the parties agree:

On the date of accident, **4/27/16**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**39,926.42**, and the average weekly wage was $**767.81**.

At the time of injury, Petitioner was **41** years of age, ***single*** with **3** dependent children.

Temporary total compensation benefits have been provided by Respondent.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury and attaches the findings to this document.

ORDER

By stipulation of the parties, Respondent will pay to Petitioner $180.00 out of pocket expenses, and $1,330.76 in medical expense.

The Petitioner is entitled to, because of the injuries sustained, an award of **12% loss of use of each hand, and 15% loss of use of each arm under section 8(e) of the Act.**

FACTS IN CASE

The Petitioner sustained a work injury on April 27, 2016. The Petitioner was a machine operator for the Respondent at that time. The Petitioner testified his work activities required constant and repetitive use of his hands and arms for the Respondent.

The Petitioner testified that his specific job duties were that of loading and unloading parts. Petitioners testified that baskets of parts would be moved using a hoist. Most often, the Petitioner was required to lift the basket parts without the hoist.

The Petitioner testified that he was required to retrieve parts put into packing tubs. Petitioner testified while performing this activity, his elbows were fluxed in towards the body and the wrists were bent in a flex position.

Petitioner testified that he would move thousands of parts a day. Petitioner is also required to use a go-gage that also required him to screw and manipulate parts for the employer. The Petitioner testified that he would use a rubber mallet to impact the parts into the tubs.

The Petitioner testified that his work required constant and repetitive use of his hands and elbows. The Petitioner worked an 8-hour day.

The parties stipulated that a work injury occurred on April 27, 2016. The Petitioner testified that his medical care was primarily with Dr. James Williams. The records show that the Petitioner underwent a left carpal and left cubital tunnel release on January 31, 2018. Dr. Williams was the surgeon for that procedure.

The Petitioner testified on April 10, 2018, he also underwent a second surgery of a right carpal and right cubital tunnel release.

The records reveal the Petitioner received treatment with Dr. Williams in 2017 and received injections to both right and left wrists. The conservative care failed, and the surgery was of the recommendation of Dr. Williams in this case.

The Petitioner testified that on May 28, 2018, he was released from care from Dr. Williams and returned to full-duty work.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

With regard to the issue of nature and extent, the Arbitrator notes that pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator makes the following findings listed below.

With regard to Sec. 8.1(b) (i); the Arbitrator notes that there was no impairment rating performed on the Petitioner in this case. This factor will not be considered.

With regard to Sec. 8.1(b) (ii); the occupation of the Petitioner, the Arbitrator notes that the Petitioner was employed by the Respondent as a machine operator at the time of the injury and performing machine operating activity upon his return to work.

With regard to Sec. 8.1(b) (iii); the Arbitrator notes that the Petitioner was 41 years old at the time of the injury and has over 20 years left to perform machine operating activity. The Arbitrator believes it is significant the Petitioner has an additional 20+ years to perform this activity which was the cause of his problems.

With regard to Sec. 8.1(b) (iv); the Petitioner did not lose any earnings as a result of the work injuries. The Petitioner was earning $2.00 more an hour at the time of trial than he was at the time of the injury.

With regard to Sec 8.1(b) (v); the Arbitrator notes that the Petitioner underwent 2 surgeries for the diagnoses provided in this case. The Arbitrator notes that the Petitioner underwent a left carpal and left cubital tunnel release on January 31, 2018 and on April 10, 2018, he also underwent a second surgery of a right carpal and right cubital tunnel release.

The Petitioner testified at the time of trial that he still notices he has occasional pain and numbness in both hands, while performing work activities for the employer. The Petitioner further testified that he still has occasional pain and numbness in both elbows while performing his work activities for the Respondent.

Based on all of the foregoing, the Arbitrator finds that the Petitioner is entitled to an award of 12% loss of use of each hand, and 15% loss of use of each arm under section 8(e) of the Act.

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

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

Signature of Arbitrator

June 30, 2019
Date

AUG 1 - 2019

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vincent Boris,
Petitioner,

vs. No. 15 WC 22642

20IWCC0137

City of Rockford,
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 the nature and extent of Petitioner's permanent partial disability, causal connection and medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed May 29, 2018, is hereby affirmed and adopted.

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

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

20 I W C C 0 1 3 7

Pursuant to §19(f)(2) of the Act, no appeal bond is set in this case. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 6 2020

Marc Parker

mp/wj
02/20/20
68

Barbara N. Flores

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

BORIS, VINCENT E Case# **15WC022642**

Employee/Petitioner

20IWCC0137

CITY OF ROCKFORD IL A MUNICIPAL CORPORATION FIRE DEPARTMENT

Employer/Respondent

On 5/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0529 TUITE LAW
GREGORY E TUITE
PO BOX 59
ROCKFORD, IL 61105

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)

)SS.

COUNTY OF **WINNEBAGO**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

VINCENT E. BORIS
Employee/Petitioner

Case # **15** WC **22642**

v.

Consolidated cases: **N/A**

CITY OF ROCKFORD, IL, a Municipal Corporation, FIRE DEPARTMENT
Employer/Respondent

20IWCC0137

An *Application for Adjustment 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 **Rockford**, on **1/18/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [x] What is the nature and extent of the injury?

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

N. [ ] Is Respondent due any credit?

O. ☐ Other ____

ICArbDec 2/10 100 W. Randolph Street #8-200 Chicago, IL 60601 312/814-6611 Toll-free 866/352-3033 Web site: www.iwcc.il.gov
Downstate offices: Collinsville 618/346-3450 Peoria 309/671-3019 Rockford 815/987-7292 Springfield 217/785-7084

FINDINGS

On **5/20/15,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**91,936.00**; the average weekly wage was $**1,768.00**.

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

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services except for an invoice of $467.13 of Gray Medical.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**. The Petitioner received full salary when restricted from work.

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

ORDER

- The Arbitrator finds that the Petitioner's condition of ill-being with respect to his right shoulder is causally connected to the 5/20/15 accident.

- Respondent shall pay reasonable and necessary medical services of $467.13 issued by Gray Medical, as provided in Section 8(a) of the Act.

- The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 45% loss of use of man-as-a-whole pursuant to §8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 225 weeks, because the injuries sustained caused the 45% loss of the whole body as provided in Section 8(d)(2) of the Act. (See attached Addendum for the Arbitrator's Permanent Partial Disability analysis pursuant to §8.1b of the Act.)

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

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

Signature of Arbitrator

5/29/18
Date

ICArbDec p. 2

MAY 29 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION OF ILLINOIS

VINCENT E. BORIS,	)	
	)	
Petitioner,	)	
vs.	)	No. 15 WC 22642
	)	
CITY OF ROCKFORD, ROCKFORD IL,	)	**20IWCC0137**
A MUNICIPAL CORPORATION, FIRE DEPT.	)	
Respondents.	)	

AMENDED
ADDENDUM TO THE DECISION OF THE ARBITRATOR
FINDINGS OF FACT

It is undisputed that on May 20, 2015, Petitioner, a firefighter for the City of Rockford ("Respondent") since 1990, was injured in the course of his work duties while responding to a fire call. After his crew suppressed a small fire on the first floor of the building, Petitioner performed an inspection of the building to ensure all fire activity had ceased. As Petitioner descended an exterior wooden staircase that was wet and slippery, he lost his balance and began to fall backwards. To break his fall, he reached back with his right arm and felt a tearing sensation in his right shoulder followed by pain and loss of motion.

Later that day, Petitioner sought medical care at Ortho Illinois (formerly known as Rockford Orthopedic Associates) where he was noted to have decreased motion in his right shoulder. X-rays indicated mild degenerative joint disease of the acromioclavicular joint. Tramadol was prescribed and a right shoulder MRI was ordered. (PX1).

On May 28, 2015, MRI of Petitioner's right shoulder performed at Ortho Illinois showed:

1. A complete, full-thickness tear of the distal supraspinatus with median tendon retraction of 4.5 cm. Mild to moderate supraspinatus muscle atrophy.

2. Mild hypertrophic infraspinatus tendinosis with small interstitial and pinhole tears at its anterior distal segment. Subscalpular tendinosis with few interstitial tears at its insertional segment.

3. Thin posterosuperior to posteroinferior labral tear. Mildly hypertrophic proximal biceps long head tendinosis. (Id.).

On June 11, 2015, Petitioner presented to Dr. Scott Trenhaile, a shoulder surgeon at Ortho Illinois, who noted Petitioner's complaints of burning right shoulder pain at an 8/10 with overhead activity, lifting and pushing/pulling. He further reported the pain was sufficient to awaken him at night. (Id.). Dr. Trenhaile examined Petitioner and reviewed the May 28, 2015

MRI noting the "tear appears acute given the minimal atrophy and tearing pattern". (Id.). The doctor diagnosed a right rotator cuff tear, supraspinatus tendon tear and biceps tendinitis on the right. (Id.). Based on Petitioner's history, clinical exam, diagnostic studies, Dr. Trenhaile recommended surgery. (Id.).

On July 8, 2015, Petitioner underwent surgery performed by Dr. Trehaile consisting of a right shoulder arthroscopy, arthroscopic rotator cuff repair, extensive debridement of the glenohumeral joint and subacromial space and arthroscopic bicep tenodesis. (Id., p. 176).

Petitioner participated in post-operative physical therapy from August 25, 2015 through December 15, 2015.

On November 17, 2015, Petitioner followed-up with Dr. Trenhaile who noted restrictions of no overhead reaching and no lifting over 5 pounds. Dr. Trenhaile recommended additional care be administered by Dr. Borchardt.

On December 15, 2015, Dr. Borchardt recommended a work-hardening program which Petitioner initiated on December 17, 2015 and continued through February 10, 2016.

On January 12, 2016, Petitioner followed-up with Dr. Borchardt with complaints of limited range of motion in his right shoulder. (PX1, p. 34). Dr. Borchardt noted that while Petitioner's right shoulder is improving, he has not gained the range of motion that he needed. The doctor further noted that Petitioner had a "massive rotator cuff tear that was repaired to about 80%". Dr. Borchardt prescribed a shoulder MRI to rule out adhesive capsulitis, noting Petitioner may have permanent range of motion limitations. Petitioner also complained of intermittent weakness and numbness in his right hand. Dr. Borchardt recommended an EMG/NCV of the right upper extremity to better evaluate any peripheral nerve involvement. (Id. p. 35).

On January 19, 2016, a right shoulder MRI showed postoperative changes and a recurrent high-grade tear with severe tendinosis of the infraspinatus. (Id. p. 28). The following day, Petitioner followed up with Dr. Borchardt, who, upon review of the most recent MRI, noted moderate tendinosis and a partial tear in the right rotator cuff. Dr. Borchardt again noted that Dr. Trenhaile was only able to repair 70 to 80 percent of the tendon during the prior surgery. (Id.). Petitioner was placed on a Medrol dose pack for tendinosis and advised to follow-up after his EMG. (Id.).

On January 27, 2016, EMG studies showed moderately severe carpal tunnel syndrome on the right and moderate left carpal tunnel syndrome, as well as probable C5-6 cervical radiculopathy. (Petitioner's Exhibit 4.)

On February 12, 2016, Dr. Borchardt noted on exam that Petitioner's forward flexion was limited to 90 degrees, abduction to 90 degrees, external rotation to 15 degrees and internal rotation to 20 degrees. Petitioner testified that the restrictions were 40 pounds lifting from ground to waist, 20 pounds from waist to shoulder and no above shoulder lifting.

Petitioner testified that Respondent had allowed him to return to light duty work. He explained that such light duty accommodation was a transitional program while the injured

firefighter was healing in anticipation of returning to full duty work. He indicated there were no permanent light duty positions.
Respondent had Petitioner evaluated by orthopedic surgeon Dr. Stephen Weiss for an AMA rating which took place on March 9, 2017. Dr. Weiss noted restricted motion, supraspinatus and infraspinatus atrophy, right arm atrophy with positive impingement signs and tenderness at the rotator cuff insertion. (Using the range of motion method to assess impairment, Dr. Weiss determined that Petitioner had sustained a 13% upper extremity impairment which equaled 8% whole person impairment. (RX1).

Petitioner testified he continues to have the diminished range of motion and can only raise his right arm to approximately shoulder level. He is unable to reach into an overhead cabinet with his right arm. This caused him to transfer his reaching activities to his left arm. This limitation has affected his ability to perform chores around his house such as painting and moving furniture. He is unable to use power tools to do repairs around the house. He still goes to the gym on a regular basis to perform cardiovascular exercises but is no longer able to lift weights overhead.

CONCLUSIONS OF LAW

(F) CAUSAL RELATIONSHIP

The Arbitrator finds Petitioner has sustained his burden with respect to the undisputed accident on May 20, 2015, his subsequent need for right shoulder rotator cuff repair and his current condition. In support, the Arbitrator notes:

- Eight days following his accident, MRI showed: 1. a complete full-thickness tear of the distal supraspinatus with median tendon retraction of 4.5 cm. Mild to moderate supraspinatus muscle atrophy; 2. mild hypertrophic infraspinatus tendinosis with small interstitial and pinhole tears at its anterior distal segment; 3. subscalpular tendinosis with few interstitial tears at its insertional segment.

- On June 11, 2015, Dr. Trenhaile reviewed the May 28, 2015 MRI noting the "tear appears acute given the minimal atrophy and tearing pattern". The doctor diagnosed a right rotator cuff tear, supraspinatus tendon tear and biceps tendinitis on the right. Based on Petitioner's history, clinical exam, diagnostic studies, Dr. Trenhaile recommended surgery.

- On July 8, 2015, Petitioner underwent surgery performed by Dr. Trehaile consisting of a right shoulder arthroscopy, arthroscopic rotator cuff repair, extensive debridement of the glenohumeral joint and subacromial space and arthroscopic bicep tenodesis.

- Petitioner participated in post-operative physical therapy from August 25, 2015 through December 15, 2015.

- On December 15, 2015, Dr. Borchardt recommended a work-hardening program which Petitioner initiated on December 17, 2015 and continued through February 10, 2016.

- On January 12, 2016, Petitioner followed-up with Dr. Borchardt with complaints of limited range of motion in his right shoulder. (PX1, p. 34). Dr. Borchardt noted Petitioner's "massive rotator cuff tear" was "repaired to about 80%" further noting Petitioner may have permanent range of motion limitations.
- On January 19, 2016, a right shoulder MRI showed postoperative changes and a recurrent high-grade tear with severe tendinosis of the infraspinatus. (Id. p. 28).
- On February 12, 2016, Dr. Borchardt indicated Petitioner had reached maximum medical improvement. (Id.). At that visit, Dr. Borchardt noted forward flexion was limited to 90 degrees, abduction to 90 degrees, external rotation to 15 degrees and internal rotation to 20 degrees.
- Dr. Stephen Weiss, Respondent's examining physician, diagnosed probable pre-existing rotator cuff tendinopathy, stating Petitioner sustained permanent aggravation of the condition secondary to the incident of May 20, 2015.
- Petitioner testified he did not have any significant treatment to the right shoulder before the May 20, 2015 accident. He further testified he performed heavy exertional duties of a firefighter without difficulty before the accident at issue.
- Respondent did not present any medical evidence showing that the Petitioner had a *significant* pre-existing condition prior to the May 20, 2015 incident. Nor did Respondent present any medical opinion that negated causal relationship.

Based on the above, the Arbitrator finds in favor of Petitioner on the issue of causal relationship.

(J) UNPAID MEDICAL BILLS

Petitioner presented a bill from Gray Medical for $467.13 (PX8). The accompanying medical bill shows charges on July 8, 2015 related to set up, delivery of and training to use a Game-Ready compression therapy machine prescribed by Dr. Trenhaile. (PX1 p.195). Petitioner testified that he used the Game-Ready machine shortly after his shoulder surgery. Having found in Petitioner's favor on the issue of causal relationship, the Arbitrator awards unpaid medical of $467.13 pursuant to the Workers' Compensation fee schedule.

(L) NATURE AND EXTENT OF THE INJURY

The Arbitrator notes Petitioner is presenting this case pursuant to Section 8(d)2 of the Illinois Workers' Compensation Act.

For injuries occurring on or after September 1, 2011, all permanent partial disability awards shall be established using the following criteria.

With regard to section (i) of § 8.1b(b), the Arbitrator notes that Dr. Weiss performed an AMA impairment rating and determined that the Petitioner's impairment of his right shoulder to be 13% of the upper extremity or 8% whole person impairment. The Arbitrator gives greater weight to this factor.

With regard to section (ii) of § 8.1b(b), the occupation of the employee, the Petitioner was employed at the time of the injury as a Lieutenant in the Rockford Fire Department. His duties continued to include fire suppression and those of a paramedic which required Petitioner to lift between 80 and 150 pounds. Based upon the permanent restrictions placed upon Petitioner, it is clear he can no longer perform his work as a firefighter for the Rockford Fire Department because of his injury. The Arbitrator gives greater weight to this factor.

With regard to section (iii) of § 8.1b(b), the Arbitrator notes Petitioner's date of birth is March 11, 1959. The Arbitrator finds this factor to be significant based upon the nature of his injuries and the number of years he will have to deal with the effects of his injuries.

With regard to § (iv) of Section 8.1b(b), Petitioner's future earning capacity, the Arbitrator notes the Petitioner is incapable of returning to work as a Lieutenant for the Rockford Fire Department due to the restrictions and limitations caused by the injury. Further, it is unlikely he will return to any work, due to his age and physical limitations. Accordingly, the Arbitrator gives greater weight to this factor.

In regard to section (v) of § 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained a significant injury to his dominant right arm as a result of the May 20, 2015 injury. On July 8, 2015, Petitioner underwent significant surgery to the right shoulder. This revealed significant pathology both within the rotator cuff, the glenohumeral joint, and the biceps tendon. Petitioner then participated in seven months of physical therapy and work conditioning in an attempt to return to full duty as a firefighter. Unfortunately, early in that process it appeared he would not be able to reverse the significant loss of motion of his shoulder joint. In December 2016, the treating surgeon indicated that the progress in regaining motion would be slow because of the massive nature of the tear. (PX1 p.84). Despite four months of therapy, on February 10, 2016 the treating physical therapist noted that Petitioner was "ready to discontinue treatment and knows additional therapy will not result in him returning to full-duty work." Two days later, Dr. Borchardt agreed with the therapist's assessment and released Petitioner from care. (PX1 p.3)

The records of the treating physicians are corroborated by the examination performed by Dr. Weiss on March 9, 2017. He noted the range of motion of the shoulders to be as follows:

	Right	Left
Flexion	100 degrees	180 degrees
Extension	60 degrees	60 degrees
Abduction	70 degrees	180 degrees
Adduction	20 degrees	40 degrees
Internal Rotation	90 degrees	90 degrees
External Rotation	30 degrees	80 degrees

The medical records document the severity of the injury to Petitioner's right dominant shoulder. Petitioner also testified to the limitations he experiences on a daily basis. Given that the treating records contained support and corroborate Petitioner's testimony with respect to chronic pain and disability, the Arbitrator assigns greater weight to this factor.

Based upon the above factors, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 45% loss of the man-as-a-whole, pursuant to Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Patton,
Petitioner,

vs. No. 09 WC 41234

20IWCC0138

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, permanent partial disability, and medical expenses and being advised, 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 25, 2018, is hereby affirmed and adopted.

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

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

20 IWCC0138

Pursuant to §19(f)(2) of the Act, no appeal bond is set in this case. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 6 2020

Marc Parker

mp/wj
02/20/20
68

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

PATTON, JERRY
Employee/Petitioner

Case# **09WC041234**

08WC029494
11WC027881

CITY OF CHICAGO
Employer/Respondent

20IWCC0138

On 6/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0113 CITY OF CHICAGO DEPT OF LAW
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60606

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

20IWCC0138

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Jerry Patton
Employee/Petitioner
v.

Case # **09 WC 41234**

Consolidated cases: **08 WC 29494**; **11 WC 27881**

City of Chicago
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **12/29/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [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 **3/31/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury of **3/31/2009**, Petitioner earned $**81,502.09**; the average weekly wage was $**1,502.09**;

On the date of accident, Petitioner was **43** 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 **$125,647.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$125,647.00**

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

ORDER

Petitioner's claim for benefits is denied for failure to prove that his sustained an injury March 31, 2009 and for failure to prove that his claimed condition of ill-being was causally related the accident on March 31, 2009.

Respondent is entitled to a credit for all TTD benefits paid.

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

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

Signature of Arbitrator

June 19, 2018
Date

JUN 25 2018

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF LA SALLE	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORI SIMMONS, a/k/a LORI HALL,
Petitioner,

vs. NO: 17 WC 036259

COURTYARD ESTATES,
Respondent.

ORDER

This matter came before Commissioner Barbara N. Flores on November 14, 2019, pursuant to Respondent's Motion to Dismiss Petitioner's Petition for Review based on Petitioner's failure to timely file an agreed statement of facts or transcript of proceedings. Counsel for Respondent presented argument and submitted exhibits to Commissioner Flores. Petitioner did not appear in person or through counsel. At the conclusion of the hearing, Commissioner Flores granted Respondent's motion, indicating that this order would follow.

I. Background

The record indicates that on February 4, 2019, Petitioner filed her *pro se* Petition for Review of the Decision of the Arbitrator in this matter. Petitioner indicated the Decision was filed on January 22, 2019 and received by Petitioner on January 23, 2019.

On March 11, 2019, the court reporter for the arbitration hearing sent an email to Respondent's counsel asking whether he would like to order a copy of the transcript of proceedings. Respondent's counsel responded the same day, requesting a copy of the transcript.

On April 11, 2019, the court reporter again emailed Respondent's counsel, indicating that she sent Petitioner a letter requesting a deposit for the original transcript and received no response. The court reporter indicated that she would not be transcribing the hearing in this matter and would be setting the case for disposition.

The record includes a May 31, 2019 email from Petitioner to Respondent, indicating that Petitioner had changed her name from Lori Simmons to Lori Hall but her address remained the

same. The address listed in the email is the same as the address Petitioner listed in her Petition for Review.

On October 25, 2019, Respondent filed the instant Motion to Dismiss Petitioner's Petition For Review, based on Petitioner's failure to timely file an agreed statement of facts or transcript of proceedings. When Respondent initially presented the motion, Commissioner Flores informed Respondent's counsel that the Commission's website indicated that Petitioner remained represented by counsel and requested Respondent's counsel to contact Petitioner's listed counsel to inform him of the pending motion. Email correspondence between counsel dated November 8 and 11, 2019 indicates that Petitioner's listed counsel had filed a motion to withdraw on June 4, 2018 and that motion was granted by the Arbitrator.[1] Petitioner's listed counsel stated that he had been discharged, was not being paid or claiming a lien in the matter and had no objection to Respondent's motion to dismiss.

The record also includes a letter sent by certified mail from Respondent to Petitioner on October 17, 2019, notifying Petitioner that the motion to dismiss was set for hearing on November 14, 2019. At the November 14 hearing, Respondent's counsel indicated that Petitioner received notice on October 28, 2019.

II. Conclusions of Law

Respondent's motion to dismiss is based primarily on section 19 of the Workers' Compensation Act, which states in relevant part as follows:

> "Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, *and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of the facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings*, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive." (Emphasis added.) 820 ILCS 305/19 (West 2016).

Similarly, the regulations governing practice before the Commission provide in relevant part that "[f]or purposes of perfecting a review, an arbitration transcript must be ordered within the time fixed by statute." 50 Ill. Adm. Code 9040.10(b)(2) (2016). The same regulation requires that "the party requesting the transcript shall deposit a sum of money covering the estimated cost before the reporter is required to complete the transcript." *Id.*

In this case, Petitioner received a copy of the Decision of the Arbitrator on January 23, 2019. Thus, in order to perfect her appeal, Petitioner was required to file an agreed statement of

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[1] The record includes the motion to withdraw, which indicates the motion was filed on April 23, 2018. The record also includes an April 18, 2018 letter from Petitioner's listed counsel to Respondent's counsel noting that Petitioner had elected to proceed with her claim *pro se* and that Petitioner's listed counsel would not be appearing before the Commission on June 4, 2019.

facts or a transcript of proceedings with the Commission by February 27, 2019. Petitioner failed to do so in this matter. Petitioner also failed to deposit money covering the estimated cost of the transcript.

Given this record, the Commission concludes that Petitioner failed to perfect her appeal in this matter and the Decision of the Arbitrator has become the decision of the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss Petitioner's Petition for Review is hereby granted.

DATED: FEB 2 7 2020
o: 11/14/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JADWIGA MAGNUSZEWSKA,

Petitioner,

vs. NO: 19 WC 9557

DOUMAK, INC.,

Respondent.

20IWCC0139

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b-1) and 8(a) 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 care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings including a determination of permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

I. FINDINGS OF FACT

A. Background, Past Treatment, and Accident

Petitioner testified through an interpreter that in September and October 2018, she worked as a packer for Respondent, a firm which produces marshmallows. Petitioner was 50 years old. Petitioner stated that she had worked for Respondent since August 2003. According to Petitioner, in 2018, she typically worked between 8 and 10 hours daily (from 6 a.m. to 2 p.m.), 6 or 7 days a week.

Petitioner testified that she would check whether the product that was supposed to be packed was suited for the box. Petitioner stated that someone from the warehouse would bring a pallet with a stack of 25 cardboard boxes which were folded flat. Petitioner also stated that these boxes were very big and very heavy.

According to Petitioner, she would unfold the boxes into a form suitable for packing. Petitioner testified that she would then pack each box with 24 bags of marshmallows, each weighing 300 grams. Petitioner stated that each box had to be filled quickly, perhaps as quickly as five seconds apiece. Petitioner added that she would push each packed box down a belt, where someone else would take them.

Petitioner testified that on September 24, 2018, she visited a general physician, Dr. Rolf Stavig, because she felt a sharp pain in her lower back and left leg. Petitioner stated that she was already taking ibuprofen but Dr. Stavig prescribed additional medication at that time. Petitioner also stated that on October 8, 2018, she telephoned Dr. Stavig's office because her pain had not gone away. Petitioner testified that she continued to work for Respondent during this period.

The medical records reflect that when Petitioner visited Dr. Stavig on September 24, 2018, she complained of chronic intermittent low back pain with a current severe flare-up over a week, with pain radiating bilaterally to the knees. Petitioner also reported bilateral lower extremity tingling and numbness. Dr. Stavig noted Petitioner had an MRI eight years prior which indicated degenerative disc disease. The doctor prescribed a Medrol dosepak and advised to apply an ice pack for 15-30 minutes three times daily as needed. The doctor also advised Petitioner to call if she did not improve soon, with a follow-up in three months or as needed.

Petitioner later testified that she previously experienced low back pain in 2013 but did not seek treatment because the pain was insignificant. Petitioner gave conflicting testimony regarding whether she ever had an MRI taken of her low back prior to September 2018.

Petitioner further testified that on October 10, 2018, she injured her back while quickly lifting boxes from the pallet to her workstation. Petitioner stated that she experienced a very heavy, sharp pain in her lower back. Petitioner also stated that she worked the remainder of the day but on October 29, 2018 completed and signed a written report of the accident with the assistance of her daughter, who speaks English very well.

B. Medical Treatment

On October 11, 2018, Petitioner returned to Dr. Stavig, reporting that the Medrol dosepak had not helped. Dr. Stavig diagnosed Petitioner with acute bilateral low back pain with sciatica, sciatica laterally unspecified. The doctor ordered a lumbar spine MRI and referred Petitioner to Dr. Jerome Kolavo for an orthopedic spine evaluation. The record for this visit does not contain a report by Petitioner of the work-related incident.

The lumbar spine MRI was performed on October 12, 2018. The interpreting radiologist found: disc desiccation at L1-L2, L4-L5, and L5-S1 levels; a focal annular tear in the right foraminal aspect of the disc at L4-L5; a 1.5mm broad-based posterior disc protrusion without central canal or neural foraminal stenosis at L5-S1; and no obvious spondylolysis or listhesis.

On October 26, 2018, Petitioner presented at the emergency department of Central DuPage Hospital. Petitioner reported chronic low back pain but particularly an episode over the prior three weeks. Petitioner also reported that she believed her twisting and bending on the job was the likely etiology. Petitioner was diagnosed with acute left-sided low back pain with left-sided sciatica. She was discharged with pain medication and a muscle relaxant and directed to follow up with her primary care physician within four days. Petitioner testified that she was off work as of this date.

On October 29, 2018, Petitioner returned to Dr. Stavig complaining of worsening low back pain and stiffness which was not being helped by Valium. The back pain continued to radiate into the lower extremities. Dr. Stavig noted that Petitioner had been seen in the emergency room recently and that the MRI disclosed some degenerative disc disease. The doctor advised Petitioner to finish the Medrol dosepak, switched Petitioner from Valium to Flexeril, and referred Petitioner for physiatric evaluation followed by an orthopedic evaluation. The doctor also reported, "Note for work was given."

On November 9, 2018, Petitioner had her initial orthopedic consultation with Dr. Kolavo. Petitioner reported "some low-grade issues over the years beginning about 10 years ago" but had no active treatment prior to a work injury on October 10, 2018. Dr. Kolavo noted Petitioner moved very dramatically and slowly getting up from the examination table to sitting and displayed "dramatic pain behavior." The doctor also noted that Petitioner jumped and withdrew "in an exaggerated dramatic fashion" when her reflexes were tested.

Dr. Kolavo ultimately assessed Petitioner with: degeneration of the lumbar or lumbosacral intervertebral disc; acute bilateral low back pain with sciatica, sciatica laterally unspecified; and pain of the lower left extremity. He recommended anti-inflammatories and avoidance of narcotics. He ordered that Petitioner would remain off work and could start physical therapy. However, Dr. Kolavo also found Petitioner's MRI to be unremarkable and follow-up with a surgeon unnecessary. Dr. Kolavo asked Petitioner to see Dr. Joshua Ward in approximately three weeks.

On November 17, 2018, Petitioner received an initial evaluation for physical therapy and would engage in dozens of sessions through May 13, 2019.

On November 29, 2018, Petitioner had her initial physiatry consultation with Dr. Ward. Petitioner reported acute onset of her low back pain and left lower extremity pain on October 10, 2018 after lifting heavy boxes at work, rating her pain at 7/10 in severity. The physical examination indicated severe restrictions in lumbar flexion and extension, a positive straight leg raise on the left, and painful SI joint motion on the left.

Dr. Ward's impression was that the lumbar spine MRI showed very mild degenerative disc disease at L4-5 and L5-S1 without obvious nerve root compression to explain her pain. Dr. Ward noted that Petitioner's symptoms were "most consistent with L5 radiculitis not clearly explained by her MRI." The differential included potential inflammatory radiculitis at L5, SI joint strain with referred pain. The doctor also noted Petitioner had significant myofascial pain. He described her as "in moderate distress during the physical exam and continually pace[d] with an antalgic gait" and was unable to sit for any length of time. Dr. Ward discussed the possibility of diagnostic injections, but Petitioner wished to continue with physical therapy first. He further recommended that Petitioner not work pending follow-up treatment.

A December 18, 2018 telephone note in Dr. Ward's file indicated an updated complaint of progressive left leg weakness. Dr. Ward noted that Petitioner's lumbar MRI was unimpressive and did not explain her weakness. Dr. Ward also noted a need to consult neurology and look for other causes. The doctor further recommended proceeding with additional MRI imaging of the cervical and thoracic spine.

On December 26, 2018, Respondent's workers' compensation case manager denied approval for the additional MRI imaging absent an explanation of how it tied in with lumbar radiculitis and leg weakness. Dr. Ward responded that he could not disagree with the assessment regarding the denial of the thoracic and cervical MRIs, adding: "At this point we are considering other systemic causes of leg weakness which may not be related to her work injury."

A December 31, 2018 note from Petitioner's physical therapy reported Petitioner had significant hypersensitivity to light touch. Petitioner expressed a fear of exercising at this session as her symptoms were exacerbated. The therapist planned to reach out to Dr. Kolavo regarding the symptom exacerbation.

Petitioner underwent a diagnostic left L5 transforaminal epidural steroid injection on January 11, 2019. During a January 14, 2019 follow-up visit, Petitioner reported mild improvement on the date of the injection, followed by increasing symptoms, at which time a proposed EMG was postponed. Indeed, on the same date, Petitioner again presented at the emergency department of Central DuPage Hospital for severe back pain radiating down both legs. Petitioner reported that she was at Dr. Ward's office for an EMG when the pain became worse. Petitioner was observed as shaking in triage and noted to have a left-sided foot drop upon examination. Petitioner was admitted to the hospital for further workup and evaluation.

On January 16, 2019, Petitioner was seen by Dr. Kolavo, who noted Petitioner continued to display dramatic pain behavior with minor motion in bed. After reviewing a new MRI and comparing it to the prior study, Dr. Kolavo found minimal disc pathology at L4-L5 and no nerve root compression. The doctor also found Petitioner's pain and disability was clearly disproportionate to radiographic findings and that no surgical condition existed. Dr. Kolavo recommended discharging Petitioner and a follow-up with Dr. Ward for nonsurgical care.

Dr. Ward examined Petitioner on January 23, 2019, noting that she was demonstrating weakness in the lower extremity well beyond the distribution of the L5 nerve root that was not explained by her lumbar MRI findings. Petitioner reported pain at a severity of 7/10. Petitioner was complaining of similar symptoms in the left upper extremity with diffuse weakness and sensory changes, "again with no clear diagnosis." Dr. Ward was concerned about a neurologic disorder not of an orthopedic nature. Dr. Ward also noted Petitioner was unable to tolerate an EMG during her recent hospitalization.

Dr. Ward further noted Petitioner was scheduled to see a neurologist in early February. He recommended that a neurologic workup begin with a cervical and thoracic MRI. The doctor acknowledged that the MRIs were refused under workers' compensation and may need to proceed under Petitioner's primary insurance.

Petitioner underwent an initial neurological consultation with Dr. Padmaja Gutti on February 8, 2019. Dr. Gutti performed a physical examination and reviewed new MRIs of the cervical spine, thoracic spine and lumbar spine taken in January 2019. Dr. Gutti assessed low back pain with left lower extremity radicular signs after a work-related injury. He increased Petitioner's dosage of Gabapentin, recommended continued physical therapy and an EMG of the left lower extremity. Dr. Gutti also kept Petitioner off work until an EMG was completed.

On February 12, 2019, Petitioner returned to Dr. Stavig for a physical examination. Petitioner continued to complain of ongoing low back pain radiating to the lower extremities but also noted chronic left posterior shoulder pain. Dr. Stavig noted that Petitioner was getting physical therapy with some benefit. The doctor recommended a low-fat, high-fiber diet and regular exercise when feeling better from back pain. He also recommended continued physical therapy.

On March 11, 2019, Dr. Gutti extended Petitioner's work note pending a March 26, 2019 follow-up appointment. During that visit, Dr. Gutti noted that Petitioner's EMG was normal, without any evidence of lumbosacral radiculopathy. The doctor again increased Petitioner's dosage of Gabapentin and referred Petitioner to a pain specialist.

On March 27, 2019, Petitioner saw Dr. Stavig, reporting that the low back pain now radiated to the left lower extremity and neck pain radiating to the left upper extremity. Petitioner reported significantly less pain with Gabapentin. Dr. Stavig referred Petitioner to Dr. Ward regarding the neck pain.

Petitioner saw Dr. Gutti for a three-month follow-up on June 26, 2019. Petitioner reported that her left lower extremity pain had improved after three lumbar epidural steroid injections by pain management.[1] Petitioner also reported returning to work when her disability payments ended, stating that she experienced severe low back pain after working for even an hour. Petitioner complained of pain in the mid and lower back. Petitioner's straight leg test was negative.

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[1] These injections were administered on April 12, May 15, and June 11, 2019.

Dr. Gutti noted that Petitioner's gait tended to favor the left lower extremity while walking "which disappears with distraction." Dr. Gutti also noted that Petitioner's lumbar MRI showed no findings suggestive of radiculopathy and her EMG showed no evidence of radiculopathy or neuropathy. Dr. Gutti again increased Petitioner's dosage of Gabapentin and referred Petitioner to Dr. Ward at her request.

On July 8, 2019, Petitioner followed up with Dr. Ward, who noted the patient's "complicated history." Dr. Ward also noted that the cervical and thoracic spine MRIs showed no evidence of spinal cord compression and that her neurologic work-up showed no clear diagnosis. Dr. Ward also did not have a clear explanation for the magnitude of Petitioner's pain as it was out of proportion to the objective MRI findings in the lumbar spine. Dr. Ward agreed with the referral to the Marionjoy pain clinic and had no additional treatment to recommend.

Petitioner had her initial evaluation for chronic back pain by Dr. Silpa Katta with the Marionjoy Medical Group on July 29, 2019. Petitioner reported that she had no low back symptoms prior to her work-related injury. According to Petitioner, she sought emergency treatment on the date of the accident and experienced radicular pain with burning and tingling into her left lower extremity two weeks later. As part of her history, Petitioner indicated that this was not a workers' compensation case and she was not on disability at the time. She added that she was amenable to a desk job in the future.

Dr. Katta assessed Petitioner with SI (sacroiliac) joint dysfunction and lumbosacral radiculopathy at the L5 level. She was determined to be an excellent candidate for a comprehensive pain management program, as well as physical therapy and psychological sessions as appropriate. On August 12, 2019, Petitioner was officially admitted to Marionjoy's pain program and was additionally diagnosed with myofascial pain.

On August 14, 2019, Petitioner assessed her pain severity as 6/10 and described the pain as sharp. Petitioner also complained of insomnia and depression. Petitioner requested a work note, as she was currently on leave due to her disability. She also requested more information on employment opportunities and was possibly applying for disability benefits. The records indicate Petitioner's treatment continued throughout August 2019 and do not indicate that she was discharged. Notably, Petitioner underwent trigger point injections on August 28 and 30, 2019.

The Decision of the Arbitrator correctly notes that Petitioner's medical records also reflect treatment unrelated to her back, including a hysteroscopy with endometrial polypectomy, headaches with vision issues, and chronic left shoulder pain.

C. Section 12 Examination by Dr. Lami

On February 22, 2019, Petitioner submitted to a section 12 examination by Dr. Babak Lami at Respondent's request. Petitioner spoke English and declined to reschedule the appointment for

an interpreter. Petitioner reported that on October 10, 2018 she lifted a box she referred to as a 10x4, resulting in low back pain. Petitioner stated her initial pain was 10/10 and her current pain was 8/10. Petitioner also reported undergoing 30 sessions of physical therapy, prescription medication, and the injection performed by Dr. Ward (which had not helped her).

During the physical examination, Petitioner ambulated very slowly with a limp and had essentially no motion of the lumbar spine. Her straight leg test was negative. Petitioner also reported pain and discomfort with all maneuvers.

Following a review of the medical records, including the lumbar MRI, Dr. Lami opined that he could not support the conclusion of a work-related injury as a result of the October 10, 2018 incident. He also opined that the mechanism of injury was not consistent in the medical records and the amount of pain and disability was not supported by any of Petitioner's reported mechanisms of injury. He further opined that the report of injury on October 10, 2018 was not an aggravation of any preexisting condition.

Dr. Lami continued, opining that Petitioner's current subjective complaints did not pertain to her work-related activities on October 10, 2018. He added that Petitioner's current subjective complaints were out of proportion to her reported mechanism of injury and that there was no good medical explanation for her symptoms. Dr. Lami noted that Petitioner's lumbar spine MRI findings were fairly benign with no neural compressive pathology and did not explain her current symptoms. Dr. Lami's reading of the October 12, 2018 MRI was that there was no neural compressive pathology at any level and the MRI was essentially normal for the patient's age.

Dr. Lami concluded that Petitioner's medical treatment in terms of the MRI and physical therapy were reasonable but unrelated to the October 10, 2018 incident. Dr. Lami believed Peitioner had sufficient treatment for her back, which was also unrelated to the October 10, 2018 incident. Dr. Lami recommended no further treatment for Petitioner's low back, though she might see her primary physician to determine other causes of her significant pain which are outside the spine. Although Dr. Lami found no work-related injury, he found Petitioner was at MMI regardless of causation.

D. Surveillance Report and Video Recording

Respondent submitted into evidence an Investigation Report dated February 21, 2019 and accompanying video recording documenting surveillance of Petitioner on February 11, 13 and 14, 2019. The report indicated that on February 11, 2019, Petitioner was observed leaving her house, walking a dog, and returning. Mobile surveillance was not maintained because the surveillance vehicle was surrounded by a school bus and children.

The report indicated that on February 13, 2019, Petitioner was observed driving to a nail salon followed by a tanning salon. When walking from her vehicle to these businesses, Petitioner was observed carrying her purse over her left forearm, conversing on a cellular telephone, and

drinking from a water bottle. Upon returning home, Petitioner also was seen placing her right boot on her right foot before re-entering. Petitioner was also observed walking a dog for approximately 22 minutes.

The report further indicated that on February 14, 2019, Petitioner was observed walking the dog briefly from the front of the residence toward the garage before Petitioner departed the area in her vehicle. According to the report, Petitioner drove along the highway to a grocery store, placing her right boot on her foot before entering. The report indicated Petitioner was recorded retrieving items from the shelves in the store, as well as carrying a case of bottles and grocery bags from her shopping cart to the vehicle. A review of the portion of the video recording at the grocery store shows Petitioner exiting the grocery store with a case of bottles on the undercarriage of the shopping cart and later shows the bottles inside Petitioner's vehicle while Petitioner is seen loading bags of groceries into her vehicle. Petitioner was also seen visiting a bookstore and another nearby business. She removed her right boot before driving to a tobacco store.

E. Current Condition and Activities

Petitioner testified that she had been off work since October 26, 2018 through the date of the hearing. Petitioner noted that she attempted to return to work for one day, March 29, 2019, but completed only two hours of work that day due to the intensity of her pain. Petitioner also testified that she received temporary disability benefits from October 26, 2018 through March 22, 2019. Petitioner further stated that she has group health insurance provided by Respondent or her union.

Regarding her current condition of ill-being, Petitioner testified that she continues to visit the pain clinic three times weekly. Petitioner stated she is also being treated for stress, depression, and anxiety at the clinic. She also stated that she is learning to cope with and manage her pain in the Marionjoy program.

Petitioner further testified that she continued to experience sharp low back pain that radiates to her left leg. Petitioner takes medication and currently rated her pain severity as a 5/10. Petitioner added that daily activities such as standing, sitting up straight, bending over, and walking for a long time aggravated her condition.

Petitioner testified that she had viewed surveillance video of her activities recorded on behalf of the insurer in this case of her over a period of days in February 2019. Petitioner acknowledged that the video shows her walking her dog. Petitioner stated that before her injury, she would walk her dog for 60-90 minutes but now only walks him for 15 minutes twice daily. Petitioner also acknowledged that the video shows her driving without her right shoe or boot. Petitioner explained that she feared her back pain would prevent her from feeling the pedals. Petitioner added that sitting straight behind the wheel of her vehicle caused intense pain.

Petitioner further testified that she does little in the way of household chores and has help

from her brother's wife. Petitioner stated that she only does exercises recommended by the doctor and physical therapist, taking perhaps 15 minutes three times daily. Petitioner acknowledged that she still has her nails done. Petitioner also acknowledged that she initially went to a tanning salon because she was told by a physical therapist that warm air was good for the sciatic nerve, but she no longer goes there. Petitioner stated that she could carry a gallon of milk and move a case of water, which she does once a week. Petitioner testified that no doctor had told her not to walk her dog, drive her car, or shop for groceries.

II. CONCLUSIONS OF LAW

A. Causal Connection

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that she suffered a disabling injury that arose out of and in the course of her employment. *Dunteman v. Illinois Workers' Compensation Comm'n*, 2016 IL App (4th) 150543WC, ¶ 40. The "in the course of" component refers to the time, place, and circumstances under which the injury occurred. *Id.* The "arising out of" component addresses the causal connection between a work-related injury and the claimant's current condition of ill-being. *Id.* An injury "arises out of" employment if it had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.*

The Arbitrator concluded that Petitioner failed to establish a causal connection between the October 10, 2018 work-related accident and her current condition of ill-being. The Arbitrator found that Petitioner reached maximum medical improvement and could return to full-duty work on February 22, 2019. The Arbitrator relied in part on Dr. Lami's independent medical examination but noted the similarities between the opinions in Dr. Lami's report and the opinions expressed by Petitioner's treating physicians.

In his IME report, Dr. Lami noted that Petitioner's lumbar spine MRI findings were fairly benign with no neural compressive pathology and did not explain Petitioner's current symptoms. Indeed, Dr. Lami's reading of the October 12, 2018 MRI was that there was no neural compressive pathology at any level and the MRI was essentially normal for the patient's age. Dr. Lami recommended that Petitioner might see her primary physician to determine other causes of her significant pain which are outside the spine.

The Arbitrator correctly concluded that Dr. Lami's opinions regarding causal connection find corroboration in Petitioner's treatment records. After Petitioner's initial orthopedic consultation, Dr. Kolavo found Petitioner's MRI to be unremarkable. On January 16, 2019, Dr. Kolavo also found Petitioner's pain and disability was clearly disproportionate to the radiographic findings and that no surgical condition existed.

Similarly, after Petitioner's initial physiatry consultation, Dr. Ward's impression was that the lumbar spine MRI showed very mild degenerative disc disease at L4-5 and L5-S1 without

obvious nerve root compression to explain her pain. Dr. Ward later noted that Petitioner's lumbar MRI was unimpressive and did not explain her weakness. Dr. Ward further noted a need to consult neurology and look for other causes of Petitioner's reported weakness. On December 26, 2018, Dr. Ward noted: "At this point we are considering other systemic causes of leg weakness which may not be related to her work injury." On January 23, 2019, Dr. Ward noted that he was concerned about a neurologic disorder not of an orthopedic nature.

Dr. Lami's opinions were further corroborated by Dr. Gutti, who noted on March 11, 2019 that Petitioner's EMG was normal, without any evidence of lumbosacral radiculopathy. Dr. Gutti later noted that Petitioner's lumbar MRI showed no findings suggestive of radiculopathy and her EMG showed no evidence of radiculopathy or neuropathy.

The Arbitrator also noted multiple suggestions of symptom magnification in Petitioner's treatment records. Evidence of symptom magnification is relevant to establish the Petitioner's current condition of ill-being.

Dr. Kolavo noted Petitioner moved very slowly and dramatically, displayed "dramatic pain behavior," and jumped and withdrew "in an exaggerated dramatic fashion" when her reflexes were tested. A December 31, 2018 note from Petitioner's physical therapy reported Petitioner had significant hypersensitivity to light touch. On January 16, 2019, Dr. Kolavo noted Petitioner continued to display dramatic pain behavior with minor motion in bed. Dr. Gutti later noted that Petitioner's gait tended to favor the left lower extremity while walking "which disappears with distraction."

The Arbitrator compared Petitioner's subjective complaints to his observation of Petitioner in the surveillance video recordings, which generally depict Petitioner ambulating normally and without visible signs of pain or distress in various locations. The Arbitrator found that Petitioner was seen walking a dog for 15-25 minutes on a snowy or icy sidewalk. The video recording at issue appears to show sidewalks with at least a light coating of snow, though Petitioner also steps off the sidewalk onto a lawn at one point.

The Arbitrator also found that Petitioner "was seen lifting a case of bottles." The portion of the video recording at the grocery store does not depict this directly but shows Petitioner exiting the grocery store with a case of bottles on the undercarriage of the shopping cart and later shows the bottles inside Petitioner's vehicle while Petitioner is seen loading bags of groceries into her vehicle. Given that Petitioner testified that she moved the case of bottles, the Arbitrator's conclusion on this point was a reasonable inference.

The surveillance video recordings partly corroborate Petitioner's complaints in one respect. The recordings indicate that Petitioner would remove her right boot when driving. Petitioner testified that she feared her back pain would prevent her from feeling the pedals and her explanation on this point was not rebutted. Nevertheless, the surveillance video recordings corroborate Dr. Gutti's observation that Petitioner's gait does not always favor the left lower

extremity.

Petitioner argues that the February 22, 2019 date of maximum medical improvement is arbitrary, which is true inasmuch as it is a function of when the independent medical examination was scheduled and conducted. However, by that date, Dr. Ward already was considering other systemic causes of leg weakness which may not be related to her work injury and was concerned about a neurologic disorder not of an orthopedic nature. Dr. Kolavo had already found Petitioner's pain and disability was clearly disproportionate to radiographic findings and that no surgical condition existed. Moreover, the surveillance videos, recorded in mid-February 2019, corroborate Dr. Lami's finding Petitioner had reached maximum medical improvement on February 22, 2019.

Petitioner also argues against the physicians' over-reliance on the objective findings indicated by MRI imaging and her EMG. Petitioner cites the subjective nature of pain and further notes that the physicians "didn't simply write her off as a liar or a fake." The treatment records, however, repeatedly contain notes suggesting symptom magnification. Moreover, the idea that a claimant may not return to complete health is inherent in the concept of maximum medical improvement. Ultimately, Petitioner is required to establish that her current condition of ill-being is causally connected to her work-related injury and the evidence is lacking on this point.

In sum, the weight of the evidence establishes that Dr. Lami's opinions are corroborated by those of Petitioner's treating physicians, who repeatedly opined that Petitioner's symptoms were not supported by the objective findings, including the MRI and EMG results. Petitioner was referred for the February 9, 2019 neurological consultation because Petitioner's treating physicians could not connect her symptoms to the October 10, 2018 accident. Given this record, the Commission agrees with the Arbitrator that Petitioner failed to establish by a preponderance of the evidence that her current condition was causally connected to her work-related accident. The Commission also adopts the Arbitrator's finding that Petitioner reached maximum medical improvement on February 22, 2019.

B. Medical Expenses

Based on the Commission's conclusions regarding causal connection, the Commission also affirms and adopts the Arbitrator's conclusions regarding the payment of Petitioner's reasonable and necessary medical expenses incurred prior to February 22, 2019. Respondent shall pay Bloomingdale Open MRI and Northwestern Medicine pursuant to the fee schedule for expenses incurred for the dates of service specified in the Decision of the Arbitrator, pursuant to sections 8 and 8.2 of the Act.[2]

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[2] Petitioner asserts that within the period prior to February 22, 2019, Respondent disputed only Northwestern Medicine's charges for the cervical and thoracic MRIs conducted on January 31, 2019. The Arbitrator specifically awarded payment to Northwestern Medicine for that date of service.

C. Prospective Medical Care

Similarly, based on the Commission's conclusions regarding causal connection, the Commission affirms and adopts the Arbitrator's conclusion that Petitioner is not entitled to prospective medical care.

D. Temporary Total Disability

Petitioner has claimed to be entitled to temporary total disability benefits from October 26, 2018 through October 15, 2019. The Arbitrator after finding Petitioner capable of full-duty work on February 22, 2019, awarded Petitioner temporary total disability benefits for the period from October 26, 2018 through March 22, 2019. The Arbitrator also awarded Respondent a credit of $14,736.33 for total disability benefits, which is the amount Respondent claimed in the Request for Hearing. Petitioner neither agreed nor disputed this amount in the Request for Hearing but did not object when Respondent submitted Respondent's Exhibit 3 which purports to show temporary total disability payments in that amount.

Petitioner testified that she received temporary disability benefits from October 26, 2018 through March 22, 2019. This testimony is corroborated by a March 22, 2019 letter from Respondent's insurer to Dr. Ward stating that based on the independent medical examination, no further care would be authorized under the workers' compensation claim. Petitioner was justified in relying on Respondent's payment of benefits until receiving this notice from Respondent's insurer. Accordingly, the Commission affirms and adopts the award of temporary total disability benefits for the period from October 26, 2018 through March 22, 2019.

E. Section 8(j) Credit

The Arbitrator found Respondent was entitled to a credit of $1,548.21 under section 8(j) of the Act. In the Request for Hearing, Respondent claimed this amount was paid through its group medical plan and Petitioner did not indicate whether she disputed or agreed with this claim. In the transcript of proceedings, the Arbitrator characterized the Request for Hearing as placing four issues in dispute: (1) causal connection; (2) unpaid medical bills; (3) lost time benefits; and (4) prospective medical care. Both parties agreed that the Arbitrator accurately stated the disputed issues. In addition, Petitioner does not raise the section 8(j) credit as an issue in her Statement of Exceptions. Accordingly, the Commission concludes that Petitioner did not dispute whether Respondent was entitled to the section 8(j) credit and affirms the Arbitrator's finding.

F. Permanent Partial Disability

The Arbitrator awarded permanent partial disability benefits to the extent of a 7.5% loss of use of the person as a whole pursuant to section 8(d)(2) of the Act. The Arbitrator noted that the parties had offered the Arbitrator the option of making a permanency determination in the event the Arbitrator concluded that Petitioner had completed treatment for her work-related injury.

In this case, however, Petitioner proceeded under section 19(b-1) of the Act, which provides in part as follows:

> "If the employee is not receiving medical, surgical or hospital services as provided in paragraph (a) of Section 8 or compensation as provided in paragraph (b) of Section 8, the employee, in accordance with Commission Rules, may file a petition for an emergency hearing by an Arbitrator on the issue of whether or not he is entitled to receive payment of such compensation or services as provided therein. Such petition shall have priority over all other petitions and shall be heard by the Arbitrator and Commission with all convenient speed." 820 ILCS 305/19(b-1) (West 2018).

Section 19(b-1) further provides:

> "No evidence may be introduced pursuant to this paragraph as to permanent disability. No award may be entered for permanent disability pursuant to this paragraph." *Id.*

The Commission, like the Arbitrator and the parties, is bound by the plain language of the Act. Section 19(b-1) bars permanency determinations even in cases where such a determination might be considered convenient. This is the balance struck by the legislature in affording claimants an accelerated and streamlined procedure for emergency hearings. Accordingly, the Commission vacates the portion of the Decision of the Arbitrator regarding the nature and extent of Petitioner's injuries and remands this case to the Arbitrator for further proceedings for a determination of a permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $701.73 per week for a period of 19 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be awarded a credit of $14,736.33 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Bloomingdale Open MRI and Northwestern Medicine, pursuant to the fee schedule, for expenses incurred for the dates of service as specified in the Decision of the Arbitrator, pursuant to §§8(a) and 8.2 of the Act.

20IWCC0139

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $1,548.21 under section 8(j) of the Act, representing the amount paid under Respondent's group medical plan.

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 $47,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 27 2020
d: 2/20/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

MAGNUSZEWSKA, JADWIGA
Employee/Petitioner

Case# **19WC009557**

DOUMAK INC
Employer/Respondent

20IWCC0139

On 12/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

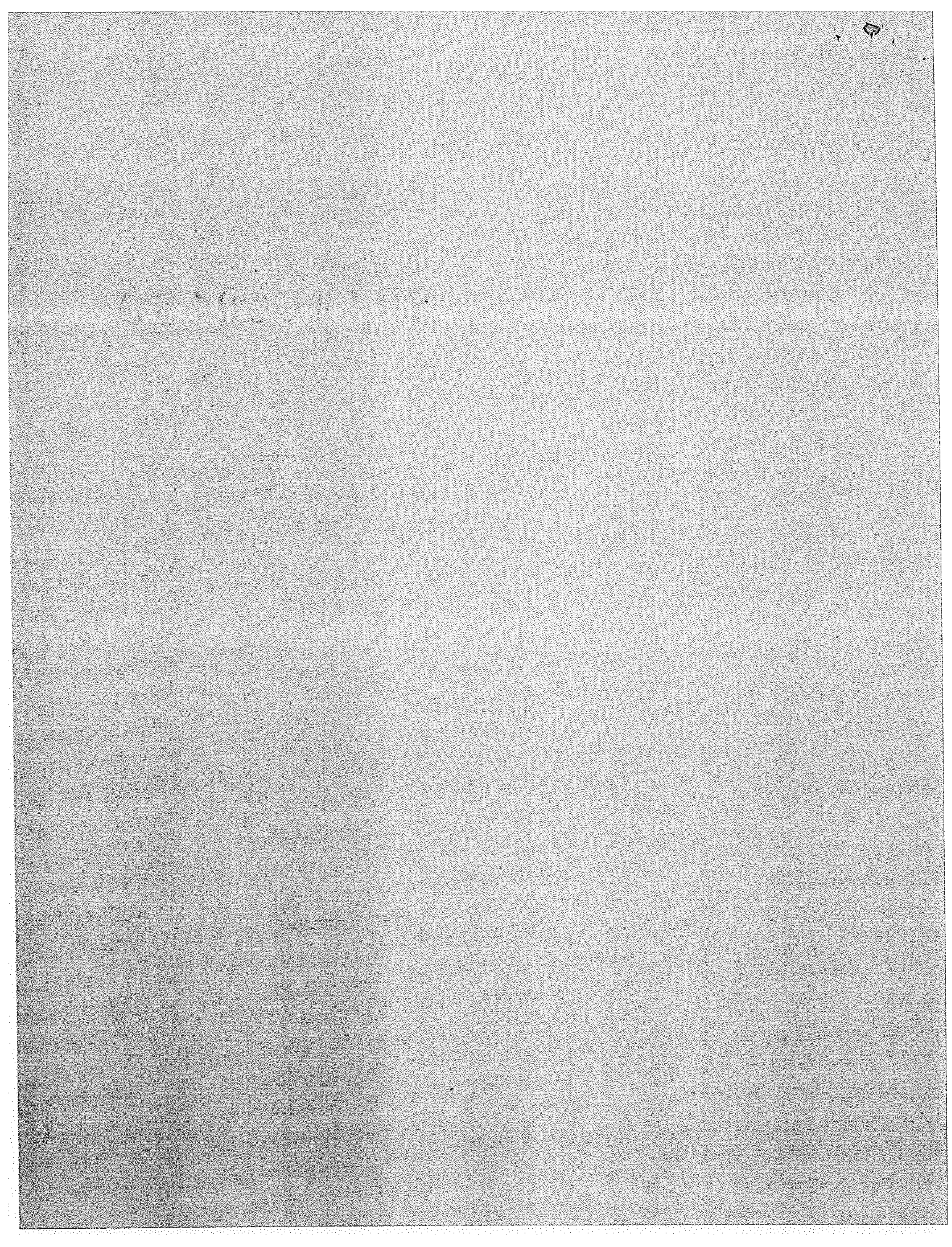
2) Certifies that he or she has paid the court reporter $ 502.40 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5669 ALEKSY BELCHER
JASON CARROLL
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

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



STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b-1)

Jadwiga Magnuszewska
Employee/Petitioner
v.
Doumak, Inc.
Employer/Respondent

Case # **19** WC **9557**

Consolidated cases: ____

20IWCC0139

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **August 2, 2019, August 14, 2019 (Addendum), September 9, 2019 (2nd Addendum) and October 3, 2019 (3rd Addendum)**. Respondent filed a *Response* on **August 29, 2019**. The Honorable **Carlson**, Arbitrator of the Commission, held a pretrial conference on **August 15, 2019, September 5, 2019 and October 7, 2019**, and a trial on **October 15, 2019**, in the city of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other **Nature and Extent of the Injury**

FINDINGS

On the date of accident, **October 10, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,735.20**; the average weekly wage was $**1,052.60**.

On the date of accident, Petitioner was **50** 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 $**14,736.33** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**14,736.33**.

Respondent is entitled to a credit of $**1,548.21** under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $701.73/week for 19 weeks, commencing 10/26/2018 through 3/22/2019, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $14,736.33 for temporary total disability benefits that have been paid.

Medical benefits
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, from Bloomingdale Open MRI (date of service 10/12/18) and Northwestern Medicine (dates of service 1/02/19-1/28/19, 1/11/19, 1/14/19, 1/14/19-1/16/19, 1/24/19, 1/31/19 and 2/08/19). The Arbitrator finds that these medical bills shall be paid directly to the treatment providers, pursuant to IL WC Fee Schedule adjustments.

Permanent Partial Disability
With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. 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 packer at the time of the accident and that she has not returned to work despite being found to be capable of full duty work by Dr. Lami. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident and had worked for the Respondent since 2013. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has been found to be capable of full duty work. She has been encouraged to work and has expressed a

willingness to secure new employment but has not actively sought employment. 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 multiple doctors (Dr. Lami, Dr. Ward, Dr. Kolavo and Dr. Gutti) has noted symptom magnification on the part of the Petitioner. The Arbitrator therefore gives lesser weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **7.5% loss of use of person as a whole** pursuant to §8(d)(2) of the Act.

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $502.40 or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

12.02.19
Date

DEC 3 - 2019

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JADWIGA MAGNUSZEWSKA,)
)
Petitioner,)
)
v.) Case 19 WC 9557
) Arbitrator Carlson
DOUMAK, INC.,)
)
Respondent.)

FINDINGS OF FACT

The Petitioner testified with the assistance of an interpreter that she was employed by Respondent as packer. T. 8. She worked 8 to 10 hour days, 6 days per week. T. 9. The Petitioner testified that she was required to assemble cardboard boxes and pack premade bags of marshmallows into the boxes. T. 11-12. Each box held 24 bags of marshmallows, with each bag of marshmallows weighing about 300 grams (0.66 lbs). T. 12. After the box had been packed, the Petitioner testified that she would push the box along the conveyor belt. T. 13. The Petitioner testified that she was required to pack boxes very quickly. T. 13.

The Petitioner testified that she saw Dr. Stavig on September 24, 2018 for pain in her lower back that radiated into her legs. T. 14-15. She was given medication. T. 15. The Petitioner testified that she called Dr. Stavig on October 8, 2018 for ongoing pain, but she continued working for the Respondent. T. 16.

The Petitioner testified that on October 10, 2018, she was working her normal job duties when she lifted a heavy box very quickly and felt a sharp pain in her lower back. T.

17-18. She testified that she continued working and experienced pain in her left leg. T. 19. She completed an incident report with the assistance of her daughter to report her injury to the Respondent. T. 18.

The Petitioner returned to Dr. Stavig on October 11, 2018. T. 19. She was referred to Dr. Kolavo and told to have an MRI of her lower back. T. 19. The Petitioner testified that went to the ER at Central DuPage Hospital on October 26, 2018 for a sharp pain in the lower back and left leg. T. 20-21. She testified that she has been ordered off of work since October 26, 2019. T. 22.

The Petitioner testified that she saw Dr. Kolavo on November 9, 2018 and was sent to Dr. Ward on November 29, 2018. T. 21-22. She underwent two courses of physical therapy and an injection, which provided a little bit of improvement in her symptoms. T. 22-23. The Petitioner testified that she was ordered to have an EMG on January 14, 2019, but instead was hospitalized at that time for back pain. T. 23-24.

She testified that she began treatment with a neurologist, Dr. Gutti on February 8, 2019. T. 25. She was given three injections on April 12, 2019, May 15, 2019 and June 11, 2019. T. 25. The Petitioner testified that her pain diminished with injections. T. 25. She testified that she began treatment with the pain clinic at Marion Joy on July 29, 2019. T. 26. There, she was given medication, exercises and instructions on how to live with chronic pain. T. 26. The Petitioner testified that the pain clinic has helped her to drive, although she admitted that she continued driving after the work accident. T. 27.

The Petitioner testified that she was examined by Dr. Lami at the request of the Respondent on February 22, 2019. T. 28. She testified that Dr. Lami suggested a full duty return to work and she attempted the same on March 29, 2019. T. 28. She testified that she

was unable to complete the work day due to intense pain. T. 28-29. She admitted to only staying at work for 2 hours. T. 38.

The Petitioner testified that she viewed surveillance of her from February of 2019. T. 29. She admitted that she was the person shown in the videos. T. 30.

The Petitioner testified at the hearing that she experienced very sharp pain in her lower back that radiates into her left leg. T. 31. She testified that her pain causes to her move slowly and was only slightly improved with medication. T. 31. She stated that standing, sitting straight up, bending over and walking for a long time caused an increase in her pain. T. 32. The Petitioner testified that before her injury she would walk her dog for up to 1-1.5 hours, but that post-accident she could only walk her dog for 15 minutes. T. 33. She admitted to walking her dog twice a day. T. 42.

The Petitioner admitted to shopping for groceries and other items and to driving. T. 41-42. She claimed that she did "very little" household activities, like cleaning and laundry. T. 42. She admitted to running errands such as going to a nail or tanning salon. T. 43-44. The Petitioner testified that she was able to lift and move a case of water. T. 44. She testified that she would do so once a week. T. 44.

The Petitioner testified that she was paid temporary total disability benefits from October 26, 2018 through March 22, 2019. T. 37. She testified that she has group health insurance. T. 38. She testified that she experienced low back pain before September of 2018 , but had not received prior low back treatment because her pain was "insignificant." T. 39. She admitted to having a prior MRI of her lumbar spine before the work accident. T. 39.

The Petitioner testified that she moved to the United States 20 years before and that she communicated in English at work. T. 41. She testified that she wanted to obtain a less physical job but admitted that she had not applied for any positions. T. 41.

Medical Records

The Petitioner sought treatment with Dr. Rolf Stavig on September 24, 2018. PX 2. She reported chronic intermittent low back pain with a current flare up for over a week. PX 2. She reported radiation of pain into her bilateral knees. PX 2. It was noted that the Petitioner had "last MRI about 8 yrs ago with DDD found." PX 2. She was given a Medrol Dosepak and told to stretch and apply ice. PX 2.

She returned to Dr. Stavig on October 11, 2018 for a re-evaluation of persistent low back pain with radiation to her left lower extremity for the past 6+ weeks. PX 2. The Petitioner provided no history of any work accident. PX 2. She was diagnosed with acute bilateral low back pain with sciatica. PX 2. A lumbar spine MRI on October 12, 2018 was read as revealing disc desiccation at L1-2, L4-5 and L5-S1 levels, a focal annular tear at the right foraminal aspect of L4-5 and a 1.5mm broad based posterior disc protrusion at L5-S1 without central canal or neural foraminal stenosis. PX 2.

She went to Central DuPage Hospital ED on October 26, 2018 for chronic intermittent low back pain that radiated into her left leg and sometimes her right side. PX 6. She also complained of upper back pain. PX 6. She was diagnosed with acute left-sided low back pain and left-sided sciatica. PX 6.

The Petitioner saw Dr. Stavig on October 29, 2018 for worsening low back pain with radiation into her bilateral legs (right worse than left). PX 2. Her MRI was noted to

have shown "some DDD." PX 2. She was referred for a physiatry evaluation and to see Dr. Kolavo. PX 2.

The Petitioner had an initial orthopedic evaluation with Dr. Jerome Kolavo on November 9, 2018. PX 4. She complained of low back and left leg pain beginning 10 years ago, with an increase in pain after a lifting injury at work on October 10, 2018. PX 4. On physical examination, the Petitioner moved very slowly, "displayed dramatic pain behavior," had diffuse lumbar tenderness with no visible spasm, her neurologic exam was normal, and her radicular pain was not really reproduced. PX 4. Dr. Kolavo noted that "she jumps and withdraws in an exaggerated dramatic fashion when reflexes are tested." PX 4. Her MRI was "very unremarkable." PX 4. She was diagnosed with degeneration of lumbar or lumbosacral intervertebral disc, acute bilateral low back pain with sciatica and pain of the left lower extremity. PX 4. Therapy was recommended, and she was ordered off of work. PX 4. She did not need to follow up with a surgeon. PX 4.

The petitioner underwent an initial physiatry evaluation with Dr. Joshua Ward on November 29, 2018. PX 1. She reported acute low back pain and left lower extremity pain after lifting boxes at work on October 10, 2018. PX 1. She stated that she experienced constant pain rated as a 7/10. PX 1. She exhibited severe restrictions on her physical exam. PX 1. Dr. Ward reviewed her MRI and found it to reveal disc desiccation at L4-5 and L5-S1 with small disc bulges worse to the right without evidence of nerve root compression or stenosis. PX 1. He noted: "Her symptoms are most consistent with left L5 radiculitis not clearly explained by the MRI.... She has significant overlying myofascial pain." PX 1. She was told to continued physical therapy and medication and to remain off of work. PX 1. Injections were discussed, but the Petitioner wanted to hold off on the same. PX 1.

A telephone note contained in Dr. Ward's on December 18, 2019 indicated that the Petitioner was experiencing progressive left leg weakness and possibly foot drop. PX 1. Dr. Ward stated: "Her lumbar MRI is unimpressive and does not explain her weakness, I think that we will need to consult neurology and look for other causes if she is that weak." PX 1.

Dr. Ward recommended cervical and thoracic MRIs in December of 2018. PX 1. After he was notified that these requests were denied under the Petitioner's WC claim (which was reported as pain in her back and left leg), Dr. Ward wrote: "I cannot disagree with your assessment regarding the denial of the thoracic and cervical MRIs. At this point, we are considering other systemic causes of leg weakness which may not be related to her work injury." PX 1. The Petitioner participated in physical therapy. PX 10. In these notes, it was documented that she exhibited "hypersensitivity to light touch." PX 10. The therapist noted plans to reach out to Dr. Kovalo regarding symptom exacerbation. PX 10.

On January 11, 2019, the Petitioner underwent a left L5 transforaminal epidural steroid injection performed by Dr. Ward. PX 1. She returned to Dr. Ward on January 14, 2019, for left lower extremity radicular pain and weakness with foot drop. PX 1. Her MRI showed age-appropriate DDD, but no nerve compression to explain her weakness. PX 1. She reported mild improvement from her injection, with increasing pain for the last several days. PX 1. Her EMG was postponed, and she was sent to the ER. PX 1.

She went to Central DuPage Hospital ED on January 14, 2019 for severe low back pain that radiated down both legs. PX 6. She was supposed to have an EMG but could not undergo and subjective complaints of worsening left foot drop. PX 6. She was admitted to the hospital. PX 6. Dr. Kolavo examined the Petitioner and noted: "She continues to display

dramatic pain behavior today with minor motion in bed." PX 6. After reviewing an updated lumbar spine MRI, Dr. Kovalo noted: "Minimal disc pathology at L4-L5 and no nerve root compression. Patient's pain and disability is clearly disproportionate to radiographic findings." PX 6. He recommended that the Petitioner be discharged and return to Dr. Ward. PX 6.

Dr. Ward examined the Petitioner on January 23, 2019 for left lower extremity pain with weakness and now left upper extremity pain and weakness of uncertain origin. PX 1. A repeat lumbar spine MRI showed no significant nerve root compression. PX 1. Her symptoms were not explained by the MRI and she had "no clear diagnosis." PX. 1. Dr. Ward noted that he was concerned about "a neurological disorder not of orthopedic nature." PX 1. He again recommended a neurological workup and cervical and thoracic MRIs. The Petitioner was unable to work. PX 1.

The Petitioner was seen for an initial neurological evaluation on February 8, 2019 by Dr. Padmaja Gutti. PX 3. She reported low back pain with radiation of pain to her lower extremities for the past 10 years, with a flare up of pain in her back and left lower extremity following a work injury in October of 2018. PX 3. She also complained of radicular pain in her left upper extremity. PX 3. Her physical examination revealed tenderness in the paravertebral muscles in the lumbar area and paraspinous muscles in the upper back and paracervical muscles with left straight leg testing with minimal pain. PX 3. She was diagnosed with low back pain and left leg radicular signs after a work-related injury. PX 3. She would continue therapy and medication and undergo an EMG. PX 3.

On February 12, 2019, the Petitioner saw Dr. Stavig for a follow up. PX 2. She complained of ongoing low back pain with radiation into her left leg and chronic left

posterior shoulder pain. PX 2. She was receiving some benefit from therapy and was told to continue therapy. PX 2. She returned to Dr. Stavig on March 27, 2019 reporting low back pain with radicular pain into her left leg and posterior neck pain with radicular pain in her left arm. PX 2. She was told to continue seeing Dr. Ward and Dr. Gutti and given an increase in gabapentin. PX 2.

Dr. Gutti ordered the Petitioner off of work for a neurological condition on March 12, 2019. PX 3. On March 26, 2019, the Petitioner returned to Dr. Gutti for sciatica of the left side. PX 3. Her EMG was normal without any evidence of lumbosacral radiculopathy. PX 3. Her assessment remained the same and she was referred to a pain specialist. PX 3.

She presented to Dr. Gutti for a follow up on June 26, 2019. PX 3. The Petitioner reported that her left lower extremity pain improved after 3 lumbar epidural steroid injections by pain management. PX 3. She reported severe low back pain and pain located in the mid and lower back. PX 3. Her straight leg testing was negative. Dr. Gutti noted: "? Functional component of symptoms raised as her walking and pain disappears when distracted." PX 3. The Petitioner wanted to see an orthopedic again and was referred to physiatry and could follow up as needed. PX 3.

The Petitioner returned to Dr. Ward on July 8, 2019 for chronic low back and left lateral leg radiating pain. PX 2. She had a "complicated history" and her MRIs showed no evidence of spinal cord compression. PX 2. "She had a neurologic work-up which showed no clear diagnosis." PX 2. The Petitioner reported having three lumbar epidural injections, which she felt helped her leg pain. PX. 2 She was referred to Marion Joy pain program and ordered off of work. PX 2.

On July 29, 2019, the Petitioner attended an initial evaluation at Marion Joy for chronic low back pain. PX 7. She reported that she first experienced low back pain after lifting a box at work 10 months before. PX 7. She denied any prior back pain and stated that she went to the ER the following day for significant pain. PX 7. Two weeks later, she experienced radicular pain with burning and tingling into her left leg. PX 7. Her lumbar MRI was noted as being negative for any findings, except a very small L5-S1 disc bulge and her EMG was negative for any lumbosacral radiculopathy. PX 7. The Petitioner was diagnosed with S1 joint dysfunction and lumbosacral radiculopathy at L5. PX 7. She participated in a comprehensive pain program, physical therapy and psychology sessions. PX 7. The notes indicate that: "She states that this is not a workman's comp case, as she was evaluated earlier in the first 6 months." PX 7.

She was admitted to the pain management program at Marion Joy on August 12, 2019. PX 7. On August 14, 2019, the Petitioner requested a work note and reported being interested in a desk job in the future or applying for disability. PX 7. She continued treatment with Marion Joy in August of 2019 for S1 joint pain and myofascial pain. PX 7. The Petitioner was given home exercises and tools to improve lumbar mechanics and behaviors to reduce pain and to her focus from her pain. PX 7. She underwent a trigger point injection on August 28, 2019 and on August 30, 2019. PX 7.

The Petitioner's medical records are significant for treatment unrelated to her back (hysteroscopy with endometrial polypectomy, headaches with vision issues, chronic left posterior shoulder pain). PX 2, PX 10.

Independent Medical Examination

At the request of the Respondent, the Petitioner was examined for an Independent Medical Examination with Dr. Babak Lami, MD, on February 22, 2019. RX 1. The Petitioner reported that she sustained low back pain after lifting a box at work on October 10, 2018. RX 1. She reported pain in with her low back, which she rated to be 8/10 with pain and a burning sensation in her left leg both posteriorly and anteriorly not in any particular dermatomal fashion. RX 1. On physical examination, the Petitioner ambulated slowly with a limp and had essentially no motion her lumbar spine (flexion to 30 degrees, extension 0 and side bending 0). RX 1. Her straight leg testing was normal. RX 1. Dr. Lami personally reviewed the Petitioner's lumbar spine MRI, which he found to show degenerative changes at L4-5 and L5-S1 and no neural compressive pathology at any level. RX 1. Her MRI was essentially normal for her age. Dr. Lami opined that her MRI, attempted EMG and physical therapy were reasonable treatment, but the Petitioner did not require any additional treatment for her back. RX 1. He recommended that the Petitioner see "her primary care physician to determine other causes of her significant pain which are outside the spine." RX 1. The Petitioner was found to be capable of full duty work and reached maximum medical improvement for her spine. RX 1.

Surveillance

The Respondent presented an Investigation Report and surveillance video into evidence as Respondent Exhibit 2. These materials document surveillance of the Petitioner on February 11, 2019, February 13, 2019 and February 14, 2019. RX 2. The Petitioner admitted that she had viewed the video and that she is the person shown on the video. T. 30. On February 11, 2019, the Petitioner was seen walking her medium sized dog on a snowy/icy sidewalk. RX 2. She appeared to be walking at a normal speed with no apparent

difficulty. RX 2. She is seen starting her walk at 8:32 AM and coming back into video completing her walk at 8:47 AM (15 minutes later). RX 2. On February 13, 2019, the Petitioner is captured on video entering and driving an SUV to go to a nail salon and tanning salon. RX 2. She carried a purse over her shoulder and appeared to walk normally. RX 2. She was seen starting to walk her dog at 12:19 PM and returning from her walk at 12:44 PM (25 minutes). RX 2. She again appeared to walk normally. RX 2. On February 14, 2019, the Petitioner was seen driving her SUV, entering a food mart, exiting the food mart while pushing a cart of groceries, lifting a heavy case of bottles and walking in and out of other shops. RX 2. She carried a purse and again moved normally and without apparent difficulty. RX 2.

CONCLUSIONS OF LAW

To prove a compensable Workers' Compensation claim, a Petitioner must show by preponderance of the credible evidence that her injuries arose out of and in the course of her employment. *Horath v. Industrial Commission*, 96 Ill. 2d 349, 449 N.E. 2d 1345. Each element of the claim, including the existence of a causal relationship between the employment and the injury, must be proven by the Petitioner for her to prevail on her claim. *Brady v. Louis Ruffalo & Sons Construction Company,* 143 Ill. 2d 542, 548. Illinois courts have soundly rejected the positional risk doctrine and instead adhere to the general requirement that one's employment must subject one to an increased risk beyond that to which the general public is exposed. *Brady*, 143 Ill. 2d 543 at 578.

The Arbitrator finds that the Petitioner sustained injuries to her back and left leg when she was lifting a box very quickly on October 10, 2018. The Arbitrator notes that the Petitioner timely reported the occurrence to the Respondent and completed an incident report. She sought treatment the following day and, while she did not provide a history of

the work injury to Dr. Stavig at that time, she did provide a history of her work activities to the ER on October 26, 2018 and of the work accident to Dr. Kolavo on November 9, 2018.

The Arbitrator notes that the Petitioner experienced prior pain in her back and was receiving treatment over the two weeks prior to the work accident. He further notes that the Petitioner claimed to have experienced chronic back pain before the accident and that her pain related to the work injury was noted as being a flare up in her chronic pain. The Arbitrator notes that the Petitioner's medical records indicate that she had an MRI about 8 years before the work accident (2010) that showed some degenerative disc disease. The Petitioner admitted to experiencing prior back pain in her testimony.

The Arbitrator notes that the Petitioner's accident of October 10, 2018 was accepted by the Respondent and that the Petitioner received medical treatment and temporary total disability benefits for this injury.

As to Issue F, is the Petitioner's current condition of ill-being causally related to the injury:

The Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her work activities with the Respondent.

The Arbitrator finds that the Petitioner sustained acute low back pain with complaints of left leg radicular symptoms in the October 10, 2018 work accident. To treat her injuries, the Petitioner required a lumbar spine MRI, medication and physical therapy. The Arbitrator finds that the Petitioner reached maximum medical improvement and could return to full duty work following her work accident on February 22, 2019.

The Arbitrator relies in part on the Independent Medical Examination report by Dr. Lami dated February 22, 2019. RX 1. Dr. Lami documented the Petitioner's complaints of low back pain with radicular symptoms in her left leg both posteriorly and anteriorly, which did not follow any particular dermatomal fashion. The Petitioner ambulated slowly with a limp and had essentially no motion her lumbar spine (flexion to 30 degrees, extension 0 and side bending 0) during her physical examination. Dr. Lami personally reviewed the lumbar spine MRI, which showed degenerative changes at L4-5 and L5-S1 with no neural compressive pathology at any level and was essentially normal for her age. Dr. Lami recommended that the Petitioner see "her primary care physician to determine other causes of her significant pain which are outside the spine." He placed the Petitioner at maximum medical improvement and opined that she did not require any additional treatment for her back.

The Arbitrator also relies on the opinions of the Petitioner's treating doctors relative to their assessments of her MRI films, their suggestions of the Petitioner's possible symptoms magnification and their opinions questioning whether her current condition is related to her work accident. The Arbitrator notes many similarities between the opinions of the treating physicians and the opinions in Dr. Lami's IME report.

In support of his findings, the Arbitrator notes that the Petitioner had two lumbar spine MRIs performed, which had unremarkable findings that could not explain her ongoing complaints. The Arbitrator cites the Petitioner's MRI reports which showed disc desiccation at L1-2, L4-5 and L5-S1 levels, a focal annular tear at the right foraminal aspect of L4-5 and a 1.5mm broad based posterior disc protrusion at L5-S1 without central canal or neural foraminal stenosis. The Arbitrator notes that Dr. Stavig read the MRI as revealing

"some DDD." He further notes that Dr. Kolavo found on multiple occasions that the Petitioner's MRI was "very unremarkable" and opined that there was no cord compression shown on either MRI study. Dr. Ward echoed this sentiment, calling the MRI "unimpressive."

The Arbitrator also cites multiple suggestions of symptom magnification by the Petitioner in her treating records. Dr. Ward found that the Petitioner exhibited severe restrictions on her physical exam on November 29, 2018 that could not be explained by her MRI findings. Dr. Ward also noted that she had "significant overlying myofascial pain." Dr. Kovalo reported that the Petitioner exaggerated her symptoms and disability in each visit note, including citing "dramatic pain behavior" with a normal neurologic exam on November 9, 2018 and finding disproportionate pain and "dramatic pain behavior today with minor motion in bed" on January 14, 2019. Dr. Gutti also questioned the Petitioner's pain complaints a March 12, 2019 record when it was noted that the Petitioner's "pain disappears when distracted." Finally, the Petitioner's physical therapy notes further document symptom exacerbation and the Petitioner exhibiting "hypersensitivity to light touch."

The Arbitrator also questions the Petitioner's pain complaints based on his observations of the Petitioner. The Petitioner testified to multiple functional limitations, including issues with driving, the inability to walk her dog for longer than 15 minutes and the inability to perform household chores, which she claimed resulted from the work injury. The Arbitrator notes that the Petitioner was seen on surveillance video in February of 2019 being active and moving without apparent difficulty. The Petitioner was viewed walking her dog for 15-25 minutes walks on a snowy/icy sidewalk. She ambulated normally and

did not show signs of pain or distress. She was also seen moving normally as she visited a tanning salon, a nail salon, driving and shopping at various stores, where she was seen lifting a case of bottles.

In further support of his opinion, the Arbitrator notes that the Petitioner's doctors have questioned whether her current condition is related to her work accident. Dr. Kovalo found that the Petitioner's "pain and disability [to be] clearly disproportionate to radiographic findings." He did not believe that the Petitioner required treatment with an orthopedic surgeon and recommended that she consult physiatry.

Dr. Ward has similar issues explaining the cause of the Petitioner's pain. On multiple occasions, he noted that the Petitioner's symptoms could not be explained by her MRI findings. After she began complaining of pain over her thoracic and cervical spine, with radicular symptoms in her arms, Dr. Ward agreed that those conditions were not related to the work accident and stated that he was "considering other systemic causes of leg weakness which may not be related to her work injury" in December of 2018. Later that month, the Petitioner complained of leg weakness and foot drop, for which Dr. Ward recommended a neurological consultation to "look for other causes if she is that weak." On January 23, 2019, Dr. Ward noted that he was concerned about "a neurological disorder not of orthopedic nature." Dr. Gutti similarly could not find a clear diagnosis in light of the MRI and normal EMG.

The opinions expressed by Dr. Ward and Dr. Kolavo questioning the cause of the petitioner's injuries are consistent with Dr. Lami's opinion that the Petitioner investigate other causes of her significant pain outside the spine.

In addition to the above, the Arbitrator finds it to be significant that the records of Marion Joy contain an inaccurate history of the work accident. The Marion Joy records indicate that the Petitioner experienced no back pain prior to the work accident and that she experienced low back pain after lifting and sought treatment from the ER the following day. The Marion Joy records further state that the Petitioner experienced radicular pain in her left leg two weeks later. This history is contradicted by the Petitioner's testimony and her medical records from every other treatment provider. The Petitioner's records show, and the Petitioner admitted to experiencing, chronic back pain years before the work accident, with an MRI performed sometime around 2010. Her records clearly document treatment for her flare up in back pain with radicular leg symptoms beginning in September of 2018. She did not go to the ER for her condition until over 2 weeks after the work accident.

The Arbitrator also notes that the doctors at Marion Joy have not offered any statements relating her current condition to work. On the contrary, it is documented in multiple places in the Marion Joy records that the Petitioner was not receiving treatment for a work-related claim.

Based on the foregoing, the Arbitrator finds that the Petitioner reached maximum medical improvement for her work-related injuries on February 22, 2019. He finds no causal connection between the Petitioner's work accident and her current condition of ill-being. Thus, any treatment that she has received after February 22, 2019 or prospective treatment is not causally related to any compensable work accident or injury.

As to Issues J, has the Respondent paid all appropriate charges for all reasonable and necessary medical services?

For the reasons set forth above, the Arbitrator finds that the Respondent is responsible for all treatment incurred prior to February 22, 2019 related to the Petitioner's low back injury. The Arbitrator finds that the Respondent shall pay the reasonable, necessary and related medical bills to the below noted providers:

Provider	Dates of Service
Bloomingdale Open MRI	10/12/18
Northwestern Medicine	1/02/19-1/28/19, 1/11/19, 1/14/19, 1/14/19-1/16/19, 1/24/19, 1/31/19 and 2/08/19.

The Arbitrator finds that these medical bills shall be paid directly to the treatment providers, pursuant to IL WC Fee Schedule adjustments.

As to Issues K, is Petitioner entitled to prospective medical care?

Based on the foregoing, the Arbitrator finds that the Petitioner reached maximum medical improvement for her work-related injuries on February 22, 2019. He finds no causal connection between the Petitioner's work accident and her condition of ill-being after February 22, 2019. Therefore, the Arbitrator finds that any treatment that the Petitioner received after February 22, 2019 or prospective treatment is not causally related to any compensable work accident or injury.

As to Issue L, what temporary benefits are in dispute?

The Petitioner claims to be entitled to TTD benefits from October 26, 2018 through October 15, 2019, representing 50 weeks 4 days. The Respondent asserts a credit for TTD paid in the amount of $14,736.33.

For the reasons set forth above, the Arbitrator finds that the Petitioner was capable of full duty work on February 22, 2019. The Arbitrator awards the Petitioner TTD benefits from October 26, 2018 through March 22, 2019, representing 19 weeks. Given that the Arbitrator finds that the Petitioner's current condition of ill-being is not related to a work

accident, she is not entitled to any additional TTD benefits after March 22, 2019 under the Illinois Workers' Compensation Act.

As to Issue O, the nature and extent of the Petitioner's injuries:

The Arbitrator notes that the parties gave him the option of making a nature and extent finding if he believed the Petitioner had completed treatment for her work injury. T. 4. As stated above, the Arbitrator finds that the Petitioner reached maximum medical improvement for her work-related injuries on February 22, 2019.

The Arbitrator finds that the Petitioner sustained acute low back pain with complaints of left leg radicular symptoms in the October 10, 2018 work accident. To treat her injuries, she required a lumbar MRI, which was read as revealing degenerative changes at L4-5 and L5-S1 with no neural compressive pathology at any level and was essentially normal for her age. She received medication and one injection and participated in physical therapy. The Petitioner had an attempted EMG but was unable to undergo the same and was hospitalized due to shaking and pain. She was unable to work for 19 weeks. At the time of her Independent Medical Examination on February 22, 2019, it was noted that she had reached maximum medical improvement and did not require additional treatment or work restrictions for her work injury.

The Arbitrator has carefully considered the factors outlined in Section 8.1b(b) of the IL WC Act in determining the permanency awarded to the Petitioner. With regard to subsection (i) of the §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the Petitioner was employed by the Respondent as a packer at the time of the injury. While she is able to return to work per the opinion of Dr. Lami, the Arbitrator notes that the Petitioner has not returned to her prior job. The Arbitrator notes a non-work-related cause for her present condition. The Arbitrator notes that the Petitioner testified that she believes she is unable to work her prior job and that she has discussed a return to work her doctors at Marion Joy, but has not attempted to secure employment. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the occurrence. The Petitioner has worked for the Respondent since 2003 in a physical job. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has been found to be capable of full duty work by Dr. Lami, but is not currently working. She has discussed a return to work with her doctors at Marion Joy, but has not actively sought employment. 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 multiple citations of symptom magnification by the Petitioner in her treating records, including notations by Dr. Kovalo that the Petitioner displayed "dramatic pain behavior" and disproportionate pain. Dr. Ward found that the Petitioner exhibited severe restrictions on her physical exam, which were not explained by the MRI films. Dr. Gutti also questioned the Petitioner's pain based, stating that it disappeared when she was distracted. Finally, the Petitioner's physical

therapy notes further document symptom exacerbation and the Petitioner exhibiting "hypersensitivity to light touch." Dr. Lami noted that the Petitioner ambulated slowly with a limp and had essentially no motion her lumbar spine during his exam.

The Arbitrator finds that the Petitioner's complaints were not corroborated by her medical records, as her doctors questioned the validity and intensity of her complaints. The Arbitrator therefore gives lesser weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the person as a whole pursuant to §8(d)(2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT E. DEAN,

Petitioner,

vs. NO: 05 WC 20611

GLENBROOK NORTH HIGH SCHOOL
DISTRICT 225,

Respondent.

20IWCC0140

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, credit pursuant to section 8(j)(2) of the Act, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator ordered that Respondent shall pay for reasonable and necessary medical services pursuant to §§8(a) and 8.2 of the Act as follows:

(a) Illinois Bone & Joint Institute: $23,156.72
(b) Dr. Alexander Prager: $582.48
(c) Dr. Daniel Wynn: $225.00
(d) The Respondent shall further pay the Petitioner directly the sum of $160,359.00 for his payments to various medical providers and for payment made by his and his spouse's group insurance carriers.

Regarding the amount to be paid directly to Petitioner, the Arbitrator's decision indicates the payments made by Petitioner's wife's group health insurance carriers and Medicare did not entitle Respondent to a credit under §8(j) of the Act. The Arbitrator determined that Respondent was responsible only for the amounts paid by the group insurers as a negotiated rate, which totaled $154,616.84. The remaining $5,742.16 represented Petitioner's payments to medical

providers listed in Petitioner's Exhibit 13, along with his payments for prescription medication.

Respondent requests that the Commission amend the award to provide that it is to pay "'all reasonable, related and necessary services pursuant to Section 8(a) and 8.2 of the Act' once the Illinois Workers' Compensation Fee Schedule has been applied to the billing information." Respondent observes that while the Arbitrator provided specific figures of remuneration and referenced §8.2 of the Act, there was no evidence introduced that these specific billing amounts were pursuant to the fee schedule.

Petitioner responds that the Arbitrator's award comported with the plain language of the Act and relevant appellate court precedent. Petitioner asserts that the only modification that would be necessary, if appropriate, would be the amounts paid to satisfy the outstanding balances owed to the Illinois Bone & Joint Institute, Dr. Prager, and Dr. Wynn.

This case is controlled by the principles set forth in *Perez v. Illinois Workers' Compensation Comm'n*, 2018 IL App (2d) 170086WC, and *Tower Automotive v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 427 (2011).

In *Tower Automotive*, the employer argued that the Commission's award of $165,289.16 for reasonable and necessary medical services was erroneous as a matter of law. *Id.* at 436. The award represented the total amount billed for medical services, not the amount that the medical service providers were actually paid. *Id.* According to the employer, the claimant's wife's group health insurance carrier paid $52,671.82 of the charges, the claimant paid $1,183.27, and the medical service providers wrote off the $111,298.35 balance of their charges. *Id.* at 436-37. The employer contended that the maximum reimbursement for medical expenses is the amount that was actually paid to the service providers. *Id.* at 437.

The appellate court agreed, reasoning that paying or reimbursing an injured employee for the amount actually paid to the medical service providers satisfied the requirement of section 8(a) of the Act that an employer "provide and pay" for all first aid, medical, surgical, and hospital services necessary to cure or relieve an injured employee from the effects a work-related accidental injury. See *id.* The court rejected the claimant's argument that the "collateral source rule" should apply, because that rule applies to recovery from a tortfeasor, while the Act abrogates the common law rights and liabilities which previously governed an injured employee's ability to recover damages from his employer, eliminating the concept of a wrongdoer or tortfeasor in this context. See *id.* at 437-38. The court believed its decision would be of limited future significance, given the 2005 amendment of section 8(a) to provide that employers are obligated to provide and pay "'the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2.'" *Id.* (quoting 820 ILCS 305/8(a) (West 2006)).

Nevertheless, in *Perez*, the court followed the principles established in *Tower Automotive* following the amendment of section 8(a). In *Perez*, the claimant testified that her medical expenses were either paid by Cigna, her then husband's medical insurance carrier, or paid out-of-pocket. *Perez*, 2018 IL App (2d) 170086WC, ¶ 8. The employer submitted an exhibit listing medical payments made by Cigna, showing payments of $17,597.96 and copayments of $260.

Id. The Commission, relying on the appellate court's decision in *Tower Automotive*, concluded that the maximum amount of medical expenses for which it was liable was the claimant's out-of-pocket expenses and the amount actually paid by Cigna, not the higher amount owed under the fee schedule. *Id.* ¶ 12.

On appeal, the *Perez* court agreed:

> "Contrary to claimant's argument, the plain language of section 8(a) of the Act indicates that the legislative intent was to provide relief to injured employees only to the extent reasonably required to cure or relieve claimant from the effects of a workplace injury. 820 ILCS 305/8(a) (West 2006). Specifically, the Act provides that the employer shall pay medical expenses "*limited*, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury." (Emphasis added.) *Id.* Here, consistent with the legislative intent of the statute, and specifically in regards to her medical expenses, claimant was cured or relieved from the effects of her injury once the employer paid the negotiated rate of $17,857.96 with a $0 balance remaining. See *Tower Automotive*, 407 Ill. App. 3d at 437 ("By paying, or reimbursing an injured employee, for the amount actually paid to the medical service providers, the plain language of the statute is satisfied."). To award claimant any amount for medical expenses beyond the amount actually paid to the medical service providers would result in a windfall to claimant." *Id.* ¶ 22.

In this case, the Arbitrator determined that Respondent was responsible to pay Petitioner $154,616.84, representing amounts paid by the group insurers and Medicare as a negotiated rate. This portion of the award is correct under *Perez* and *Tower Automotive*. Similarly, the award of $5,742.16 representing Petitioner's out-of-pocket payments is consistent with case law, given that the award confirmed in *Perez* included an out-of-pocket expense.

The awards to the Illinois Bone & Joint Institute, Dr. Prager, and Dr. Wynn are a different matter. The amounts reflected in these awards match the charges listed in Petitioner's Exhibit 13. These charges are unpaid and not the result of a negotiated rate. Accordingly, the Commission modifies the Arbitrator's decision to clarify that with respect to these three awards, Respondent is responsible for paying "the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2." 820 ILCS 305/8(a) (West 2006).

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $449,165.30, representing $666.70 per week for a period of 673 and 5/7ths 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 is awarded a credit $449,165.30 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent and total disability benefits of $666.70 per week for life, commencing January 23, 2018, as provided in §8(f) of the Act, because the injury sustained caused the complete disability of the Petitioner rendering him wholly and permanently incapable of work.

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 the cost of living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $160,359.00 for medical expenses under §§8(a) and 8.2 of the Act, representing amounts paid by the group insurers and Medicare as a negotiated rate, plus out-of-pocket expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills of the Illinois Bone & Joint Institute, Dr. Prager, and Dr. Wynn, pursuant to §§8(a) and 8.2 of the Act and the fee schedule.

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

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

DATED: FEB 27 2020
d: 1/23/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DEAN, ROBERT E Case# **05WC020611**

Employee/Petitioner

GLENBROOK NORTH HIGH SCHOOL DISTRICT 225

Employer/Respondent

20IWCC0140

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:

1497 MORICI FIGLIOLI & ASSOCIATES
DAVID FIGIOLI
150 N MICHIGAN AVE SUITE 1100
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW P SHERIFF
10 S 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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT F. DEAN
Employee/Petitioner

Case # **05** WC **20611**

v.

Consolidated cases: **n/a**

GLENBROOK NORTH HIGH SCHOOL DISTRICT 225
Employer/Respondent

20IWCC0140

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, 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 _____

FINDINGS

On **AUGUST 20, 2004**, Respondent ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
Timely notice of this accident ***was*** given to Respondent.
Petitioner's current condition of ill-being ***is*** causally related to the accident.
In the year preceding the injury, Petitioner earned $**52,002.60**; the average weekly wage was $**1,000.05**.
On the date of accident, Petitioner was **69** years of age, ***married*** with **2** dependent children.
Petitioner ***has*** received all reasonable and necessary medical services.
Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
Respondent shall be given a credit of $**449,165.31** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**449,165.31**.
Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*:

1) The Respondent shall pay reasonable and necessary medical services pursuant to Section 8(a) and 8.2 of the Act for the following:
   a. Illinois Bone & Joint Institute - **$23, 156.72;**
   b. Dr. Alexander Prager - **$582.48;**
   c. Dr. Daniel Wynn; **$225.00;**
   d. The Respondent shall further pay the Petitioner directly the sum of **$160,359.00** for his payments to various medical providers and for payment made by his and his spouse's group insurance carriers;

2) The Respondent shall pay the Petitioner permanent and total disability benefits (PTD) of **$666.70 per week for life**, commencing January 23, 2018, as provided in Section 8(f) of the Act, because the injury sustained caused the complete disability of the Petitioner rendering him wholly and permanently incapable of work;

3) 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;

4) The Respondent shall pay the Petitioner compensation that has accrued from August 20, 2004 thru January 23, 2018, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

FEBRUARY 20, 2018
Date

FEB 21 2018

ROBERT F. DEAN v. GLENBROOK NORTH HIGH SCHOOL DISTRICT 225

05 WC 20611

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on January 23, 2018. The issues in dispute were causal connection, medical bills and the nature and extent of the injury. (*Arbitrator's Exhibit* 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b). (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

The Petitioner, a 69-year-old custodian/janitor for the Respondent, had been employed by the Respondent in this position for approximately five years prior to his August 20, 2004, accident. [1] The Petitioner's afternoon shift typically ran from 3:00 p.m. to 11:00 p.m., although he noted his work hours could vary if the school had special events or a special task needed to be completed. In this position, the Petitioner was required to clean classrooms and hallways throughout Glenbrook North High School. He was assigned to wash and wax floors throughout the facility, and would move chairs and large tables when special events were scheduled in the school. The Petitioner also testified that he would lift and carry large buckets of water and containers of cleaning supplies to perform his job duties. He also used large cleaning and buffing machines to wash and wax the floors in the school. To prepare rooms or the gym for special events, the Petitioner would have to lift and carry tables, each which could weigh more than 50 pounds, and several dozen chairs. During his eight-hour shift, he was constantly standing and walking throughout the school while performing his assigned tasks. The Petitioner

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[1] In addition to working as a custodian/janitor for the Respondent, the Petitioner also worked in the same position at a Sears store in Niles. He testified he had worked for Sears for approximately thirty years and was assigned to work the morning shift so he then would be able to report to work for the Respondent. In this position with Sears, the Petitioner performed similar duties to those he had with the Respondent, including cleaning and other tasks. He reported he carried out these duties for Sears without difficulty prior to the work accident of August 20, 2004.

testified he could perform all his job duties without difficulty prior to his August 20, 2004, accident.

On August 20, 2004, the Petitioner was assigned to wash and wax a floor in the Respondent's facility. As he began this task, he slipped on wax that had been spilled onto the floor. He then fell onto a large "slop sink" located in a maintenance closet striking his left shoulder and left side of his body. The Petitioner then fell onto his right knee, which struck the floor near the sink. After this incident, he began to experience increasing symptoms including pain in his left shoulder and neck area which radiated down his left arm and pain, swelling and stiffness in his right knee.

The Petitioner initially sought medical treatment for his work injuries at ENH Omega Clinic on August 26, 2004. He was advised by the physician at this clinic to utilize ice and heat for his symptoms, and to perform various therapeutic exercises. However, when his symptoms did not improve, an MRI of the left shoulder was recommended. After the MRI study was reviewed, the Petitioner was referred to an orthopedic specialist for further care. (*Petitioner's Exhibit* 1).

The Petitioner's medical care turned to Dr. Craig Phillips, an orthopedic specialist affiliated with Illinois Bone & Joint Institute. Dr. Phillips evaluated the Petitioner's left shoulder, reviewed the MRI study, and recommended physical therapy. Dr. Phillips also administered an injection to the Petitioner's left shoulder and evaluated his right knee during a follow-up appointment. After the Petitioner's right knee symptoms did not improve, Dr. Phillips referred him to Dr. Robert McMillan, an orthopedic knee specialist. Dr. McMillan then recommended a right knee MRI and performed an injection to the right knee.

Dr. Phillips also referred the Petitioner to Dr. David Shapiro, a spine specialist, to determine if the Petitioner's worsening symptoms were emanating from his cervical spine. On March 22, 2005, Dr. Shapiro evaluated the Petitioner and reviewed a cervical spinal MRI study. Dr. Shapiro diagnosed the Petitioner as suffering from acute myelopathy caused by cervical spinal stenosis at C4-5 with myelomalacia, aggravated by his fall. He recommended the Petitioner undergo surgery to prevent neurologic worsening. Also, in preparation for this surgery, Dr. Shapiro referred him for a second opinion with Dr. Sami Rosenblatt, a neurosurgeon On March 23, 2005, Dr. Rosenblatt evaluated the Petitioner and agreed with Dr. Shapiro as to the need for surgery, but also recommended additional diagnostic tests before moving forward with that surgery. (*Petitioner's Exhibit* (hereinafter, *PX*) 3).

After completing this additional diagnostic testing, the Petitioner underwent surgery to his cervical spine at Evanston Hospital on April 1, 2005, where Dr. Rosenblatt performed an anterior C4 and C5 vertebrectomy and, contemporaneous with this procedure, Dr. Shapiro

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performed an anterior cervical fusion from C3 to C6 with allograft and cervical plate. Subsequently, on April 4, 2005, Dr. Shapiro performed another surgical procedure consisting of a posterior cervical fusion from C3 through C6 utilizing a bone graft and hardware. (PX 4). The Petitioner then participated in a course of in-home physical therapy and continued with follow-up appointments with Dr. Shapiro. (*PX* 3).

Pursuant to a Section 12 request by the Respondent, the Petitioner met with Dr. Edward Goldberg, an orthopedic spine specialist affiliated with Midwest Orthopedics, on May 18, 2005. Dr. Goldberg evaluated the Petitioner, reviewed his medical records and prior diagnostic tests, and opined:

> "I feel that the patient aggravated his preexisting asymptomatic spinal stenosis of his cervical spine. It appears that the fall caused an aggravation of his cervical stenosis and he presented with some myelopathy. There is no history of previous cervical problems. Granted, his cervical stenosis predated the accident, but I feel the accident may have aggravated this condition. I do feel that it is from the accident of August 20, 2004. I do feel that the surgery both anterior and posterior was indicated. Treatment has been reasonable and medically necessary for the accident of August 20, 2004." (*PX* 10).

During his ongoing cervical spinal medical care with Dr. Shapiro, the Petitioner also continued under the care of Dr. McMillan for his right knee. Dr. McMillan reviewed an MRI study and reported it revealed meniscal tears and chondromalacia, along with other degenerative changes in the knee. He opined these conditions required surgical intervention, but reported such an intervention should be delayed until the Petitioner's cervical spine condition improved. However, Dr. McMillan did perform an injection to the right knee. (*PX* 3).

After Dr. McMillan's surgical recommendation, and pursuant to another Section 12 request by the Respondent, the Petitioner met with Dr. Charles Bush-Joseph on September 2, 2005. Dr. Bush-Joseph evaluated the Petitioner, reviewed his diagnostic tests, and agreed with Dr. McMillan that the MRI showed a joint effusion and degenerative meniscal tears which would require a surgical procedure to repair the torn menisci. (*PX* 11).

Additionally, after recovering from his cervical spine surgeries, the Petitioner continued to experience walking and balance issues, as well as bowel and bladder problems. Dr. Shapiro then referred him to Dr. Susie Roe, a neurologist. Dr. Roe evaluated the Petitioner on numerous occasions and recommended many additional tests, including further MRI studies and nerve conduction tests. Based upon her evaluations and review of these various tests, she

opined the Petitioner's continued gait problems, along with his bowel and bladder issues, were a result of his cervical myeolopathy and subsequent fusion surgery. She prescribed medications and recommended continued therapy for the Petitioner. (*PX* 5).

On April 18, 2007, after a sufficient recovery from his cervical spinal surgeries, Dr. McMillan performed a surgical procedure on the Petitioner's right knee consisting of a repair of a degenerative tear of the medial meniscus and a complex tear of the lateral meniscus. Post-surgery, Dr. McMillan recommended and administered a Synvisc injection in the right knee. However, the Petitioner continued to experience on-going symptoms in his right knee, including pain and swelling. He then was referred to Dr. William Robb, another knee specialist.

Due to the Petitioner's complaints of gait difficulties, balance issues and bowel and bladder incontinence symptoms, the Respondent issued another Section 12 request that the Petitioner be re-evaluated by Dr. Goldberg. On November 21, 2005, after completing his evaluation and reviewing additional diagnostic test results, Dr. Goldberg opined the Petitioner's ambulation difficulties and bowel and bladder issues were related to the original cervical spinal cord compression and not to any lumbar spine condition. He also recommended an evaluation by a urologist. (*PX* 10).

The Respondent issued yet another Section 12 request, asking the Petitioner to meet with Dr. Martin Lanoff. During that August 2, 2007, appointment, Dr. Lanoff reviewed medical records, diagnostic tests, and conducted an evaluation of the Petitioner. Dr. Lanoff then opined:

> "This gentleman has cervical myelopathy as a residual of the cervical injury. I would expect this man had a history of cervical stenosis prior to the injury itself. It is likely a preexisting condition. One should try to obtain his record prior to the accident if it is feasible. However, this man was asymptomatic or minimally symptomatic and became symptomatic as a result of the accident at work. This is obviously a work-related scenario."

With respect to the Petitioner's right knee, Dr. Lanoff also opined:

> "He had a degenerative tear of the right knee. This may or may not be related to the accident. I simply do not have enough information to make that definitive decision." (*PX* 12).

Due to Dr. McMillian's referral, the Petitioner sought further medical care for his problematic right knee with Dr. Robb. Dr. Robb evaluated the Petitioner, reviewed past medical records and a new MRI of the right knee, and recommended a total knee replacement

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surgery. On November 19, 2009, the Petitioner underwent this total knee replacement surgery at Glenbrook Hospital. (*PX* 5). He then participated in as course of physical therapy and continued to see Dr. Robb for follow-up care. Over the next few years, the Petitioner continued to have stiffness, pain, and swelling in his right knee, and had to utilize a cane for balance when walking. Dr. Robb also provided an injection to the right knee that only rendered temporary relief to the Petitioner.[2] (*PX* 3).

The Petitioner then received another referral, in November of 2011, for his gait and balance issues, to Dr. Daniel Wynn, a neurologist. Dr. Wynn recommended and subsequently reviewed additional diagnostic tests, while also ordering further physical therapy. The Petitioner participated in this therapy prescription from May through September of 2012. (PX 8). Dr. Wynn also recommended various medications, and has continued to see the Petitioner to the present time. (*PX* 7).

Dr. Robb recommended, in August of 2012, a revision surgery of the right total knee replacement hardware components. He also referred the Petitioner for a second opinion on this revision surgery recommendation to Dr. Alexander Gordon. Dr. Gordon evaluated the Petitioner on February 26, 2013, and agreed a revision to a posterior substituting type of knee implant would improve the Petitioner's range of motion and function. (*PX* 3).

The Petitioner returned, on November 8, 2011, to Dr. Bush-Joseph pursuant to the Respondent's Section 12 follow-up request. Dr. Bush-Joseph then opined the Petitioner's gait deformity was the result of his on-going neurological condition and was unrelated to the treatment he received to his right knee. He also stated no further treatment was warranted at that time. On February 29, 2012, Dr. Bush-Joseph replied to the Respondent's direct inquires as to his opinions, first stating:

> "As you know, I first examined Mr. Dean on 9/02/2005 and felt that at that point arthroscopic intervention was warranted as a result of the work-related injury. The patient clearly had preexisting osteoarthritic change of the knee but his symptoms were dramatically aggravated."

[2] Due to his continued difficulties with walking and balance, the Petitioner's family physician referred him to the Rehabilitation Institute of Chicago for further physical therapy. This therapy program ran from June through September of 2010. (*PX* 9).

He also noted:

> "There appears to be a causal connection of the work-related injury of 8/20/2004 and the subsequent necessity of total knee replacement."

Finally, Dr. Bush-Joseph observed:

> "The work-related injury of 8/20/2004 did indeed seem to aggravate the preexisting osteoarthritis that was present." (*PX* 11).

On March 12, 2013, Dr. Robb performed a revision surgery of the right total knee replacement utilizing a different component style. (*PX* 5). Thereafter, the Petitioner continued under the care of Dr. Robb and participated in a course of therapy from April through July of 2013. During subsequent visits to Dr. Robb, the Petitioner reported a decrease in pain in his right knee and increased range of motion. He last saw Dr. Robb on February 25, 2016 and, due to complaints of weakness in his right leg, Dr. Robb ordered additional physical therapy for strengthening. The Petitioner completed this additional course of therapy in May of 2016. (*PX* 3).

The Petitioner testified Dr. Shapiro has retired and Dr. Mark Mikhael has taken over his spinal medical care. On October 22, 2013, Dr. Mikhael first met with the Petitioner and recommended additional diagnostic tests to rule out adjacent segment breakdown due to the fusion surgery. These diagnostic tests were completed and did not reveal any spinal cord compression. Dr. Mikhael then referred the Petitioner to another neurologist, Dr. Wang, who prescribed water therapy. The Petitioner last saw Dr. Mikhael on March 4, 2016, and, as his condition was deemed stable, was directed to follow-up with Dr. Mikhael on an annual basis. (*PX* 3).

The Petitioner testified he continues to experience pain in his neck and left shoulder that radiates into his left arm and hand every day. He also experiences numbness in both hands constantly. He has dizziness and balance issues on a regular basis. The Petitioner further indicated he continues to experience pain, stiffness, and weakness in his right knee and right leg. Due to these continued symptoms, he utilizes a walker or cane when standing for any period or walking any distances. He related his walking tolerance is approximately twenty minutes with the use of a cane.

The Petitioner further testified he does not lift or carry any items that weigh more than approximately four pounds. He also continues to have issues with bowel and bladder control and he cannot perform any activities unless there is a bathroom available nearby. He utilizes an

adult diaper when he leaves his home for extended periods of time. He stated he has not attempted to drive due to the weakness in his hands and legs, and clarified he only drives his car onto his driveway or into his garage from the driveway.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue F: *Causal connection*

The Arbitrator finds the Petitioner's current condition of ill-being is causally related to the work accident he sustained on August 20, 2004. This finding is based upon the Petitioner's unrebutted testimony that the Arbitrator finds to be credible. In addition, with respect to medical causation, the Arbitrator notes the Petitioner's treating spine specialist, Dr. Shapiro, along with the Respondent's multiple Section 12 physicians, have opined the Petitioner's conditions of ill-being with respect to his cervical spine and right knee are causally related to his August 20, 2004 work accident.

The Petitioner credibly testified it only was after he had sustained the injuries to his left shoulder, cervical spine, and right knee due to his August 20, 2004, work accident that he was unable to perform the job duties required of a custodian/janitor for both the Respondent and Sears. Moreover, his left shoulder, cervical spine and right knee symptoms that arose after the August 20, 2004, work accident were the first time he had experienced those symptoms. The Petitioner also testified he had not been involved in any other accidents or suffered any other injuries to his left shoulder, cervical spine or right knee during the period after the August 20, 2004, work accident through the present.[3]

Dr. Shapiro specifically and credibly opined:

> "My impression is that Mr. Dean has an acute myelopathy. This is related most likely due the presence of preexisting cervical spinal stenosis and was aggravated by the fall. I base this on the fact that there were no symptoms prior to his fall."

[3] The Arbitrator notes the Petitioner's testimony stands unrebutted and, moreover, the Respondent offered no medical or other evidence to contradict his testimony.

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Subsequently, Dr. Shapiro reported:

> "All of (the Petitioner's symptoms) stem from the accident and are most likely due to a residual injury to his spinal cord." (*PX* 3).

The Arbitrator observes the Respondent's multitude of Section 12 physicians also commented as to the existence of a causal connection between the Petitioner's August 20, 2004, work accident and his current condition of ill-being. Notably, Dr. Goldberg stated:

> "I feel that the patient aggravated his preexisting asymptomatic spinal stenosis of his cervical spine. It appears that the fall caused an aggravation of his cervical stenosis...Granted, his cervical stenosis predated the accident, but I feel the accident may have aggravated this condition. I do feel that it is from the accident of August 20, 2004."

Dr. Goldberg also commented:

> "Regarding the patient's difficulty with ambulation and his reports of bowel or bladder dysfunction, I feel this is likely from the original cervical spinal cord compression...Again, I feel the patient's cervical condition is from the work-related accident."

And:

> "I had previously seen this gentleman and felt that he aggravated his cervical spinal stenosis from the work-related accident." (*PX* 10).

Additionally, Dr. Lanoff reported:

> "This gentleman has cervical myelopathy as a residual of the cervical injury. I would expect this man had a history of cervical stenosis prior to the injury itself. It is likely a preexisting condition. One should try to obtain his record prior to the accident if it is feasible. However, this man was asymptomatic or minimally symptomatic and became symptomatic as a result of the accident at work. This is obviously a work-related scenario." (*PX* 12).

As to the Petitioner's right knee, Dr. Bush-Joseph stated:

> "As you know, I first examined Mr. Dean on 9/02/2005 and felt that at that point arthroscopic intervention was warranted as a result of the work-related injury. The patient clearly had preexisting osteoarthritic change of the knee but his symptoms were dramatically aggravated."

Dr. Bush-Joseph next opined:

> "There appears to be a causal connection of the work-related injury of 8/20/2004 and the subsequent necessity of total knee replacement."

Finally, Dr. Bush-Joseph reported:

> "The work-related injury of 8/20/2004 did indeed seem to aggravate the preexisting osteoarthritis that was present." (*PX* 11).

As such, the Arbitrator finds the Petitioner's current left shoulder, cervical spine, and right knee conditions of ill-being is causally connected to his work injury of August 20, 2004.

Issue J: *Medical bills*

The Arbitrator also finds the medical treatment the Petitioner received to his cervical spine and right knee was causally related to the work accident of August 20, 2004. To that end, the Arbitrator further finds the medical bills submitted by the Petitioner constitute reasonable and necessary medical treatment pursuant to Section 8(a) of the Act. (*PX* 13). Moreover, the Arbitrator notes the Respondent's Section 12 physicians, including Drs. Goldberg, Bush-Joseph and Lanoff, all have opined the treatment the Petitioner received for his cervical spine injury and his right knee injury was reasonable and necessary.

The Petitioner testified with respect to the chronology of his medical treatment and the various providers who offered this care and treatment. The Arbitrator notes, after reviewing the voluminous medical records submitted in this case, the treatment outlined in these records is for attempting to provide a cure and relief to the Petitioner for the sequelae from his work accident of August 20, 2004. The Respondent offered no contrary evidence on this issue.

Based upon the above, the Respondent is responsible under Section 8(a) of the Act and the Medical Fee Schedule for the following unpaid medical bills:

1. Illinois Bone & Joint Institute (physicians and therapy): **$23,156.72**,
2. Dr. Alexander Prager: **$582.48**, and
3. Dr. Daniel Wynn: **$225.00**.

As to the Petitioner's payments made to various medical providers listed in *PX* 13, along with his payments for prescription medication, the Respondent is responsible for reimbursement to the Petitioner the sum of **$5,742.16**.

Lastly, concerning payments made to the Petitioner's various treating medical providers and facilities identified in *PX* 13 by a group health insurance carrier or Medicare, the Respondent is responsible for payment to the Petitioner for the amounts paid by those group health insurance carriers[4] and Medicare. The Arbitrator notes the Petitioner testified these group health insurance carriers were his wife's group health insurance companies from her employer and the Respondent is not entitled to credit for these payments under Section 8(j) of the Act. The Respondent however, shall only be responsible for the amounts paid by these various group health insurance carriers and Medicare to those medical providers given that these are negotiated rates as defined under Section 8(a) of the Act. *Rocio Perez v. Illinois Workers' Compensation Comm. 2018 IL App (2d) 170086WC.* These payments total **$154,616.84**.

__Issue L__: *Nature and extent*

The Arbitrator finds the Petitioner is permanently and totally disabled (PTD) as provided for under Section 8(f) of the Act. The onset date of the Petitioner's PTD is January 23, 2018, the date of the arbitration hearing. This decision is supported by the testimony of the Petitioner relating to his current physical condition which the Arbitrator finds credible and the medical evidence submitted in this case. Moreover, the Arbitrator notes the Respondent offered no evidence to dispute the severity of the Petitioner's injuries or his inability to perform work activities.

The principles applicable to a finding of PTD are well settled. An employee is totally and permanently disabled when he or she is unable to make some contribution to the work force sufficient to justify the payment of wages. *Ceco Corp. v. Industrial Commission, 95 Ill.2d 278,*

[4] Cigna, Aetna, BCBS, and Medicare. (*PX* 13).

447 N.E.2d 842(1983). However, a claimant is not required to demonstrate total physical incapacity or helplessness before a PTD award may be granted. *Interlake Inc. v. Industrial Commission, 86 Ill.2d 168, 427 N.E.2d 103 (1981).* A person is totally disabled when he cannot perform services except those that are so limited in quantity, dependability or quality that there is no reasonable stable market for them. *A.M.T.C. of Illinois, Inc. v. Industrial Commission, 77 Ill.2d 482, 397 N.E.2d 804 (1979).* Given the degree of symptoms the petitioner testified he continues to experience daily and the limitations he has with respect to performing various activities of daily living, he has met his burden of proof with respect to an award under Section 8(f) of the Act as outlined by these cases.

The Petitioner was 69-years-old at the time he sustained his work-related accident on August 20, 2004. At the time of his arbitration hearing, he was 83-years-old. The Petitioner testified he went to school only until the seventh or eighth grade and never completed a GED certification. Prior to working for the Respondent, he worked for A.B. Dick Company as a punch press operator and retired from that company after 31 years. As noted previously, he then worked as a custodian/janitor for Sears for thirty years up to his August 20, 2004 work accident. Finally, he worked as a custodian/janitor for the Respondent for approximately five years up to the date of his work accident. He further testified that he has minimal reading and writing skills, his math and spelling skills are also deficient, and he has minimal skills in the use of a computer.

As to his current physical condition, the Petitioner testified he continues to experience pain in his neck and left shoulder that radiates into his left arm and hand every day. He also experiences numbness in both hands constantly, along with dizziness and balance issues on a regular basis. The Petitioner continues to have pain, stiffness, and weakness in his right knee and right leg. Due to these continued symptoms, he utilizes a walker or cane when standing for any extended period or walking any distances. However, he also noted his walking tolerance only is twenty minutes with the use of a cane. The Petitioner further related he has difficulty with lifting and continues to experience issues of bowel and bladder control. Finally, the Petitioner reported his ability to drive is severely compromised because of his injuries.

The Arbitrator finds the Petitioner's testimony with respect to his current condition and abilities is both credible and consistent with what is documented in the medical records.[5] Additionally, the Respondent has offered no evidence the Petitioner's symptoms are not as

[5] Dr. Ro stated: "Mr. Robert Dean has been under my care since 12/05 for cervical myelopathy following a fall 8/04 and cervical fusion 4/05. He has chronic weakness, pain, numbness, imbalance and urinary urgency due to cervical myelopathy. Since he has shown incomplete recovery from his myelopathy after >2 years following his injury, it is likely that his neurologic deficits are permanent...For the above stated reasons, I believe the pt is unable to return to work in any capacity and should be considered for permanent disability." (*PX* 5).

severe as he testified to or that he performs activities contrary to his described limitations.[6] Given this testimony and supporting medical records, the Arbitrator finds it would be impossible for the Petitioner to perform any type of work activities for any employer in today's labor market on a consistent and regular basis.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner to be permanently and totally disabled (PTD) under the meaning of Section 8(f) of the Act and awards the Petitioner the sum of **$666.70 per week for life**. The Petitioner is entitled to receive such weekly benefits commencing January 23, 2018, the date of the arbitration hearing.

Signature of Arbitrator

FEBRUARY 20, 2018
Date

[6] Interestingly, Dr. Lanoff, a Section 12 physician for the Respondent, opined: "This gentleman has cervical myelopathy as a residual of the cervical injury... This makes him relatively unemployable... This gentleman should be disabled with no lifting more than 5 pounds or so, no overhead work, he cannot climb ladders or stairs. He must have a sedentary job with minimal walking and certainly no balance requirements. This gentleman has limited balance and this is a permanent residual of the myelopathy. He should not work on scaffolding, he cannot work overhead, and he must use a cane for balance... This gentleman's bowel and bladder incontinence is relatively controllable because of his bowel and bladder maintenance program, but again, this makes it difficult to be employed out of the home." (*PX* 12).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRI CLAYTON,

Petitioner,

vs. NO: 16 WC 12828

ILLINOIS VETERANS HOME,

Respondent.

20 I W CC0141

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, credit pursuant to section 8(j)(2) of the Act, 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.

In this case, the Arbitrator awarded temporary total disability benefits (TTD) for 2 and 5/7th weeks at the rate of $704.69 per week. The Arbitrator also awarded Respondent a credit under section 8(j) of the Act to the extent of what it owed in temporary total disability benefits based on the vacation days Petitioner used during her lost time. Neither party disputes the calculation of the temporary total disability benefits award. Petitioner has appealed the award of the credit to Respondent.

The relevant portion of section 8(j) of the Act provides:

> "Nothing contained in this Act shall be construed to give the employer or the insurance carrier the right to credit for any benefits or payments received by the employee other than compensation payments provided by this Act, and where the employee receives payments other than compensation payments, whether as full or partial salary, group insurance benefits, bonuses, annuities or any other payments, the employer or insurance carrier shall receive credit for each such payment only to the extent of the compensation

> that would have been payable during the period covered by such payment." 820 ILCS 305/8(j)(2) (West 2018).

The Illinois Appellate Court has construed this provision in three decisions relevant here.

First, in *Tee-Pak, Inc. v. Industrial Comm'n*, 141 Ill. App. 3d 520, 529 (1986), the employer sought credit "for the vacation pay it paid to claimant because he received workers' compensation benefits and vacation pay is intended to be for 'time off.'" The payments were made under a benefit program which ensured full salary to employees who are off work due to an accident or illness, less any payments from the company's group insurance plan. *Id.* The claimant had not received benefits under the group insurance plan. *Id.* The appellate court ruled:

> "Tee-Pak has no written policies regarding how these benefits are to be credited in workers' compensation cases. Because Tee-Pak failed to show that these benefits are limited to occupationally related disabilities, the credit section of the Act does not apply." *Id.*

Second, in *Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 943 (2011), which involved an employee's use of accumulated sick leave, the appellate court distinguished *Tee-Pak, Inc.*:

> "In *Tee Pak, Inc.*, there was evidence from which the Commission could infer that the employer intended its employees to collect *both* TTD benefits and salary payments for the same period of time. *Tee Pak, Inc.*, 141 Ill. App. 3d at 529. In the present case there was no evidence that respondent had in place a similar policy. Thus, the limitation of section 8(j) imposed in *Tee Pak, Inc.* does not apply here. Therefore, we hold that pursuant to section 8(j)2 of the Act (820 ILCS 305/8(j)(2) (West 2002)), respondent is entitled to credit for salary paid to claimant, but only to the extent of its TTD liability." *Elgin*, 409 Ill. App. 3d at 954.

Third, the appellate court adhered to both *Tee-Pak, Inc.* and *Elgin* in *Wood Dale Electric v. Illinois Workers Compensation Comm'n*, 2013 IL App (1st) 113394WC, ¶ 19. In *Wood Dale Electric*, the court determined the employer was not entitled to a credit for normal pension payments, which were unrelated to the claimant's workers' compensation accident. *Id.* ¶ 20.

In this case, the Arbitrator took judicial notice of a provision of the Illinois Administrative Code, which provides in relevant part:

> "a) An employee who suffers an on-the-job injury or who contracts a service-connected disease shall be allowed full pay during the first 3 working days of absence without utilization of any accumulated sick leave or other benefits. Thereafter the employee shall be permitted to utilize accumulated sick leave or other benefits unless the employee has applied for and been granted temporary total disability benefits in lieu of salary or wages pursuant to provisions of the Workers' Compensation Act [80 ILCS 305] or through the

State's self-insurance program. **20IWCC0141**

b) In the event such service-connected injury or illness becomes the subject of payment of benefits provided in the Workers' Compensation Act by the Industrial Commission, the courts, the State self-insurance program or other appropriate authority, the employee shall restore to the State the dollar equivalent which duplicates payment received as sick leave or other accumulated benefit time, and the employee's benefit accounts shall be credited with leave time equivalents." 80 Ill. Adm. Code 303.135(a),(b) (eff. Dec. 3, 2004).

The Arbitrator reasoned that the award of TTD benefits to Petitioner would require her to remit the pay she received during her lost time, thus entitling Respondent for a credit to the extent of the TTD benefits owed to Petitioner.

Petitioner argues that the vacation payments are a benefit that can be utilized by an employee regardless of the occurrence of a work-related accident. Petitioner also argues that it was outside the Arbitrator's jurisdiction to apply the Illinois Administrative Code to Petitioner's case. Lastly, Petitioner maintains that application of the regulation would unfairly disadvantage Petitioner, who would not receive the TTD benefits, yet still be required to repay her vacation payments out of pocket.

Respondent replies that section 8(j) of the Act may provide a credit for vacation days when received in lieu of TTD benefits, unless the employer's policies allow the claimant to receive both. Respondent maintains that the State's policy governing employees' use of vacation time in lieu of TTD benefits is stated in the Illinois Administrative Code. Respondent asserts that when no payment is made, such as when a credit under 8(j) is due, Petitioner is not required to pay back vacation days she has used.

The Commission concludes that the Arbitrator reached the correct result but modifies the Decision to clarify the manner in which the credit should be awarded in this case. *Tee-Pak, Inc.* and *Elgin* turn on whether the employer had written policies regarding how benefits are to be credited in workers' compensation cases, particularly whether such policies permitted employees to collect both TTD and other payments. Here, the Illinois Administrative Code evidences an "either/or" policy.

The Arbitrator exceeded his jurisdiction in suggesting the *outcome* under the regulation. See *Baker v. Silver Cross Hospital*, 6 IWCC 311 (There is no provision in the Act for the Arbitrator to reinstate the Petitioner's PTO and sick days). Cf. *Wood Dale Electric*, 2013 IL App (1st) 113394WC, ¶ 10 (Issues relating to the claimant's right to pension benefits themselves are not governed by the Act). Nevertheless, the regulation is evidence that the State's policy as an employer is significantly different from the policies at issue in *Tee-Pak Inc.* Thus, the Arbitrator did not err in determining Respondent is entitled to a credit pursuant to section 8(j)(2) of the Act. Our analysis, however, does not end there.

On review, Respondent states that Petitioner is not required to "pay back" vacation days

in cases where a credit exists. However, importantly, the reinstatement of Petitioner's vacation days is outside the Commission's jurisdiction. Moreover, the possibility of a future claim by the State against Petitioner for repayment cannot be foreclosed despite the assertion in the State's brief to the contrary. The Commission can only direct the specific procedures by which benefits and credits are awarded under the Act.

Accordingly, the Commission modifies the language in the Decision to specify that Respondent is liable for TTD benefits awarded for the period from July 19, 2016 through August 7, 2016, but a credit is awarded *only against payment* by the State of the awarded TTD payments. Petitioner is not required to repay the State for any such credit awarded until after receipt of the TTD award payment.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $704.69 per week for a period of 2 and 5/7th weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $634.22 per week for a period of 25.625 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused a 12.55% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2.291.04 for medical expenses under §§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. The credit awarded pursuant to §8(j)(2) of the Act is awarded only against payment by the State of the awarded temporary total disability payments. Petitioner is not required to repay the State for any such credit awarded until after receipt of the temporary total disability award payment.

20IWCC0141

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: FEB 27 2020
d: 1/9/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAYTON, TERRI
Employee/Petitioner

Case# **16WC012828**

ILLINOIS VETERANS HOME
Employer/Respondent

20IWCC0141

On 1/18/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
PHILIP A BARCEK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

JAN 18 2018

RONALD A RASCIA, Acting Secretary

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terri Clayton
Employee/Petitioner

Case # **16** WC **12828**

v.

Consolidated cases: **N/A**

Illinois Veterans Home
Employer/Respondent

20IWCC0141

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **December 6, 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. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **February 19, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,966.30**; the average weekly wage was $**1,057.04**.

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 $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**0** for other benefits, for a total credit of $**0. See Arbitrator's explanation of Issue"N", attached**.

Respondent is entitled to a credit for Medical paid by its Group provider as well as amounts received by the Petitioner as vacation pay to the extent of what she is owed in TTD benefits..

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $704.69 per week for 2 5/7 weeks commencing July 19, 2016 through August 7, 2016 as provided in Section 8(b) of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $634.22/week for 25.625 weeks, because the injuries caused the 12.5 % loss of use of the right hand, as provided in Section 8 (e) of the Act.

Medical Benefits
Respondent shall pay reasonable and necessary medical services of $2,291.04, as provided in Section 8(a) and 8.2 of the Act. Respondent shall be given a credit for the group medical benefits paid by its group carrier pursuant to Section 8(j) of the Act and shall hold Petitioner safe and harmless up to the amount of the credit/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.

20IWCC0141

Signature of Arbitrator

1/5/2018
Date

ICArbDec p. 2

JAN 18 2018

STATE OF ILLINOIS)
)
COUNTY OF ADAMS)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATOR DECISION

Terri Clayton
Employee/Petitioner
v.

Case No. 16 WC 12828

Illinois Veterans Home
Employer/Respondent.

20IWCC0141

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On February 19, 2016, Petitioner testified she was employed by Respondent as a Certified Nursing Assistant (CNA)/Veteran Nursing Assistant Certified (VNAC). Petitioner testified that she was hired by Respondent to work as a CNA in January of 2000. As a CNA, Petitioner was responsible for the residents' care which included feeding, bathing and transferring patients and their general well-being. Between January, 2000 and February 19, 2016, Petitioner testified she worked full time, 40 hours per week. Prior to February 19, 2016, Petitioner testified that she never had any issue or problem with reference to her right hand, right wrist or right forearm and never had restrictions, treatment or needed medication for these body parts.

On February 19, 2016, at approximately 9:30 a.m., Petitioner testified that a resident's alarm went off indicating he was in a dangerous situation. Petitioner testified that this particular resident was unstable, wore a helmet for head protection, should not be standing alone, and the alarm signified that he was attempting to stand without assistance. Therefore, Petitioner testified she rushed into his room and noticed he was trying to stand up by himself in his bathroom. Petitioner testified that she immediately attempted to seat him in his wheelchair at which time he grabbed her right wrist and lower forearm and began squeezing and twisting her wrist/arm. After about a minute of trying to pry his hand loose from her wrist/arm, Petitioner testified that she yelled for help. A co-worker, Michelle Albert, responded and came to aid and assist Petitioner. Petitioner testified that his grip was very forceful and tight and caused immediate pain. With Albert's help, Petitioner's hand/arm was freed. Petitioner testified she immediately reported the incident. According to the Illinois Department of Veteran's Affairs Incident Report, at 9:30 a.m. the resident "grabbed" Petitioner's right wrist and as she tried to get the resident to let it go, he began to twist it even "harder". (PX1, RX1). The report notes that Petitioner hollered for help and Michelle Albert came to help free her "right wrist/arm". The incident report states that Petitioner "told resident he was hurting" her arm. (PX1, RX1) Michelle Albert, Petitioner's co-worker, completed a Workers' Compensation Witness Report. (RX4) According to the report, at 9:30 a.m. on February 19, 2016, "I heard Terri yell for help so I went into the member's room

and the resident had a hold of Terri's wrist and was twisting. I helped her get her arm free from resident's hands". (RX4). A Supervisor's report was completed by Respondent. The Supervisor's report was a "fall alarm" and resident was attempting to transfer and when Petitioner went to assist the patient he "grabbed her right wrist and twisted". (PX1, RX4). Petitioner attempted to release the resident's hands and was unable to do so therefore another staff member was alerted to assist. (PX1, RX4). The Supervisor Report of Injury or Illness noted that she witnessed this occurrence. (PX1, RX4). The Workers' Compensation Employees Notice of Injury/Tri-Star form was also completed. This form also indicated that Petitioner was helping the member sit back into his wheelchair and her injury was her right wrist/arm "painful, throbbing and now swollen". This was completed by Petitioner on February 19, 2016. (PX1, RX4). The Notice of Injury Workers' Compensation form indicated that "the more we ask him to let go the harder he squeezed and twisted my right wrist/arm. It took both staff to release his hands from my arm". (PX2, RX4). After the accident, Petitioner asked for medical treatment and was directed by Respondent to go to Blessing Physician Services (BPS).

On February 19, 2016, Petitioner was seen at the BPS and Dr. Mueller. Dr. Mueller noted that Petitioner was injured when she was grabbed by a resident while trying to assist him in the bathroom. (PX4). The doctor noted that the incident occurred in the morning and Petitioner thought it may go away but seems to have become worse and has a "constant throb." Dr. Mueller noted that Petitioner complained of a "burning sensation" in her right forearm that radiates to the medial elbow and he diagnosed a right wrist injury, prescribed Tylenol 500 mg, heat to the area, ice to the area and x-rays. (PX4). Petitioner was provided restrictions which included "limited use of the right upper extremity". Dr. Muller examined the Petitioner's right wrist. He notes a normal appearance with tenderness in the area of the TFCC. In the section of his notes referred to as "Review of Systems," the office record notes pain, with history of trauma or injury, no swelling, no weakness, no numbness, no loss of motion, not locked up, no redness, no popping/sticking, no instability or giving. On the same date, Dr. Muller signed a "Work Ability Report" diagnosing a contusion of the right forearm/wrist. (Id)

The Blessing Hospital radiology records of the same date show that the tests were ordered by Dr. Muller. Under 'Clinical Indications" It listed a right wrist injury. Pain and swelling following injury today. (PX4). The x-ray revealed no acute findings. (PX4). Following those appointments, Petitioner testified that she returned to Respondent and was told to follow up with Respondent's Occupational Physician(s) for ongoing treatment which was Dr. Child at SIU School of Medicine.

On February 26, 2016, Dr. Child's records noted that Petitioner sustained an injury to her right wrist and he recommended continued ice and Tylenol. (PX3). Dr. Child's records also indicated that Petitioner had tenderness in the appearance of what might be ecchymosis occurring. (PX3).

On March 10, 2016, Petitioner followed up with Dr. Child. His records indicate that Petitioner has "shocks going from her elbow down to her hand" and he completed paperwork providing her ongoing work restrictions. (PX3). Dr. Child also recommended an EMG test. (PX3).

On March 31, 2106, Petitioner followed up with Dr. Child for what he listed was a W/C follow up wrist condition. (PX3). Dr. Child noted that Petitioner continued to have right wrist

and right elbow pain, worse at night which seemed to be worsening and now Petitioner was dropping items. (PX3). Dr. Child noted that the EMG test revealed mild carpal tunnel syndrome. (PX3).

On April 8, 2016, Petitioner testified she followed up with Dr. Child. According to his records, he recommended that Petitioner purchase a splint at Wal-Mart "until we can get workers' comp to approve the one we ordered." (PX3). On examination, Dr. Child noted decreased sensation of the first three fingers of the right hand, decreased right grip strength at the level of 4/5 and normal grip of the left hand at the level of 5/5. Dr. Child recommended Naproxen 500 mg twice a day and noted that her right wrist pain was worsening nightly, throbbing and he noted that the Tinel and Phalen Tests were positive on the right side. (PX3). He noted that that the orthopedic referral was pending. (PX3).

On April 29, 2016, Dr. Child diagnosed carpal tunnel syndrome on the right side along with chronic right elbow pain. (PX3). Concerning the carpal tunnel syndrome diagnosis, the doctor opined in his records that "I do believe that this is an exacerbated by the work-related incident as the time line shows that this is when her symptoms mainly started". (PX3). I will refer her to an Orthopedic Specialist at the Springfield Clinic. (PX3). The doctor completed a Work Ability Report with restrictions. (PX3). Petitioner testified that Dr. Child referred her to Dr. Greatting at the Springfield Clinic.

On June 10, 2016, Petitioner was seen by Dr. Greatting. According the Dr. Greatting's records, on February 19, 2016, a resident grabbed and jerked her right wrist which caused electrical throbbing and shocking type pain which occurred intermittently with activity. (PX5). Dr. Greatting diagnosed Petitioner with right carpal tunnel syndrome and recommended surgery. (PX5).

On July 19, 2016, Petitioner underwent an open right tunnel release performed by Dr. Greatting. Petitioner testified that she followed up with Dr. Greatting for post-operative treatment.

On August 9, 2016, Petitioner testified that Respondent sent her to Dr. Sudekum for a Section 12 examination. According to Dr. Sudekum, the accident on February 19, 2016 did not cause or aggravate Petitioner's right carpal tunnel syndrome condition. (RX1). Respondent deposed Dr. Sudekum.

Petitioner testified that she followed up with Dr. Greatting in September of 2016 and June 21, 2017. According to Dr. Greatting's records, Petitioner was doing well since her surgery and he explained that "I do feel the injury contributed to the development or caused the development of her carpal tunnel syndrome". (PX5).

Petitioner testified that Respondent denied her workers' compensation benefits. Petitioner testified she was off of work from July 19, 2016 through August 7, 2016 and did not receive temporary total disability benefits. Rather, she used her earned, accrued vacation days for payment during that period of time. Petitioner testified that she earned her vacation bank through her years of service for Respondent and that such vacation days were not made by any Respondent group plan covering non-occupational disability benefits contributed by the employer, rather these vacation days were accrued by the employees based upon service and

could be used at any time as long as there was prior approval with Respondent. Petitioner testified that it was her understanding that these vacation benefits could be utilized even if she was drawing her workers' compensation benefits, concurrently, and if she did not use the vacation benefits during this period of time she could have used the vacation benefits for any other period of time or they could have been carried over to the following year. Petitioner also testified that upon retirement, it is her understanding that any accrued vacation time not used could be converted into cash/payment.

Concerning her medical bills, Petitioner testified that Respondent paid some initial bills under workers' compensation and later denied the medical expenses. Petitioner testified that $2,201.04 remained outstanding to the following providers: SIU School of Medicine - $510.00, Quincy Medical Group - $500.62, Springfield Clinic - $845.72, Blessing Hospital - $288.20, and Clinical Radiologists - $56.50. (PX6). Petitioner testified that she spent $90.00 out of pocket for medical expenses pertaining to her right hand carpal tunnel syndrome treatment. (PX6). The remaining expenses were paid by Respondent's group medical carrier or the workers' compensation carrier as noted in Petitioner's bill work-up Exhibit 6. (PX6).

CONCLUSIONS OF LAW

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

On February 19, 2016, Petitioner was involved in a single, traumatic accident which was witnessed and well documented. Petitioner testified credibly, believably and consistently with the accident reports and medical records presented. Her testimony concerning the accident is unrebutted.

Prior to the accident, Petitioner testified she did not have any right wrist, hand or right elbow symptomatology which is supported by the records. Immediately after the accident, the medical records indicate that Petitioner had discoloration, swelling and symptomology in her right wrist which was confirmed to be carpal tunnel syndrome by the Nerve Conduction Studies within 6 weeks. Both Respondent's Occupational Physician, Dr. Child, as well as the treating surgeon, Dr. Greatting, noted that the right carpal tunnel syndrome condition was caused or exacerbated by the February 19, 2016 work accident. (PX5, PX3). The only doctor to refute causation was Dr. Sudekum, Respondent's Section 12 examiner. Dr. Sudekum wrote in his report, and reiterated in his testimony, that there was "no objective evidence of any injury". (RX1, RX2 – Pages 15 & 16). Dr. Sudekum indicated that to have traumatic carpal tunnel syndrome, "normally you have to have very significant amounts of swelling" which he denied Petitioner suffered. (RX2 – Page 19). Dr. Sudekum repeatedly testified that there was no significant trauma nor residual from the February 19, 2016 accident although he admitted that he did not have the Blessing Hospital's radiologist reports that noted pain and swelling to Petitioner's right wrist on the date of accident, immediately after the accident. (RX2 – Page 64). Dr. Sudekum opined that Petitioner could have had the symptoms on February 19, 2016 even if she was not involved in the accident and he was not certain the accident caused any right wrist and forearm symptomology. (RX2 – Pages 64 – 72). On cross examination, Dr. Sudekum stated he "can't say when her symptoms began" although the evidence is unrebutted that Petitioner had no prior or pre-existing right wrist or hand condition. (RX1 & RX2). Dr. Sudekum agreed that the Petitioner did have carpal tunnel syndrome on the right side and that the surgery performed

by Dr. Greatting was reasonable. (RX 2 at 43) Dr. Sudukum testified that the Petitioner's condition was likely the result of her personal risk factors, including obesity, diabetes fluid retention and hypothyroidism. (RX 2 at 44)

The Arbitrator concludes that the causation opinions from Drs. Greatting and Child are more persuasive and credible than the opinion of Dr. Sudekum. Dr, Sudukum contends that, based upon his review of the records on and around the accident date, that there was no evidence of injury. In coming to that conclusion, he only looks at Dr. Muller's record of February 19, 2016, which is detailed above. He refused to find persuasive the clinical indications on the radiologist report indicating there was pain and swelling following the injury. He also did not place importance on the Work Ability Report authored by Dr. Muller following his exam wherein he describes the Petitioner as having a contusion of the wrist. He repeatedly refused to accept the idea that the Petitioner's right-hand symptoms did not pre-date the accident, despite being unable to cite any evidence to the contrary. He also discounted the opinion of Dr. Child, who treated the Petitioner extensively between February 26, 2016 and April 29, 2016 before giving his positive opinion on causation. Dr. Sudukum also determined the condition to be due to other risk factors. If that were the case, the Arbitrator wonders why the Petitioner was only found to have carpal tunnel in the hand that was twisted at work? As noted above, the Petitioner never complained about her left wrist and Dr. Child found her with normal pinch strength on that side during his April 8 exam. Finally, Dr. Sudukem's credibility is hurt by his insistence that he performed an examination under the AMA Guidelines, Sixth Edition. He did not perform such an exam. His opinion is contained in a one sentence response to a question posed to him by the Respondent's agent, Tristar. The Sixth Edition of the Guides clearly describes in Chapter 2 how they are to be used and how to prepare impairment reports. It directs the examiner to prepare a report utilizing the applicable table of impairments, citing them in detail. Dr. Sudukum not only did not prepare such a report, he could not state with any certainty whether he even opened the Guidebook in deriving his rating. (RX 2 at 122)

The timeline, as well as the contemporaneous medical and other documents admitted into evidence establish that the Petitioner injured her wrist as alleged. The Arbitrator finds a causal connection between said accident and the Petitioner's right carpal tunnel syndrome.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?, the Arbitrator concludes as follows:

After finding causation, explained above, the Arbitrator concludes that Petitioner's medical expenses are related to the February 19, 2016 accident. Therefore, Respondent shall pay reasonable and necessary services of $2,291.04, as provided in Section 8(a) and 8.2 of the Act. These itemized medical expenses were identified in Petitioner's bill work-up Exhibit 6. (PX6).

Issue (K): What temporary benefits are in dispute? TTD? and Issue (N): Is Respondent due any credit?, the Arbitrator concludes as follows:

Petitioner testified that she was off work following carpal tunnel surgery from July 19, 2016 through August 7, 2016 which is supported by Dr. Greatting's medical records (PX5). After finding causation, explained above, the Arbitrator awards temporary total disability

benefits for 2-5/7 weeks at the TTD rate of $704.69 per week. Respondent claims a credit for Petitioner's vacation days which she used during her lost time.

The Arbitrator takes judicial notice of 80 Illl. Admin. 303.135 which states

a) An employee who suffers an on-the-job injury or who contracts a service-connected disease shall be allowed full pay during the first 3 working days of absence without utilization of any accumulated sick leave or other benefits. Thereafter the employee shall be permitted to utilize accumulated sick leave or other benefits unless the employee has applied for and been granted temporary total disability benefits in lieu of salary or wages pursuant to provisions of the Workers' Compensation Act [80 ILCS 305] or through the State's self-insurance program.
b) In the event such service-connected injury or illness becomes the subject of payment of benefits provided in the Workers' Compensation Act by the Industrial Commission, the courts, the State self-insurance program or other appropriate authority, the employee shall restore to the State the dollar equivalent which duplicates payment received as sick leave or other accumulated benefit time, and the employee's benefit accounts shall be credited with leave time equivalents.
c) Employees whose compensable service connected injury or illness requires appointments with a doctor, dentist, or other professional medical practitioner shall, with supervisor approval, be allowed to go to such appointments without loss of pay and without utilization of sick leave.

Based on the above, if Petitioner had Petitioner been awarded TTD benefits, she would be required to remit the pay she received while off work in lieu of TTD benefits. By virtue of this decision, she will be receiving her TTD benefits. By virtue of the above statue, as well as the Appellate Court decision in the case of Elgin Board of Education v. IWCC, 409 Ill. App. 3d 943 (1st Dist.), Respondent is entitled to a credit under Section 8 (j) to the extent of what it owes in TTD for the above referenced period of time.

Issue (L): What is the nature and extent of the injury?, the Arbitrator concludes as follows:

Petitioner underwent an open, right hand carpal tunnel syndrome release/surgery.

With regard to subsection (i) of Section 8.1b(b) the Arbitrator notes that the record contains an impairment rating of 0% of Petitioner's right hand as determined by Dr. Sudekum. However, Dr. Sudekum's testimony indicated that he was not certified in Impairment Ratings, never referenced a Grid or page number in his analysis, never completed a QuickDash report any grade modifiers in determining his rating. (RX2, Page 117 – 121). Therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of 8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Certified Nursing Assistant at the time of the accident and she returned to her work in her prior capacity. The Arbitrator notes that Petitioner is required to use her hands on a daily basis for daily care of the residents. Therefore, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. Because Petitioner has approximately 20 years of work life remaining until retirement, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of 8.1b(b), Petitioner's future earnings capacity, the Arbitrator finds Petitioner did not sustain a wage loss as a result of the accident. Petitioner has returned to

work in the same capacity making the same salary as prior to the accident. Therefore, the Arbitrator gives lesser weight to this factor.

With regard to subsection (v) of 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent an open, right carpal tunnel release performed by Dr. Greatting. In surgery, Dr. Greatting noted that there was compression of the median nerve. (PX 5) Petitioner's symptoms reported at arbitration are consistent with such a finding. Petitioner testified that she notices her right hand is weaker, has additional soreness, and takes Ibuprofen over the counter to treat her symptomology. Petitioner testified she is right-hand dominant. 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 12.5% loss of use of Petitioner's right hand pursuant to 8(e)9 of the Act. Because this is a traumatic carpal tunnel syndrome claim, the Arbitrator concludes that Petitioner's permanent partial disability is based on 205 weeks.

STATE OF ILLINOIS	)
	) SS.
COUNTY OF WILL	)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Salvator,
Petitioner,

vs. NO. 07 WC 36503

11IWCC0572

G A Blocker Grading,
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 temporary total disability, medical expenses, prospective medical care, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator with regard to medical expenses, vacates the Arbitrator's award of penalties and attorney's fees, 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).

After considering the entire record, the Commission modifies the Decision of the Arbitrator with regard to medical expenses and vacates the Arbitrator's award of penalties and attorney's fees as stated below.

Medical Expenses

The Arbitrator specifically awarded the following outstanding medical expenses totaling $28,629.09: Bloomington Medical Lab Physicians -- $637.20, Duffy Ambulance Service --

$708.00, McLean County Orthopedics -- $4,631.65, Mid-Central IL Gastroenterology -- $1,172.00, OSF Medical Group -- $1,330.75, OSF St. James Hospital -- $20,193.27 and Wal-Mart Pharmacy -- $19.22.

Respondent argues that the bills from Bloomington Medical Lab, Duffy Ambulance, and Mid-Central, along with the August 21, 2007 ER bill from OSF St James, should not have been awarded as they relate to an abdominal condition rather than the work injury. The Commission disagrees. Dr. Hough opined in his treatment record of July 12, 2007 that Petitioner had a strain to his abdomen, most likely from the fall at work on June 28, 2007, and that he still required Hydrocodone and Flexeril (PX2). In his next office visit note of September 13, 2007, Dr. Hough stated that Petitioner had a GI workup due to coughing up blood and it was found he had erosive gastritis, probably from the anti-inflammatories given for the rib injury. Dr. Hough also stated in that same note that since the June work injury Petitioner had a ventral hernia and diastasis recti and it was his opinion that both the herniations were secondary to the fall and further, that the medications prescribed for erosive esophagitis were likely necessitated, to some degree, by the anti-inflammatories prescribed for the work injury (PX2). Dr. Hough also opined that the right rib injury, the right oblique ventral hernia and the para rectus muscle diastasis hernia were related to the fall at work on June 28, 2007 (PX2).

Respondent also argues that it is not liable for payment of several other medical bills submitted by the Petitioner. The Commission agrees that Respondent is not liable for the following medical bills totaling $9,200.15 as they are either unsupported by treatment notes or unrelated to the June 28, 2007 work injury:

McLean County Ortho: 11/12/2008 $80.00 (no supporting treatment notes in record)

OSF St. James Hospital:	11/07/2007	$ 190.75 (blood work)
	11/27/2007	$5,209.90 (stress test)
	07/22/2008	$ 158.75 (PSA)
	12/08/2008	$ 340.50 (blood work)
	06/24/2009	$ 474.75 (blood work)
	08/27/2009	$ 690.25 (PSA and blood work)
	08/31/2009	$ 138.25 (blood work)
	01/05/2010	$ 619.00 (blood work)
	01/19/2010	$1,298.00 (ER, forearm laceration)
		$9,200.15.

The Commission therefore modifies the Arbitrator's Decision on the issue of medical expenses. For the reasons stated above, the medical award is reduced by $9,200.15 and Respondent shall pay $19,491.94 for medical services, as provided in Section 8(a) of the Act.

Penalties and Attorney's Fees

The Arbitrator awarded penalties under §19(k) in the amount of $49,772.22, under §19(l) in the amount of $10,000.00, and §16 fees in the amount of $11,954.44 for a total of $71,726.66 in penalties and fees. The Commission finds, after consideration of the evidence, that Respondent acted reasonably in relying on the opinions of its Section 12 examiner, Dr. Singh, and therefore denying TTD and medical benefits. As such, the Commission vacates the Arbitrator's award of penalties and attorney's fees.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 2, 2010 is hereby modified as stated herein, and all else is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $19,491.94 for medical expenses under §8(a) of the Act, pursuant to the Fee Schedule.

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 is hereby fixed at the sum of $75,000.00. The probable cost of the record to be filed as return to Summons is the sum of $35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

DATED: JUN 16 2011

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drd/adc
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James F. DeMunno

Kevin W. Lamborn

PARTIAL CONCURRENCE AND DISSENT

I disagree with the majority's decision to vacate the Arbitrator's award of penalties and fees. Respondent failed to meet its burden of proving that it acted in an objectively reasonable manner, under all of the existing circumstances, in relying on its Section 12 examiner, Dr. Singh, in denying treatment and benefits. Dr. Singh admitted he performs at least eight Section 12 examinations per week. Dr. Singh also admitted he acts as an expert for employers or carriers 85 to 90 percent of the time. His bias is readily apparent. When Dr. Singh initially examined Petitioner, he noted several positive Waddell signs and recommended Petitioner undergo a functional capacity evaluation to "determine validity of effort." He clearly viewed the validity of the evaluation as the single most important factor in determining whether Petitioner would require work restrictions. RX 1. After the two-day evaluation was determined to be valid, however, with the evaluator noting "consistent reliable performance" and concluding Petitioner could not resume his heavy equipment operator job (PX 3), Dr. Singh abruptly decided to "disagree with the assessment of the functional capacity evaluation" and find Petitioner capable of full duty. Whereas the doctor had previously placed all of his faith in the evaluator, he subsequently criticized the evaluator for giving any consideration to Petitioner's pain complaints, even though the evaluator viewed those complaints as completely legitimate. At his deposition, however, Dr. Singh did another "about face" and conceded that there was a legitimate basis for the conclusions underlying the evaluator's recommendations. RX 2 at 25. He also conceded that Waddell findings are "not an absolute," further undermining his own credibility. RX 2 at 26.

In its Statement of Exceptions, Respondent argues that it acted in good faith in relying on Dr. Singh because the doctor is "a highly experienced and accredited orthopedic surgeon." If credentials alone rendered an expert's opinions worthy of reliance, employers would rarely, if ever, be found liable for penalties and fees. Citing Brinkmann v. Industrial Commission, 82 Ill.2d 462 (1980), Respondent alternatively argues that it acted reasonably in terminating the payment of benefits because a question existed as to whether Petitioner's accident constituted a new injury. In asserting this argument, Respondent conveniently ignores two significant factors: its own stipulation to accident (Arb Exh 1) and its examiner's concession as to causation (albeit only as to a strain).

I respectfully dissent.

Molly C. Mason

Molly C. Mason

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

SALVATOR, GARY
Employee/Petitioner

Case# **07WC036503**

11IWCC0572

G A BLOCKER
Employer/Respondent

On 3/2/2010, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MARK WEISSBURG
25 E WASHINGTON SUITE 900
CHICAGO, IL 60602

G A BLOCKER GRADING
CONTRACTOR INC
18 STONE HILL ROAD
OSWEGO, IL 60543

0210 GANAN & SHAPIRO PC
JAMES M BYRNES
210 W ILLINOIS ST
CHICAGO, IL 60654

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)

Gary Salvator
Employee/Petitioner

v.

G. A. Blocker
Employer/Respondent

Case # **07** WC **36503**

Consolidated cases: ______

11IWCC0572

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Joliet**, on **2/16/2010**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

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

K. ☒ 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 ______

11IWCC0572

Findings

On the date of accident, **6/28/07**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,499.80**; the average weekly wage was **$1534.47**.

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

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

Respondent shall be given a credit of **$68,697.83** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$68,697.83**.

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

Order

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1022.88/week for 136 3/7 weeks, commencing 7/8/7 through 2/16/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 7/8/7 through 2/16/2010, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $68,697.83 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $28,692.09, as provided in Section 8(a) of the Act and shall authorize the surgeries and follow up care as prescribed by Petitioner's treating physicians, as set forth more fully herein.

Penalties

Respondent shall pay to Petitioner penalties of $49772.22, as provided in Section 16 of the Act; $11954.44, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) of the Act.

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

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

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

Robert E. [signature]
Signature of Arbitrator
ICArbDec19(b)

February 24, 2010
Date

MAR - 2 2010

I. On the issue of causal connection, (F), the arbitrator finds the following:

Mr. Salvator has worked for G.A. Blocker since 2002. During that entire time he has worked as a large equipment operator. He has had ongoing issues with his neck and back.

On 7/15/04 Dr. Delheimer notes long standing but progressive neck and back pain, with radiation into the shoulders. A cervical MRI showed a fairly significant left sided C6-7 disc herniation. The plan was to schedule an anterior cervical diskectomy and fusion after he is laid off from work in the fall.

On 12/6/05 Dr. Steven Delheimer prescribed a cervical MRI with a diagnosis of degenerative disc disease status post ACDF C6-7.
An MRI performed on 12/13/05 showed degenerative spurring and disc space narrowing at C6-7

On 1/10/05, Dr. Delheimer diagnosed a herniated disc at C6-7 and performed an anterior cervical diskectomy with allograft bone fusion at C6-7.

There was a recovery period after which Mr. Salvator returned to work full duty for his employer. He continued to experience pain in his neck and back, but was able to perform his job duties. He continued to do so for over two years until his accident on 6/28/07, which is the subject of this claim for benefits. On that day he was getting off a piece of equipment with an oil leak. As he was descending the stairs he fell about 5 feet to hard ground, falling flat on his back and hitting his head. He reported the injury to his foreman, but did not seek medical treatment right away, instead attempting to continue working.

On 7/8/07 the pain had reached a level that Mr. Salvator could no longer tolerate. Mr. Salvator was seen at the ER with back pain and right flank pain. A preliminary radiology report noted "[Patient] with [right flank] pain X 1 Day. [Patient] fell 1 week ago and landed on his right side. Also has right lower rib pain. No [history] of stones." PX1

On 7/12/07 Mr. Salvator was seen by Dr. William Hough after being in the hospital with a right flank pain. It was "basically just contusion of his right chest wall and strain of the right oblique muscle in his abdomen most likely from the fall that he sustained at work four or five days prior to his being hospitalized." The doctor further noted, "He operates heavy equipment machinery for construction. There is no way he should be working taking Flexeril and Hydrocodone." The doctor therefore took Mr. Salvator off work. PX2

On 7/24/07 Dr. William Hough wrote a slip stating "Can't operate machinery – no lifting over 5# - no repetitive lifting, twisting, or bending at waist. No work till pain subsides and is on no pain meds." PX2

On 9/13/07 Dr. Hough noted erosive gastritis "probably from the anti-inflammatories we had been giving him for the rib injury and the injury to his neck and back." Dr. Hough reviewed MRIs and noted disk disease with a lot of arthritic changes and spurring. He noted myofascial spasm across his neck and shoulders. He opined that both his herniations are secondary to the fall. He notes erosive esophagitis "which was more likely induced to some degree by the anti-inflammatories." The diagnosis was degenerative disk disease; degenerative arthritis, cervical and lumbosacral spine; impingement syndrome L3-4, L4-5 with L4 radiculopathy; ventral hernia, right oblique muscle and diastasis rectus herniation; erosive esophagitis with upper GI bleed. PX2

On 10/10/07 Dr. Atwater noted that Mr. Salvator was to remain off work "due to fall at work 6/28/07." The doctor noted low back pain that goes from the buttocks to the thigh. He notes, "It is apparent that the fall caused an aggravation of some degenerative discs and maybe caused some steonsis with a herniation at the 4-5 level that is central foraminal. Secondly, I think it aggravated his neck which has a history of previous fusion at C6-7 with some arthritic changes at C4-5, C5-6 level." PX3

On 11/12/07 Dr. Atwater noted neck and low back pain. He scheduled an epidural steroid injection. He also noted that a provocative discogram of the cervical spine would be reasonable. PX3

On 12/10/07 Dr. Atwater performed a bilateral ESI injection at L4-5. PX3

On 1/9/08 Dr. Atwater notes he has been trying to treat both the neck and lumbar spine "since a fall on 6/28/07 where he immediately had onset of his neck discomfort and his low back discomfort." He opined, "It is my belief to medical certainty that the onset of his symptoms came secondary to the fall on 6/28/07, i.e. the neck pain and also the low back pain. He had pre-existing conditions of some slight degeneration in the cervical spine and also in the lumbar spine, but the aggravation of those symptoms became clearly apparent after the fall in June 2007." PX3

On 1/31/08 Mr. Salvator said he was feeling better after the injection. He was scheduled for a cervical epidural steroid injection and nerve blocks to be performed by Dr. Ji Li. PX3

On 3/5/08 Dr. Atwater noted that the cervical spine injections helped relieve neck pain. PX3

On 3/19/08 Dr. John Atwater noted that Mr. Salvator had pain going down the fight side. He reviewed Mr. Salvator's CT scan and MRI. He opined that the best course would be to consider a revision ACDF at C6-7 in order to help elevate the neuroforamen because the neuroforamen on the right is relatively tight. This would hopefully decrease some of his axial neck pain and radicular discomfort in the right chest and the right arm. PX3

On 3/27/08 Dr. Hough noted, "Patient here as follow up on Workman's Comp. injury which resulted in cervical and lumbar spine disk disease." The diagnosis was cervical degenerative disk disease wth cervical spinal stenosis; lumbar disk disease with lumbar spinal stenosis." PX2

On 5/7/08 at respondent's request Dr. Kern Singh performed a section 12 exam. His diagnosis was cervical strain, lumbar strain, and s/p anterior cervical diskectomy and fusion, C6-7. He opined that petitioner's symptoms were no causally related to his accident on 6/28/07. He agreed that there should be work restrictions of no lifting over 35 pounds, but he did not agree that surgery was appropriate. He suggested an FCE. RX2 The Petitioner reported to Dr. Singh that the pain in his neck and low back was at a level of 10 out of 10 and no type of activity would decrease his pain. (RX 1) The examination by Dr. Singh showed normal strength in the upper and lower extremities, as well as full range of motion in the cervical and lumbar spine. He also had negative seated and supine straight leg raise. (Id.) Dr. Singh noted that the Petitioner exhibited several nonorganic/Waddell findings on examination,

including hyper-exaggeration of the symptoms with percussion of the cervical and lumbar spine, pain with simulated axial loading and pain with simulated axial rotation and a positive distracted straight leg raise in the lumbar spine. (Id.)

Based on his examination, Dr. Singh diagnosed a cervical and lumbar muscular strain and was of the opinion that the current symptoms were not causally related to the work accident of June 28, 2007. (RX 1) He did not feel that surgical intervention was necessary, noting that the MRI scan did not delineate any neural impingement in the cervical spine and there was minimal evidence of central or foraminal stenosis. (Id.) He noted a discrepancy between the subjective symptoms and objective findings, suggesting a potential secondary gain with significant Waddell findings. He recommended a functional capacity evaluation and return to work. (Id.)

The Petitioner participated in the functional capacity evaluation at OSF St. James Medical Center on July 8 and 9, 2008. The results of this evaluation showed an ability to frequently lift up to 25 pounds and occasionally lift up to 35 pounds and the therapist noted that he exhibited an ability to perform at a medium level of work. It was further noted that the position as a heavy equipment operator was established as a light level of work under the Dictionary of Occupational Titles (DOT). It was the opinion of the therapist, however, that the Petitioner was not capable of returning to work as a heavy equipment operator at that time, due to his "elevated pain levels and high pain response to specific positional, flexibility and static work tasks." (PX 3)

Dr. Singh reviewed the FCE and disagreed with the assessment of the therapist that the Petitioner was unable to return to his duties as a heavy equipment operator. In his report of September 1, 2008, Dr. Singh notes that the evaluation found the Petitioner capable of performing work at a medium demand level and his job only requires a light demand level. He refers to the nonorganic and Waddell findings during his examination, including hyper-exaggeration of symptoms, and states that, "I do not believe that the subjective complaints given forth in the FCE can be used as objective criteria for determination of the patient's return to work." (RX 1)

On 5/28/08 Dr. Atwater again took Mr. Salvator off work pending review of the IME report. PX3

On 6/25/08 Dr. Atwater agreed that an FCE is warranted. He also felt a lumbar discogram might be appropriate. PX3

On 7/21/08 Dr. Atwater noted that Mr. Salvator is "unable to return to his job as a heavy equipment operator because of chronic low back pain and cervical discomfort." He opined that Mr. Salvator might benefit from a C6-7 revision ACDF where hemicorpectomies are going to be performed to remove the old bone and then subsequently realign the disc space. This would help resolve his axial low back pain syndrome and his radiculopathy in his lower extremities. PX3

On 8/26/08 Dr. Hough notes, "everybody now seems to be in agreement that he is disabled from doing construction work which is what he has done all his life." He further notes, "I did write a note to his former employer that he remains totally disabled and unable to perform work which is confirmed by his functional capacity examination." PX2

On 9/1/08 respondent's section 12 doctor, Dr. Singh, reviewed the FCE report from 7/8/08 and 7/9/08. The FCE was valid. Dr. Singh stated that the work of a heavy equipment operator was light level work. Dr. Singh opined that Mr. Salvator could return to work full duty. RX2

On 10/6/08 Dr. Hough notes, "Patient here for re-evaluation of chronic medical problems most of which center around work injury which occurred well over a year ago in which he sustained injury to his neck and back and since then the patient has been found to have degenerative disk disease in his spine. Secondary to that he has a lot of weakness in his lower legs because of spinal stenosis and paraparesis. He also developed a bulge in his right upper quadrant, identified as ventral hernia which wasn't there prior to the fall. Patient has had to take a lot of pain medication as well as anti-inflammatories which has in turn created GERD and Nsaid induced gastritis issues so he has had to take PPI and Carafate on a regular basis." The diagnosis was degenerative disk disease, lumbosacral spine; paraparesis, lower extremities; chronic pain syndrome; GERD (Nsaid induced gastritis); ventral abdominal hernia, right upper quadrant. PX2

On 10/17/08 Dr. Hough noted that nothing had changed. He noted, "I once again wrote that he is disabled and he cannot go back to his previous line of work which was basically construction and moderate to heavy lifting. This has not changed and it will not change. Certainly after he has a surgical correction of both lumbar and cervical disk problems he will not be able to go back to this line of work. Right now he is not even fit for sedentary work or even desk work because of the amount of drugs that he takes for pain relief would render him basically unreliable for any type of cognitive type of work." PX2

On 11/3/08 Dr. Hough continued Mr. Salvator off work "due to injury dated 6/28/07." On this date he also authored a report in which he stated "I believe that the accident which occurred 6-28-07 is directly and causally related to his cervical disk disease as well as his lumbar disk disease, in addition to the ventral hernia which he also suffered in that fall, he still is in a great deal of pain." He further stated, "I defer to Dr. Atwater and Dr. Grieco whom he has seen regarding the disk disease and the ventral hernia. Both of them feel that he will need surgery to fix these entities . . .". "I firmly disagree with Dr. Singh's evaluation that the FCE is invalid and that he should be able to return to work because his job is light duty. I really believe Dr. Singh needs to know exactly what Mr. Salvator does for a living, and it is anything but light duty." PX2

On 11/12/08 Dr. Atwater continued Mr. Salvator off work "due to injury sustained at work on 6-28-07." PX3

On 12/29/08 Dr. Hough noted "Patient had an accident in June, 2007 which left him with injuries which are now being fought over regarding etiology as well as what to do about them." PX2

On 1/26/09 Dr. Hough saw Mr. Salvator for re-evaluation of his back and work status. He noted that Mr. Salvator was still disabled from work. PX2

On 2/23/09 Dr. Hough noted "He really needs surgery on both his cervical and lumbar spine but it is one of those cases where everybody argues about who is responsible for it so therefore not really much of anything is getting done." PX2

On 3/26/09 Dr. Hough wrote "unable to work due to work injury occurring on 6/28/07. Remains totally disabled." He noted limited motion in neck and low back. PX2

On 4/24/09 Mr. Salvator was interviewed by Certified Rehabilitation Counselor Susan A. Entenberg. She noted that his former job of operating engineer is considered to be medium in terms of exertional level. She further noted:

> Upon review of the medical records and my interview with Mr. Salvator, it is my opinion that Mr. Salvator is not capable of returning to his past work as an operating engineer or as a truck driver. It is further my opinion that Mr. Salvator is not an appropriate candidate for a vocational rehabilitation program nor does a stable labor market exist for him. These opinions are based on the following:
>
> Mr. Salvator is not released to work by his treating physicians. At best, an FCE limited him to light activity, but recognized his high level of pain and interference with functional tasks. His past work is medium in exertion and requires significant bouncing and jolting and is therefore precluded based on all restrictions.
>
> Mr. Salvator has been an operating engineer and truck driver for his entire work history, has a high school education, remains in severe pain and has difficulties maintaining any position for any extended period of time. He has a significant amount of bad days, in which he is ill and remains in bed for most of the day. He would have difficulty performing Light or sedentary activity on a sustained basis due to his chronic pain, and his inability to be reliable on a daily basis. Dr. Atwater has recommended the possibility of surgical intervention, both at the cervical and the lumbar areas. It is therefore my opinion that a stable labor market does not exist for him.
>
> It is my also opinion that Mr. Salvator is not an appropriate candidate for vocational rehabilitation.
>
> . . .
>
> In summary, it is my opinion that Mr. Salvator cannot return to his past work as an operating engineer. It is further my opinion that Mr. Salvator is not an appropriate candidate for job placement and that a stable labor market does not exist for him.

PX9.

Mr. Salvator testified at trial that if the surgery that his treating doctors have recommended were authorized by Workers' Compensation he would go through with the surgery. Therefore a permanency determination would be premature as his condition has not stabilized.

While it is clear that Mr. Salvator had ongoing neck and back pain from as far back as 2004, it is equally clear that on 6/28/07 he sustained a serious traumatic incident at work that aggravated that condition, with the pain reaching a new intensity. There had been no prescription for surgery in the two years prior to this accident, but now surgery is recommended. He was able to work full duty before this accident, now he cannot work at all. He now has trouble with simple day to day tasks and his sleeping is impaired.

It is noteworthy that respondent's section 12 doctor, Dr. Singh, focused on the misstatement in the FCE that Mr. Salvator's work was exertionally light, but he chose to ignore the conclusion in that same document that Mr. Salvator could not return to work.

The treating doctors have been clear and consistent in their repeated statements that the current condition and need for treatment is causally related to the work accident on 6/28/2007. The arbitrator gives great weight to these opinions and finds causation.

Based upon the above and the record as a whole the arbitrator finds that petitioner's condition of ill being arose out of and in the course of the 6/28/07 work accident.

II. On the issue of the average weekly wage, (G), the arbitrator finds the following:

Petitioner testified that overtime is mandatory and that he is required to be available for work 7 days a week. In *Sylvester v. Industrial Comm'n*, 197 Ill. 2d 225, 756 N.E.2d 822 (4th Dist. 2001), our supreme court noted that section 10 provides four methods of calculating average weekly wage: (1) by default, average weekly wage is "actual earnings" during the 52-week period preceding the date of injury, illness or disablement, divided by 52; (2) if the employee lost five or more calendar days during that 52-week period, "whether or not in the same week," then the employee's earnings are divided not by 52, but by "the number of weeks and parts thereof remaining after the time so lost has been deducted;" (3) if the employee's employment began during the 52-week period, the earnings during employment are divided by "the number of weeks and parts thereof during which the employee actually earned wages;" and (4) if the employment has been of such short duration or the terms of the employment of such casual nature that it is "impractical" to use one of the other three methods to calculate average weekly wage regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer. *Sylvester*, 756 N.E.2d 822.

In the present case the appropriate method is the second. The calculation is therefore as follows:

ANALYSIS OF THE AVERAGE WEEKLY WAGE UNDER SECTION 10 OF THE ACT.

Period Ending	Gross	O.T.Prem	Hours	Days	Wks	Vac	Wage
6/23/2007	$1,493.50	$137.20	33.00	5.00	0.71		$1,356.30
6/16/2007	$2,979.40	$431.20	62.00	7.00	1.00		$2,548.20
6/9/2007	$2,277.55	$284.20	48.50	7.00	1.00		$1,993.35
6/2/2007	$1,714.80	$235.20	36.00	5.00	0.71		$1,479.60
5/26/2007	$2,372.40	$235.20	52.00	7.00	1.00		$2,137.20
5/19/2007	$2,635.20	$313.60	56.00	7.00	1.00		$2,321.60
5/12/2007	$2,736.60	$352.80	58.00	7.00	1.00		$2,383.80
5/5/2007	$2,736.60	$352.80	58.00	7.00	1.00		$2,383.80
4/28/2007	$982.60	$78.20	22.00	3.00	0.43		$904.40
4/21/2007	$2,736.60	$352.80	58.00	7.00	1.00		$2,383.80
4/14/2007	$532.40	$39.20	12.00	2.00	0.29		$493.20
12/2/2006	$1,229.20	$78.40	28.00	4.00	0.57		$1,150.80
11/25/2006	$2,286.40	$313.60	55.20	7.00	1.00		$1,972.80
11/11/2006	$2,230.40	$313.60	88.00	7.00	1.00		$1,916.80
11/4/2006	$2,637.60	$352.80	58.00	7.00	1.00		$2,284.80
10/21/2006	$1,174.80	$352.80	20.00	3.00	0.43		$822.00
10/14/2006	$2,100.50	$333.20	43.00	6.00	0.86		$1,767.30

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10/7/2006	$966.15	$205.80	18.50	3.00	0.43		$760.35
9/30/2006	$2,407.80	$352.80	50.00	7.00	1.00		$2,055.00
9/23/2006	$2,116.95	$205.80	46.50	6.00	0.86		$1,911.15
9/9/2006	$1,057.20	$235.20	20.00	3.00	0.43		$822.00
9/2/2006	$935.80	$196.00	18.00	3.00	0.43		$739.80
8/26/2006	$982.60	$78.40	22.00	3.00	0.43		$904.20
8/19/2006	$1,922.20	$196.00	42.00	6.00	0.86		$1,726.20
8/12/2006	$2,075.20	$431.20	40.00	5.00	0.71		$1,644.00
8/5/2006	$1,918.40	$274.40	40.00	5.00	0.71		$1,644.00
7/29/2006	$2,316.75	$323.40	48.00	6.00	0.86		$1,993.35
Totals	**$51,555.60**	**$7,055.80**	**1132.70**	**145.00**	**20.71**	**0.00**	**$44,499.80**

TOTAL EARNINGS UNDER SECTION 10:	$44,499.80
NUMBER OF WEEKS AND PARTS THEREOF WORKED:	29
SECTION 10 AVERAGE WEEKLY WAGE:	$1534.47

Based upon the above the arbitrator finds the average weekly wage is $1534.47 per week.

III. On the issue of medical services, (J), the arbitrator finds the following:

The arbitrator finds that the respondent is liable under Section 8(a) for all medical bills incurred as stated in petitioner's exhibit x. Petitioner has requested payment for the following bills:

The arbitrator adopts Dr. Hough and Atwater's opinions, and further finds based upon the treatment records that all treatment was reasonable and necessary to cure petitioner of his condition of ill being. (PX2,3,8).

The respondent must pay the following bills:

Provider	Beginning	Ending	Total	WC Pd.	Balance
Bloomington Medical Lab. Physicians	8/21/2007	8/22/2007	$637.20	$0.00	$637.20
Duffy Ambulance Services	8/21/2007	8/21/2007	$708.00	$0.00	$708.00
McLean County Orthopedics	8/29/2007	12/12/2008	$16,440.00	$11,808.35	$4,631.65
Mid-Central IL Gastro	8/21/2007	8/22/2007	$1,172.00	$0.00	$1,172.00
OSF Medical Group	7/9/2007	1/14/2010	$2,424.57	$1,093.82	$1,330.75
OSF St. James Hospital	7/8/2007	1/19/2010	$36,104.05	$15,910.78	$20,193.27
Wal-Mart Pharmacy	7/16/2007	9/2/2008	$19.22	$0.00	$19.22
Total			**$57,505.04**	**$28,812.95**	**$28,692.09**

IV. On the issue of prospective medical care, (K), the arbitrator finds the following:

The surgery recommended by the treating doctors is awarded as well as any follow up care.

V. On the issue of temporary total disability, (L), the arbitrator finds the following:

A review of the medical records indicates petitioner was kept off work for 136 3/7 weeks. His temporary total disability rate is $1022.88, resulting in a total temporary total disability amount of $139,550.18. Subtracting the credit of $68,697.83 leaves a balance due of $70,852.35.

Respondent shall pay Petitioner temporary total disability benefits of $1022.88/week for 136 3/7 weeks, commencing 7/8/7 through 2/16/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 7/8/7 through 2/16/2010, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $68,697.83 for temporary total disability benefits that have been paid. This leaves a balance due of $70852.35to be paid to petitioner through his attorney.

VI. On the issue of penalties, (M), the arbitrator finds the following:

Petitioner has filed a petition for penalties and attorneys' fees under §19(k), §19(l) and §16 of the Act.

A Section 19(k)

Respondent has apparently relied on the opinion of Dr. Singh in denying the claim. However, as discussed above, his opinion is based on his bizarre reading of the FCE report. It is abundantly clear from the medical records, as well as the FCE that Dr. Singh pretends to rely upon, that petitioner is not able to work with the level of pain he experiences and the medication he is currently taking. Dr. Singh testified:

> during his accident, on June 28, 2007, he did sustain a cervical and lumbar muscular strain.

RX2 at 19. This is absurd on its face, given the extensive medical records documenting a condition far more serious than a muscular strain. The only rational explanation for Dr. Singh's opinion in this matter is found in this admission:

> 24 Q. In how many cases – and you can express this as raw numbers or a percentage, whatever is easiest for you. In how many cases are you hired as an expert by a respondent or defendant as opposed to a plaintiff or petitioner? A. I would say it's approximately 85 to 90 percent for the insurance company or the employer.

He further testified:

> 22
> A. I do four to five independent medical exams per clinic. A. And a typical week is about two clinics a week or two-and-a-half clinics a week.

At minimum this would mean that Dr. Singh is doing 8 independent medical exams per week. At most it would be more than 12 a week.

Respondent has deprived petitioner of needed medical care and income without any rational basis. The opinion of Dr. Singh seems to be biased. His opinion is completely at odds with the medical record and the opinions of the treating doctors.

In denying compensation, the respondent has not reasonably relied in good faith on a medical opinion, and has not met the burden of demonstrating a reasonable belief that its denial of liability was justified under the circumstances, as required by *Continental Distrib. Co. v. Indus. Comm'n*, 98 Ill.2d 407, 456 N.E.2d 847 (1983), *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 20, 442 N.E.2d 883 (1982) ("*Norwood*" case) and *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 1, 442 N.E.2d 861 (1982) ("*Tully*" case). In *Tully*, the Illinois Supreme Court held that where a delay has occurred in payment of workers' compensation benefits, the employer bears the burden of justifying the delay and the standard he is held to is one of objective reasonableness in his belief. Thus it is not good enough to merely assert honest belief that the employee's claim is invalid or that his award is not supported by the evidence; the employer's belief is "honest" only if the facts that a reasonable person in the employer's position would have would justify it. 42 N.E.2d at 865. The Court added in *Norwood* that the question whether an employer's conduct justifies the imposition of penalties is a factual question for the Commission. The employer's conduct is considered in terms of reasonableness. 442 N.E.2d at 885. It was further held in *Continental Distributing* that a Respondent's reliance on its own physician's opinion does not establish, by itself, that its challenge to liability was made in good faith. The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all the circumstances presented. 56 N.E.2d at 851. Moreover, the Appellate Court has noted that the burden of proof of the reasonableness of its conduct is upon the employer. *Consol. Freightways, Inc. v. Indus. Comm'n*, 136 Ill.App.3d 630, 483 N.E.2d 652, 654 (1985); accord, *Ford Motor Co. v. Indus. Comm'n*, 140 Ill.App.3d, 488 N.E.2d 1296 (1986).

Based on the failure of respondent to present a reasonable basis for denying TTD benefits and medical treatment, there has been an unreasonable delay of payment. There has been a failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of the Act (relating to payment of TTD), which is presumed to be an unreasonable delay. 820 ILCS 305/19. There has also been an unreasonable delay in payment of medical bills, without adequate basis for that decision.

Accordingly, the Arbitrator finds that Respondent shall pay penalties under §19(k) in the amount of **$49,772.22**, representing fifty percent of the total amount due to date in TTD and medical expenses.

B Section19(L)

Respondent has failed to pay TTD for more than 530 days. The Arbitrator therefore finds, pursuant to section19(l) of the Act, that Respondent shall pay the maximum sum of **$10,000**.

C Section16

Pursuant to §16 of the Act, the Arbitrator finds that Respondent shall pay attorneys' fees calculated upon the above penalties. Accordingly, Respondent shall pay the sum of **$11954.44**in attorneys' fees, with the remainder of Petitioner's attorneys' fees, if any, to be paid by Petitioner to his attorneys.

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

George Wiekert,

Petitioner,

vs. NO: 11 WC 06418

12IWCC0769

Lazer Spot, Inc.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, causal connection, medical expenses, prospective medical expenses, credit 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 5, 2012 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.

12IWCC0769

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 probable cost of the record to be filed as return to Summons is the sum of $35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

DATED: JUL 19 2012

MB/mam
o:7/12/12
43

Mario Basurto

David L. Gore

Michael P. Latz

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

WIEKERT, GEORGE
Employee/Petitioner

Case# **11WC006418**

12IWCC0769

LAZER SPOT INC
Employer/Respondent

On 1/5/2012, an arbitration decision on this case 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:

0412 JAMES M RIDGE & ASSOC
CAROLEANN GALLAGHER
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL PO 1288
ROCKFORD, IL 61105-1288

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)

George Wiekert — Employee/Petitioner — Case # 11WC 06418

v.

Lazer Spot, Inc. — Employer/Respondent — Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Joliet**, on **12/20/2011**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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: 12IWCC0769

On the September 10, 2010 Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,786.00**; the average weekly wage was **$880.50**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** children under 18.

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

Respondent shall be given a credit of **$8,923.05** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,923.05**.

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

ORDER:

Respondent shall pay Petitioner Total Temporary Benefits of $587.00 per week for 53 and 6/7th weeks for the following periods; September 11, 2010 through January 5,2011 and April 4, 2011 through December 20, 2011 representing as provided in Section 8 (b) of the Act because the injuries sustained caused the disabling condition of the Petitioner.

The disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19 (b) of the Act.

Respondent shall pay $1,387.42 in Medical expenses as provided in Section 8 (a) of the Act, subject to the Medical Fee Schedule created by Section 8.2 of the Act.

Respondent shall be liable for the prospective medical care and treatment prescribed by Dr. Anthony Rinella and Dr. Ronald Michaels to include repeat imaging studies, physical therapy and epidural steroid injections.

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

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

[signature]
Signature of Arbitrator

December 28, 2011
Date

ICArbDec19(b)

JAN 5 - 2012

12IWCC0769

STATEMENT OF FACTS:

Mr. Wiekert is a dock spotter who worked for Lazer Spot Inc for approximately three years when he was involved in a work related accident on September 10, 2010. He was employed by the Respondent as a dock spotter. The physical aspects of the job included getting in and out of the trucks, going up and down ladders and/or stairs, opening and closing heavy doors, lifting goods and unloading and loading the trucks.

On September 10, 2010 at approximately 10.50 am he was unloading a truck and was attempting to close the door on the truck, when the door got stuck. The truck door which was made of steel weighed approximately 600 pounds. Mr. Wiekert was using his arms to pull down on the door when he felt a 'pop' in his neck area and he experienced immediate severe pain in his neck into his back area. The pain was so severe that it caused him to drop to his knees. After a few minutes he composed himself and then went to the guard shack to talk to Frank, the head security guard. He advised Frank of what had happened. He sat in the guard shack for up to an hour trying to work out the pain. After about an hour he returned to his job and finished his shift at approximately 4.45 pm.

While in the guard shack, Mr. Wiekert attempted to make contact with his Supervisor Robert Cook. Mr. Cook did not answer the phone and the Petitioner left a voice mail on Mr. Cook's office phone to advise him that he has hurt his back area. He asked for a call back. He never received a call back. He also retrieved his time sheet from a folder in the guard shack and he wrote on the sheet the facts of how he was hurt. He indicated that he had pain in his neck and back area and that it had caused him to fall to his knees. The Petitioner then returned the time sheet to its folder and after about an hour he went back to work. **(P.E. # 4)**

On September 22, 2010 the Petitioner faxed a copy of the time sheet to his supervisor Robert Cook. He received confirmation that the said fax was delivered. Mr. Wiekert also indicated that he had e mailed Mr. Cook about the accident to inform him that he had injured himself on September 10, 2010. He never had a response to any of the contact that he attempted to make with Mr. Cook

The Petitioner's accident occurred on a Friday and he called that day to make an appointment to see his primary care doctor, Dr. Marlene Henze. The earliest appointment he could get was Monday September 20, 2010. He rested up over the weekend and was in a lot of pain. He returned to work on Monday September 13, 2010 and attempted to carry out his regular job for the remainder of that week and he then saw Dr. Henze. The Petitioner did manage to work his regular job before he saw Dr. Henze but he was in pain and did so with great difficulty.

On September 20, 2010 when he was examined by Dr. Henze, the Petitioner complained of lower back pain and neck pain following an injury at work when he felt a "popping" in his neck. He also complained of shoulder pain on the left and dizziness. Dr. Henze recommended an MRI of Petitioner's brain, an MRI of his cervical and lumbar spine and a CT scan. Dr. Henze took the Petitioner off of work at this time. **(P.E. # 1)**

The Petitioner did not have the MRI's or CT carried out at this time as they were not approved by the workers compensation carrier.

Mr. Wiekert returned to see Dr. Henze on October 22, 2010. He continued to complain of neck and back pain, dizzy spells, blurred vision, difficulty getting from a sitting to standing position, numbness to the left and right legs. He complained further of both feet dropping and parathesis to his upper extremity on both his left and right side. Dr. Henze noted an antalgic gait, increased pain to his lumbar sacral region and decreasing range of motion in his neck. She prescribed pain medication and she continued to recommend the imaging studies that she had earlier recommended. She wanted Mr. Wiekert to return to see her in 2-3 weeks. Dr. Henze continued the Petitioner off work at this time.
(P.E. # 1)

The MRI that were recommended were eventually approved by the workers compensation carrier and were carried out on October 25, 2010 and they revealed the following;

Cervical Spine: Disc protrusion on the sagittal images at C3-4. Significant foraminal stenosis on the axial images on the left at C3-4 as well as a central disc herniation at C4-5. It was unclear if there was a compression at C5-6 as there was a motion artifact present at that level.

Lumbar spine: Left sided foraminal stenosis at L5-S1, left sided disc herniation at L4-5 and moderate central stenosis at L3-4. **(P. E. # 2)**

The Petitioner was examined by Dr. Henze on November 5, 2010. There were no improvements in his symptoms. He continued to have dizziness. Dr. Henze noted that his neck had poor range of motion and he still had an antalgic gait. Dr. Henze added steroids to his current pain medications and ordered that the Petitioner commence physical therapy. She also referred the Petitioner for further evaluation to a neurologist. Dr. Henze continued the Petitioner off work. The evaluation by a neurologist was however not approved by the workers compensation carrier and the Petitioner did not see a neurologist at this time. **(P.E. # 1)**

Mr. Wiekert commenced physical therapy and underwent this for approximately five weeks. He did not notice any improvement in his symptoms, in fact he felt as if the physical therapy was making things worse. He remained off work on the recommendation of Dr. Henze.

The workers compensation carrier hired a nurse case manager and the Petitioner was advised by that nurse case manager that he should commence treatment with a Dr. Anthony Rinella of the Illinois Spine and Scoliosis Center in Homer Glen. The Petitioner expressed a preference to go and see the neurologist that Dr. Henze had recommended but the nurse case manager assured him he would be in good hands with Dr. Rinella . The petitioner testified that the nurse case manager advised him that the neurologist he was referred to by Dr. Henze was a "butcher" and that he would be in better hands with Dr. Rinella and that he should treat with him.

At his first appointment with Dr. Rinella on December 8, 2010, the petitioner complained of numbness and tingling throughout the right upper extremity, which seemed to focus on the right thumb, numbness and tingling over the anterior thigh and anterior aspect of the right lower extremity. He also complained of headaches about the occipital region since the date of injury.

Dr. Rinella noted that in terms of his neck he had a 50% of expected flexion/extension as well as 45 degrees of rotation bilaterally. From a strength perspective and reflex perspective he was neurologically intact. He had diminished sensation in the right C6 and C7 nerve root distribution. In

the thoracolumbar spine he had tenderness at the lumbosacral junction. He had significant pain over bilateral sacroiliac joints (left greater than the right).

Dr. Rinella's diagnoses were as follows: (1). Cervical strain, (2). Cervical spondylotic radiculopathy, (3). Lumbar strain, (4). Lumbar spondylotic radiculopathy.

Dr. Rinella recommended that the petitioner undergo epidural steroid injections both in his cervical and lumbar spine. He specifically believed that the Petitioner would benefit from a C 3-4 and C4-5 injection as well as a L3-4 and L4-5 epidural steroid injections. Dr. Rinella was confident this would address the cervical headaches as well as the lumbar spondylotic radiculopathy that the Petitioner was experiencing. Dr. Rinella recommended that the Petitioner discontinue physical therapy as it only made things worse in terms of the Petitioners overall symptoms. Dr. Rinella indicated that he should follow up with him in four to six weeks.

In terms of his work ability Dr. Rinella was of the opinion that the Petitioner could return to work at a sedentary level with 10 minute breaks per hour, after he had obtained the steroid injections. (Emphasis added) **(P.E. # 2)**

The workers compensation carrier rejected approval of the epidural steroid injections which had been recommended by their own choice of treating doctor. The Petitioner did not return to Dr. Rinella after the 4-6 week period as he felt it was futile to do so given that he had not had the injections that Dr. Rinella had recommended.

On December 29, 2010 the Petitioner received a letter from Melissa Burdick, the workers compensation claims administrator for the Respondent, informing him that transitional employment was available to him at the Respondents Company and that he should report for work to Mr. Robert Cook on Tuesday January 4, 2011. **(P.E # 7)**

The Petitioner returned to work on this date and worked in a light duty capacity for the Respondents from January 5, 2011 until April 4, 2011 when he was suspended without pay from the Respondents employment. The Petitioner indicated that on the day in question he was working at a customer's premises at Kraft Foods. He was approached by a supervisor/manager for Kraft Foods who asked him what was wrong with him, as it was clear that the Petitioner was limping. Mr. Wiekert indicated that he was injured at work and that he was waiting for treatment and that matters were delayed because it was a workers compensation claim. That was the extent of the conversation. He continued to do his job for a couple of hours more and he was then approached by an employee of the Respondent company named Aaron and he was told that he was being sent home. He was not given any reason as to why he was being sent home. He left work that day and has not been permitted to return since that date. He has tried to make contact with the Company but he was unsuccessful and no one ever called him back. He has not received any income whatsoever since April 4, 2011.

The Petitioner attended for a follow up visit with Dr. Rinella on August 18, 2011. On this occasion he complained of lumbar back pain, bilateral anterior thigh pain and bilateral hand numbness. He also complained of cervical spine tenderness and left knee tenderness that was getting worse with time. The Petitioner indicated that he had pain in both of his thighs which caused him to loose strength in his legs and on one occasion on a date unknown he feel onto his left knee as his leg gave way from under him. It was on this occasion that he hurt his left knee initially. The Petitioner had been experiencing bilateral thigh pain and numbness since the date of his work accident on September 10, 2010.

On August 18, 2011 Dr. Rinella noted that Mr. Wiekert stood with a forward pitched posture. He had tenderness in his cervical spine that limited his rotation to 45 degrees. He had slow flexion and extension and he guarded his upper extremities. He had left knee pain along his medial meniscus.

Dr. Rinella recommended the following:

(1). A new MRI of the Petitioners cervical and lumbar spine.
(2). Physical therapy for the left knee injury and;
(3). He continued to recommend epidural injections for the cervical and lumbar spine.

In terms of his work capabilities Dr. Rinella indicated that the Petitioner could work light duty with a 10 pound lifting restriction, no repetitive bending and twisting and no overhead activity. He advised Mr. Wiekert to follow up with him after he had obtained the new imaging studies. **(P.E. # 2)**

Approval for the imaging studies, the injections to his cervical or lumbar spine or the physical therapy on his left knee was never forthcoming despite the fact that these recommendations were made by a doctor that the Company chosen to send the Petitioner to for treatment.

The Petitioner cannot afford his own insurance at this time given that he has had no income since April 4, 2011. The only treatment that the Petitioner has had since his work related accident of September 10, 2010, has been five weeks of physical therapy which he indicates made his situation worse.

Mr. Wiekert did eventually go to see the neurologist to whom he was referred by Dr. Marlene Henze. He saw Dr. Ronald Michaels on November 14, 2011. Dr. Michaels agreed to see Mr. Wiekert after he accepted a letter of protection from Mr. Wiekert's attorneys. Mr. Wiekert made the appointment with Dr. Michaels on the recommendation of Dr. Henze who had referred him to Dr. Michaels when she initially examined him.

On November 14, 2011 when he was examined by Dr. Michaels he complained of neck pain with bilateral arm pain equal on both sides, bilateral shoulder pain, bilateral hand numbness and tingling worse on the left than the right, to the point that he was dropping objects out of his left hand. In addition he complained of severe low back pain much worse than bilateral leg pain, which was worse on the left than on the right, his pains were worse when he walked. He complained of bilateral lower extremity numbness and tingling worse on the left than on the right. He also complained of bilateral extremity weakness to the point where his legs gave out, which was equally severe on both sides. He also complained of left knee pain since March of 2011.

Dr. Michaels wished to update the MRI studies as the only ones available were from October 2010. Dr. Michaels did not make any other recommendations at this time as he obviously would need the benefit of the new imaging studies to make any such recommendations.

The new MRI's had not been authorized by the workers compensation carrier at the time of trial.

<u>Testimony of Dr. Anthony Rinella, Orthopaedic Surgeon,Illinois Spine & Scolosis Centre:</u>

The Petitioner had to schedule the deposition of Dr. Rinella in order to present medical evidence of the Petitioner's disability. The deposition was taken on November 30, 2011 and the transcript of same was admitted into evidence at the trial of this action. Dr. Rinella is a board certified orthopedic spine specialist.

Dr. Rinella undertook treatment of Mr. Wiekert after he had been assigned his case by the workers compensation nurse case manager. He saw him initially on December 7, 2010. On this occasion he had pain in his neck, his mid thoracic spine and his lumbar spine. He also had pain in his left anterior thigh as well as occipital headaches and he noted numbness in his right arm and in both legs. The Petitioner had given Dr. Rinella a history of being involved in a work related accident on September 10, 2010 in which "he was attempting to close an overhead door pulling from a right to left direction when he felt the symptoms begin". **(P.E. # 8, TR, Pg. 7)**

Dr. Rinella indicated that the Petitioner had a disc herniation many years ago before this work related accident but he had no sequelae after that and had no symptoms whatsoever prior to his work related accident on September 10, 2010.

Dr. Rinella carried out a physical exam on Mr. Wiekert and noted that he had a 20% range of motion in all planes in terms of his neck and he had diminished sensation in the right C6 and C7 nerve root distribution. In his thoracolumbar spine he had tenderness in his low back as well as tenderness over his sacroiliac joints more on the left than the right. **(P.E. # 10 Tr. Pg. 7)**

Dr. Rinella also viewed two MRI's of the Petitioners cervical spine and lumbar spine and indicated that the cervical spine showed disc protrusion at C3-4. On the axial images there was foraminal narrowing on the left at C3-4 as well as a central disc herniation at C4-5. The remainder of the study was difficult for Dr. Rinella to interpret because of motion artifact. In the lumbar spine he had a left sided foraminal stenosis at L5-S1 as well as left sided disc herniation at L4-5 and moderate central stenosis at L3-4.
(P.E. # 10 Tr. Pg. 8)

Dr. Rinella indicated that in terms of the foraminal stenosis that this in layman's terms basically meant a pinched nerve and at the levels that this was exhibited by the Petitioner it could "definitely cause in his neck the occipital headaches which are back of the head headaches, and may have contributed to some of his symptoms in his arm. And in his lumbar spine it may have contributed to the numbness in his legs and the pain in his anterior thigh" **(P. E # 10, Tr. Pg. 9)**

Dr. Rinella indicated that in terms of the herniated disc, it meant that the back of the Petitioner's disc was protruding back towards the nerves causing at times pressure on the nerves and therefore causing him to have pain.

Based upon the imaging studies and Dr. Rinella's physical exam, Dr. Rinella was of the view that the Petitioner had a cervical lumbar strain with associated lumbar and cervical radiculopathies.
(P.E. # 10, Tr. Pg. 10)

Dr. Rinella recommended a series of epidural injections in both the Petitioners cervical and lumbar spines to address to what extent those various areas of pinching were causing his symptoms. Specifically he thought that the Petitioner would benefit from a C3-4 and C4-5 nerve root injection as well as a L3-4 and L4-5 nerve root injection. Dr. Rinella discontinued physical therapy as it was causing the Petitioner pain. **(P.E. # 10, Tr. Pg. 10)**

Dr. Rinella opined that the Petitioner was able to work at sedentary level per US Department of Labor Statutes which was essentially less than 10 pounds of lifting. He also recommended that the Petitioner have ten minute breaks every hour to stretch as needed. Dr. Rinella indicated that he made these recommendations on the basis of the capabilities that the Petitioner exhibited. He advised the Petitioner to follow up with him in four to six weeks.

Dr. Rinella did not treat the Petitioner again until August 18, 2011. The Petitioner continued to have neck tenderness and he had a new left knee tenderness that had been getting worse over time. He also complained of bilateral anterior thigh pain as opposed to unilateral pain which he complained of in his earlier visits. In general the Petitioner felt as if he was deteriorating.

(P.E. # 10, TR, Pg. 12)

Dr. Rinella noted that the Petitioner stood with a forward pitched posture which he said was common for people with pinched nerves in their back. He had limited range of motion in his neck and in his upper extremity. He was guarding his arms. He had tenderness along the medial meniscus of his knee that he developed after a fall.

Dr. Rinella recommended a new MRI of his cervical and lumbar spine as his previous studies were between 10 and 11 months old. He recommended physical therapy for the Petitioners left knee as well as the same recommendations for epidural steroid injections. He continued the Petitioners work restrictions and asked him to follow up after the imaging studies were carried out.

The imaging studies have never been carried out and the Petitioner did not follow up with Dr. Rinella. The tests were never approved by the workers compensation carrier. Mr. Wiekert has had no treatment for his condition other than five weeks of physical therapy that simply worsened his situation.

Dr. Kern Singh:

The Petitioner was sent to Dr. Kern Singh on two occasions by the Respondents for the purposes of preparing two reports for litigation purposes. The initial exam took place on December 22, 2010. On that occasion, Dr. Singh recorded that "on September 10, 2010, the Petitioner was working overheard, reaching high above where he was pulling down a trailer door, weighing approximately 800 pounds. The trailer door was jammed, he pulled hard and suddenly and then was brought down by the trailer door. He states that he was twisted into a pretzel." **(R.E. # 1)**

Dr. Singh noted that the petitioner rated his pain as a ten out of ten and that his pain had been worsening in nature. The pain was increased with climbing stairs, walking and lying on his back. He noted that he had had physical therapy, heat and ice with minimal relief. Dr. Singh diagnosed the Petitioner as follows:

1. Cervical degenerative disc disease C5-6 and C6-7
2. Degenerative disc disease L4-L5,
3. Cervical muscular strain,
4. Lumbar muscular strain.

Dr. Singh recommended that the Petitioner work light duty with less than 10 pounds of lifting, less than ten pounds of push/pull activities with minimal bending, kneeling, stooping and squatting. Dr. Singh also recommended that the Petitioner undergo a program of work conditioning which he did undergo.

The above work restrictions are identical to the work restrictions placed on the Petitioner by Dr. Rinella when he saw him on December 8 2010 and again on August 18, 2011.

Dr. Singh saw the Petitioner again on June 1, 2011. At this point the Petitioner had been suspended from his job, was not working and had no income. His complaints remained the same. He continued to complain of neck pain on a scale of 9 out of 10 and low back pain on a scale of 10 out of 10. Dr. Singh noted that he could only sit, stand and walk for one minute at a time. On this occasion despite that fact that his symptoms had not improved Dr. Singh indicated that the Petitioner has sustained a soft tissue muscular strain which had resolved. He therefore indicated that the Petitioner was at MMI and could return to work full duty work without restrictions. He was concerned about symptom magnification. Dr. Rinella testified that he did not have any concerns of symptom magnification when he examined the Petitioner. **(P.E. # 10, Tr. Pg. 23).**

The petitioner testified that he spent in total approximately five minutes with Dr. Singh and that Dr. Singh only carried out a physical exam for at most 2-3 minutes. He testified that between December of 2010 when he first saw Dr. Singh and June of 2011 when he next saw him, he had had no treatment whatsoever and his symptoms had worsened not improved.

Dr. Singh indicated that epidural injections would not be appropriate for the Petitioner because he did not have any evidence of radicular symptoms and because the changes on his MRI's were degenerative in nature.

Dr. Rinella distinctly disagreed with this opinion. Dr. Rinella specifically noted that Mr. Wiekert had radicular symptoms in "both his upper extremity which included headaches, some radiating into his arms and lumpar spine issues which were mostly anterior thigh pain and numbness in his legs". He further stated that those symptoms were "most commonly radicular in nature meaning originating from a pinched nerve in the spine" **(P.E. # 10, Tr. Pg. 21)**

Petitioner has not been able to work since April 4, 2011 when he was suspended from the Respondent Company. He remains disabled and off work under a work restriction by Dr. Rinella. He has no income at present. He cannot apply for unemployment benefits as he is not able to work. When Petitioner was suspended from his job on April 4, 2011 he remained under a work restriction from both Dr. Anthony Rinella and Dr. Kern Singh. Dr. Singh did not lift his recommended work restriction until he saw the Petitioner on the second occasion on June 1, 2011.

Outstanding Medical Bills:

The outstanding bills are as follows; Dr. Marlene Henze, $625.00 for dates of service between 9/20/2010 and 11/5/2010, Dr. Anthony Rinella, $195.00 for date of service 8/18/2011 and Dr. Ronald Michaels, $567.42 for date of service, 11/4/2011. The total outstanding medical bills are $1,387.42 **(P.E #'s 5, 6 & 9)**

DISPUTED ISSUES:

(c). Did an accident occur that arose out of an in the course of the Petitioner's employment with the Respondent.

The Arbitrator finds that Mr. Wiekert suffered an accident that arose out of and in the course of his employment with Lazer Spot Inc on September 10, 2010. This decision is based on Mr. Wiekert's testimony, the consistent medical records, the report of the accident by Petitioner to his supervisor and his handwritten account of same on his time sheet on September 10, 2010 and the lack of contrary evidence presented by the Respondent.

The medical records submitted show that at all times that the Petitioner gave a precise and consistent history of the accident. The records of Dr. Henze and Dr. Rinella are consistent with Petitioners testimony as to the mechanisms of the injury sustained by him on September 10, 2010. The Respondent has offered nothing to the contrary to rebut the aforementioned evidence and the Petitioners evidence in this regard is accepted.

Dr. Henze first examined the Petitioner on September 20, 2010 and the Petitioner reported that he had neck and back pain and that he felt he had injured his neck at work. On October 12, 2010 when he was again examined by Dr. Henze , he gave a consistent history of his work accident and the records reflect that "on 10th of Sept in am, while shutting a trailer door, pulled door shut – popping in neck and lower back and snap – couldn't move neck x 1 hour, told security about incident". **(P.E. # 1)**

The Petitioner was examined by Dr. Rinella on December 8, 2010 and Dr. Rinella recorded the history as follows; "Mr. Wiekert states that he was reaching above his head while attempting to close some doors. He was pulling on the doors in a right to left manner when he states, he began to experience severe discomfort in his neck and back. He did fall." **(P.E. #2)**

The Petitioner similarly gave a consistent account of the accident to Dr. Kern Singh when he saw him on December 22, 2010 for the purposes of an independent medical exam.

The Respondent offered no evidence to alternatively explain how the Petitioner came to have sustained the injuries that he did on September 10, 2010. The Respondent offered no evidence of the Petitioner sustaining any injury after this date, which could explain the injuries he sustained to his neck and back area and which injuries the Petitioner's medical doctors clearly noted when they examined him. The Petitioner testified that was not having difficulties with his neck or back area prior to September 10, 2010 and he had been gainfully employed working full duty prior to this time. The Petitioner's evidence in this regard is accepted by the Arbitrator.

Based on the above, the Arbitrator finds that Petitioner sustained an accident on September 10, 2010, that arose out of and in the course of his employment for Lazer Spot Inc.

(e). **Was timely notice of the accident given to the Respondent.**

The Arbitrator notes that Respondent disputed notice in this case but did not call any witnesses to refute Petitioner's account of these events nor produced any evidence, documentary or otherwise, which disputes Petitioner's account of the occurrence of the accident on September 10, 2010. The Petitioner testified that he called his supervisor Robert Cook after the accident to inform him that he had sustained injuries to his neck and back. He testified that he left Mr. Cook a voice mail and he asked for a return call, which was never returned. The Respondent had Mr. Cook present in court at the trial of this case but did not call him to refute the testimony of Mr. Wiekert.

In addition the Petitioner produced a document which he referred to as his time sheet for his employment on September 10, 2010. **(P.E. # 4)**. He testified that he wrote out the facts of the accident on this time sheet as there was no other official accident report/form available to him. He testified that he placed this time sheet back into the file which was held in the guard shack. The Petitioner further testified that he faxed this time sheet to Mr. Cook on September 22, 2010 and that he received a confirmation that the fax was received.

Again the Arbitrator takes note of the fact that although Mr. Cook was present in court at the hearing of this action he was not called to refute the testimony of the Petitioner with regard to this fax and in that regard the testimony of the Petitioner is accepted as credible and accepted by the Arbitrator and the Arbitrator finds that the Respondents did have notice of the accident which occurred on September 10, 2010.

Based on the above the Arbitrator finds that timely notice of the accident was given by the Petitioner to the Respondent.

(f). Is the Petitioners current condition of ill being causally related to the injury?

The Arbitrator finds that the Petitioner's condition of ill being is causally related to his accident, which occurred on September 10, 2010, while Petitioner was engaged in his employment with the Respondent. The records and reports of Petitioners treating physicians clearly support a finding of causal relationship between the Petitioner's neck and back injury and his accident of September 10, 2010

Mr. Wiekert attended initially with Dr. Henze on September 20, 2010, ten days after the accident and complained that he had injured his neck and back at work. On October 12, 2010 he further gave a concise history of his work accident to Dr. Henze and this is clearly recorded by her in her notes which were presented at the trial of this action. When the Petitioner attended with Dr. Rinella on December 8, 2010, once again a consistent history of the facts of the accident were given by him and clearly recorded by Dr. Rinella. The consistent history of the mechanism of the accident and the Petitioner's subsequent complaints of pain in his neck and back points to causal connection between the work related accident and the onset of the Petitioners complaints.

The Arbitrator finds causal connection in the mechanism of the injury sustained by Petitioner and his subsequent neck and back pain. The Arbitrator accepts Petitioner's testimony of how the accident happened as credible and finds that the medical records support this testimony.

Dr. Rinella in his evidence deposition stated that in his opinion to a reasonable degree of medical and surgical certainty that he "felt that the cervical and lumbar strain with associated radiculopathies were directly related to the September 10, 2010 injury. While the left knee meniscal tear arose after he fell to

his knee causing the left knee pain, this made it a more indirect association but still related to the initial injury".

(P.E. # 10, Tr. Pg. 16)

The Arbitrator accepts Dr. Rinella's opinion with regard to the causal connection of the accident which occurred on September 10, 2010 and the Petitioners subsequent injuries.

Dr. Singh in his report dated June 1, 2011 stated that the Petitioner had sustained a soft tissue muscular strain which had resolved. In his December 22, 2010 report he opined that the strain suffered by the Petitioner had not aggravated the Petitioner's underlying condition.

Dr. Rinella disagreed with this opinion. Dr. Rinella stated that "I believe he developed radiating symptoms as a result of his degenerative disease that most likely existed prior to the injury."

Dr. Rinella further stated …"I do disagree with him (Dr. Singh). What's hard to know at times is to what extent these various degenerative regions that he outlined were symptomatic. And without the injections or any of the therapies I recommend over time, I couldn't explain more clearly the extent to which those, that aggravation was causing his symptoms. So we would need the treatment I recommend to strengthen my argument that he's (Dr. Singh) is wrong.

(P.E. # 10, Tr. Pg. 19)

The Arbitrator accepts the opinion of Dr. Rinella over the opinion of Dr. Singh. The Arbitrator takes particular note of the fact that when Dr. Singh saw the Petitioner initially on December 22, 2010 he agreed that the Petitioner could only work at light duty. Dr. Singh's restrictions and diagnoses in that regard were almost identical to the diagnoses and restrictions placed on the Petitioner by Dr. Rinella. However when the Petitioner returned to Dr. Singh in June of 2011, Dr. Singh lifted all of those restrictions and placed the Petitioner at MMI.

Dr. Rinella stated that it was hard for him to understand Dr. Singh's thinking at this point, and he testified as follows; "I don't understand his (Dr. Singh) thought process here. He basically said he had more or less the same clinical scenario, yet the original restrictions that were set at the lowest possible level at his first visit, were now completely removed at the second visit. I don't understand how that could be possible." The Arbitrator agrees with Dr. Rinella's bewilderment on this point.

(P. E. # 10, Tr, Pg. 22)

The Arbitrator favors the opinion of Dr. Rinella in this regard and finds it difficult to reconcile how Dr. Singh could place the Petitioner at MMI when he had received no treatment whatsoever for his injuries, when his symptoms remained the same if not worse and when he had essentially the same clinical findings as he did when originally seen by Dr. Singh in December of 2010, at which time he had placed him on a light duty capacity.

In addition to the above proof, the Arbitrator notes that a competent method of determining causation is by comparing the condition of a claimant prior to an accident with his condition thereafter. Proof of the state of health of a claimant prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. Kress Corp v Indus Comm'n, 190 Ill. App. 3d 72 (1989).

The Petitioner had no problems with his neck or back prior to September 10, 2010. The Petitioner did undergo a laminectomy in 1999/2000 but testified that as of September 10, 2010 he was not experiencing any problems with his back. The Respondents have offered no evidence, documentary or otherwise, to show that the Petitioner had sustained any injuries to his neck or back area either prior to or after September 10, 2010.

There is no indication in the record that Petitioner experienced any problems in performing his job for the Respondent at any time prior to September 10, 2010. The Petitioner testified that he had not missed any time off work and that he had been gainfully employed up until his work accident on September 10, 2010. The Arbitrator notes that the Petitioner's testimony in this regard remained undisputed by the Respondent.

Given the severity of Mr. Wiekert's symptoms immediately following the injury and continuing thereafter, as well as his continued need for medical treatment and restrictions from work, the Arbitrator finds that this establishes that Petitioner's impaired condition was due to him injuring his neck and back area at work on September 10, 2010. The symptoms he experienced on September 10, 2010 caused an inability of Mr. Wiekert to perform his full job duties. He has not been able to return to full duty work since September 20, 2010 as a result of the injuries sustained by him in this accident.

Based on the above the Arbitrator finds that Petitioner met his burden of proof that his condition of ill being is causally related to his accident on September 10, 2010 while in the course of employment with the Respondents, Lazer Spot Inc.

(j). Were the medical expenses that were provided to the petitioner reasonable and necessary?

The Arbitrator finds that the Petitioner is entitled to causally related medical expenses necessary to relieve the effects of this accident.

The Petitioner underwent treatment with Dr. Marlene Henze between September 20, 2010 and November 5 2010 for injuries sustained by him in the accident the subject matter of these proceedings and a total of $625.00 remains outstanding. The Arbitrator finds that said treatment was necessary to relieve the Petitioner of the effects of this accident and therefore the Respondent shall pay this bill in accordance with the fee schedule.

The Petitioner underwent treatment with Dr. Anthony Rinella on August 18, 2011 and a total of $195.00 remains outstanding. The Arbitrator finds that said treatment was necessary to relieve the Petitioner of the effect of this accident and therefore the Respondent shall pay this bill in accordance with the fee schedule. The Arbitrator notes that it was the Respondent who sent the Petitioner to Dr. Rinella for treatment.

The Petitioner underwent treatment with Dr. Ronald Michaels on November Fourteenth, 2011, for injuries sustained by him as a result of this accident and a total of $567.42 remains outstanding. The Arbitrator finds that said treatment was necessary to relieve the Petitioner of the effects of this accident and therefore the Respondent shall pay this bill in accordance with the fee schedule.

(k). Is Petitioner entitled to any Prospective medical care?

At the time of trial, Petitioner had not received any treatment other than five weeks of physical therapy after the initial accident. According to Dr. Rinella he continues to require the epidural injections that were recommended for him as far back as December of 2010. In addition Dr. Rinella wanted to repeat

the Petitioners MRI studies as they were old and unsatisfactory. The Arbitrator takes note of the fact that Dr. Rinella was the doctor that the work comp carrier choose for Mr. Wiekert to treat with and despite the, the work comp carrier continued to refuse to authorize the treatment that he recommended.

In his evidence deposition Dr. Rinella stated "it is clear without treatment he is not going to improve. And he is not going to safely be able to work beyond that 10-pound restriction that both myself and Dr. Singh at least initially placed him on. I recommend a treatment strategy to identify his pain generators the best we could. That included a series of epidural injections. Depending on how he responded, we would typically be waiting to see whether it improved with time but since time has passed, we're really asking whether any other interventions would be necessary, namely if he had a very positive response to whatever injection in the cervical spine, possible removing his headaches or improving his range of motion.". **(P.E # 10, Tr. Pg. 25).**

Dr. Rinella further indicated that because of the fact that the Petitioner had not received treatment for a prolonged period of time he was now "less optimistic that his pain will simply go away with time. Certainly observation has been very ineffective with hm. The longer there's pressure on the nerves causing symptoms the more likely they are to cause longer term pain patters. So it's unclear – it's unclear to me that he won't improve without some type of intervention. " **(P.E # 10, Tr. Pg. 17)**

When Petitioner attended with Dr. Michaels on November 14, 2011 Dr. Michaels agreed with Dr. Rinella that the MRI studies needed to be repeated.

At the time of trial it was clear that Mr. Wiekert remains disabled and unable to return to full duty work and that he had not reached maximum medical improvement. The Respondent has presented no evidence that Mr. Wiekert has been relieved of the effects of his injury. The Arbitrator finds that Respondent is liable for prospective medical treatment to relieve Petitioner of the effects of his injury as is prescribed by Dr. Rinella and Dr. Michaels.

(l). What amount of compensation is due for Temporary Total Disability?

Mr. Wiekert has been incapacitated from work since the date of his initial visit with Dr. Henze on September 20, 2010. He was initially paid TTD between the period of September 20, 2010 and his return to light duty work on January 4, 2011. He worked light duty for the respondents between January 4, 2011 and April 4, 2011, when he was suspended from his job. He has had no income since April 4, 2011 to present. He is unable to return to work and requires ongoing medical treatment to relieve the effect of his injuries. The Respondent has produced no evidence documentary or other wise to show that Petitioner has been cured of his ill condition.

The Respondent voluntarily paid petitioner temporary total disability from September 20, 2010 until they accommodated his light duty restriction on January 4, 2011 being a total of 16 and 5/7th weeks.

The Arbitrator finds that the Respondent shall pay Petitioner temporary total disability benefits from September 11, 2010 through January 4, 2011 and from April 4 2011 to the date of trial, December 20, 2011 being a total of 53 and 6/7th weeks.

(n). Is Respondent due any Credit?

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The Respondent paid a total sum of $8,923.05 in Temporary Total Disability benefits from September 20, 2010 to January 4, 2011 being a total of 16 and 5/7th weeks. Respondent is entitled to credit in that amount.