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

Amy Stoner,

Petitioner,

vs.

NO: 13 WC 09452

Belleville Area Special Services,

19IWCC0136

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, causal connection, medical expenses, prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 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.

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

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

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

DATED: FEB 28 2019
SJM/sj
o-2/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

STONER, AMY
Employee/Petitioner

Case# **13WC009452**

BELLEVILLE AREA SPECIAL SERVICES
Employer/Respondent

19IWCC0136

On 8/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

4888 LAW OFFICE KEITH SHORT
KEITH SHORT
1355 N BLUFF ROAD
COLLINSVILLE, IL 62234

0560 WIEDNER & MCAULIFFE LTD
KHRISTOPHER S DUNARD
8000 MARYLAND AVE STE 550
ST LOUIS, MO 63105

19IWCC0136

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)

Amy Stoner
Employee/Petitioner

v.

Belleville Area Special Services
Employer/Respondent

Case # 13 WC 9452

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **6/21/18**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, 2/9/12, 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 $54,302.56; the average weekly wage was $1,044.28.

On the date of accident, Petitioner was 39 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 $n/a for TTD, $n/a for TPD, $n/a for maintenance, and $n/a for other benefits, for a total credit of $n/a.

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

ORDER

The Arbitrator finds that Petitioner has proved that she injured her cervical spine in the course of her employment.
The Arbitrator finds that Petitioner has proved that her cervical spine injuries are causally connected to the work-related assault and that surgery proposed by Dr. Gornet is reasonable and necessary and is hereby awarded. For the reasons stated above Petitioner is here in awarded medical bills in the amount of $77,928.54 as set forth in Petitioner's exhibits 14 through 27. Respondent is entitled to a credit for all amounts 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.

Edward Lee
Signature of Arbitrator

8/12/18
Date

AUG 14 2018

ICArbDec19(b)

WORKERS' COMPENSATION COMMISSION

Amy Stoner,	)	
Petitioner,	)	
vs.	)	13 WC 009452
Belleville Area Special Services,	)	
Respondent.	)	

DECISION

Issues in Dispute:

Accident, causal connection, medical bills and 8(j) credit. Respondent does not dispute that Petitioner's right shoulder was injured nor does it dispute liability for medical bills and TTD associated with the right shoulder. Respondent disputes that Petitioner's cervical spine was injured and disputes all medical treatment related thereto.

Facts:

On 2/9/12 Petitioner, then 39 years old, was physically assaulted during the course of her employment with Respondent. There is no dispute the assault occurred. Petitioner was attacked by a 6', 200 lbs. teenage boy. Petitioner was a teacher in a school district that specialized in educating troubled or emotionally unstable children.

The employer completed a Form 45 accident report. (Resp. ex 2). The report corroborates Petitioner's testimony as to the nature of the assault. Petitioner testified that the student became agitated and turned over a desk. He then charged toward her and swung downward at her. Petitioner raised her right arm to block the blow and was forcibly struck. She was up against a wall and felt her head go back, striking the wall. She noticed the immediate onset of right shoulder pain.

Prior to the assault on 2/9/12 Petitioner had never treated with any physician for injury or complaints involving the right shoulder or cervical spine. Prior to the date of the assault she was working full duty, without any restrictions.

Medical Treatment:

Petitioner testified that she waited a few days after the assault before seeing her physician. She was hoping that her

symptoms would resolve on their own. Eventually she was seen at Memorial Hospital in Belleville Illinois on 2/26/12. Petitioner also followed up with her family physician, Dr. Astrides Gargia.

On 4/5/12 Petitioner had an MRI of the right shoulder. It revealed a partial tear of the long head of the biceps tendon. (Pet. Ex. 6) There was an abnormal supraspinatus tendon. A follow-up arthrogram on 5/7/12 confirmed the tendon and supraspinatus tears. Petitioner was then referred to orthopedic surgeon, Dr. Donald Weimer.

Dr. Weimer saw Petitioner from May 1, 2012 through April 6, 2014. (Pet. Ex. 7). Dr. Weimer reviewed the diagnostic studies and recommended physical therapy. Petitioner did not improve and ultimately was told that surgery was the best option. On 7/17/12 Petitioner had a right shoulder bursectomy, biceps tendon repair, and debridement of the supraspinatus tendon. Petitioner participated in postoperative physical therapy but did not notice significant improvement in her symptoms. Despite that, she was released to return to full duty on 11/1/12 and has continued to work in full duty until this day. All TTD payments have been made and no claim for TTD is pending.

On 4/16/14 Petitioner had a subacromial diagnostic injection by Dr. Weimer. She noted some improvement. However, her condition remained painful for the next year. Eventually, Dr. Weimer felt he could offer no additional help and referred her to Dr. Nathan Mall.

On 5/11/15 Petitioner saw Dr. Mall complaining of pain and numbness extending into her right shoulder and arm. Dr. Mall noted that Petitioner had a complicated history with her right shoulder. Petitioner gave a history of injury consistent with that given to all other providers. Dr. Mall noted that Petitioner had been suffering, "anterior shoulder pain ever since the injury." Dr. Mall also noted that Petitioner had complaints of numbness that goes into her hand and arm. Numbness went into the ulnar two digits of the hand. She was having difficulty sleeping. Although Petitioner was working for a new employer, she was continuing to have difficulty with activities of daily living and with specific aspects of her new job.

Dr. Mall clearly related all of Petitioner's shoulder complaints including subcoracoid impingement, subscapularis tears and biceps tendon injuries to the assault at work. He felt there might still be a remaining subscapularis tear. He also believed that an MRI of the cervical spine was necessary to rule out any companion injury to the neck.

Dr. Mall noted on the first visit that there was, "possible cervical involvement." (Pet. Ex. 10). Dr. Mall's working diagnosis was subacromial impingement and potential cervical disc herniation at C-5 – C6, C6 – C7 and C7-T1.

On 6/2/15 Petitioner underwent a cervical MRI at MRI partners of Chesterfield. The radiologist read that study showing a, "broad-based central disc herniation at C6 – C7 extending toward the foramina worse on the right than left". He also found "subtle right-sided disc herniation at C-5 – C6 with left side component possible impingement of either C6 root

more prominent on the right than the left." The radiologist found annular disc bulge superimposed on the right lateral recess with care and cranial extruded disc fragments. (Pet. Ex. 5)

Petitioner return to Dr. Mall on 6/2/15 for follow-up and review of the MRI study. The doctor felt there could be a narrow cortical humoral index suggesting subcoracoid impingement as the source of her subscapularis tear and current symptoms. He also noted the cervical spine findings mentioned above. He stated, "I do believe that her cervical spine is causally connected with her initial injury as a special education teacher." He allowed Petitioner to continue to work without restrictions and made a recommendation for referral to Dr. Gornet. (Pet. Ex. 10)

Petitioner first saw Dr. Gornet on 6/22/15. Dr. Gornet reviewed the MRI study and felt there was a large annular tear at C6 – C7 on the right side. He also felt there was foraminal encroachment at C-5 – C6. Dr. Gornet directly attributed the cervical findings to the assault at work on 2/9/12. He also referred Petitioner to Dr. Boutwell for pain management cervical injections.

Petitioner had her first series of injections by Dr. Boutwell on 7/16/15 and a second set on 7/30/15. She noted some improvement following the injections.

On 8/8/16 Petitioner return to Dr. Gornet who noted that the injections had caused some relief in pain. He kept Petitioner on her regular work duties.

On 10/14/16 Petitioner underwent a repeat MRI per Dr. Gornet. She had seen the doctor the day before and noted continuing and increasing discomfort into the right arm. Dr. Gornet reviewed the study and found severe right greater than left foraminal stenosis with herniated disc at C-5 – C6 and C6 – C7. He recommended disc replacement and fusion. He also allowed Petitioner to continue working and sent her back to Dr. Boutwell for injections at C6 – C7.

The Petitioner returned to Dr. Gornet on 1/19/17. She advised that the shots were not successful in resolving her symptoms. He reiterated the need for disc replacement and fusion.

IME and Testimony of Dr. Bernardi:

Respondent obtained an IME with Dr. Robert Bernardi in regard to the cervical spine and took the deposition of Dr. Michael Milne regarding petitioner's right shoulder. Both men testified via deposition.

Dr. Bernardi testified that he believes Petitioner suffered a shoulder injury and cervical sprain is a consequence of the assault at work. However, he did not believe she had any symptomology that was directly attributable to her cervical spine. He agreed that it would be difficult to distinguish if any ongoing pathology would be related to pre-existing conditions which might or might not have been aggravated as a consequence of the assault. (Resp. ex 3, pg. 9) He also

agreed that there could be an overlap between shoulder symptoms and neck symptoms. However, the doctor did not believe that the symptomology allegedly expressed to Dr. Gornet was consistent with the symptomology presented in his examination. (at 15)

Dr. Bernardi reviewed the MRI and concluded that Petitioner had disc disease at C-5 – C6 and C6 – C7. He did not believe the findings could explain her bilateral hand numbness nor her residual right shoulder/parascapular pain. (at 16) Dr. Bernardi did not believe that the MRIs, the epidural injections or cervical fusion and disc replacement were reasonable or necessary. He did not believe Petitioner required work restrictions.

On cross examination Dr. Bernardi agreed that the force of the assault would be expected to affect both Petitioner's right arm, shoulder and cervical spine. (at 29) Dr. Bernardi agreed that Petitioner was, "very nice, very straightforward. Nothing to suggest to me that she was magnifying her symptoms." However, Dr. Bernardi was unable to explain the symptom patterns expressed by the Petitioner. This was despite the fact that the MRI read by the radiologist and Dr. Gornet showed a broad central disc herniation at C6 – C7. When pressed on the findings in Petitioner's exhibits four and five, Dr. Bernardi testified that the images actually showed disc bulges rather than herniations. (24) He equivocated on whether there was an annular tear at C6 – C7. However, he later added, "it's possible that the protruded part is acute, it's possible, if this lady has the right symptom in the right physical exam findings and you might be able to make such a statement" (that there exists an acute injury requiring surgery). Dr. Bernardi did not believe that Petitioner's complaints were consistent with findings of the MRI.

<u>Testimony of Dr. Gornet:</u>

Dr. Gornet testified at the request of Petitioner. He felt her right trapezius discomfort, tingling in the fingertips and right shoulder pain were a direct result of injury to the C-5-6, C6-7 nerve roots. Dr. Gornet testified that the MRI of June 2, 2015 revealed, "an obvious large annular tear at C6 – 7 with a central right-sided herniation present... Foraminal views revealed a large foraminal fragment encroaching on the nerve roots at C5-6 and a small fragment of foramen at C6-7." (Pet. Ex 1, pg7) He initially believe she would be a candidate for conservative care and recommended the injections by Dr. Boutwell.

After a year of conservative management Dr. Gornet believe that a repeat MRI was warranted. He again saw structural anomalies at C5-6 and C6-7. He testified that the herniation and tears were classic of some of the shoulder and arm pathology that Petitioner exhibited. Dr. Gornet specifically countered the opinions of Dr. Bernardi. He testified, "what we know is that there's objective pathology. We know that she's already been evaluated by shoulder specialists and they determine it's not coming from her shoulder. We also know that Dr. Bernardi feels that she a reasonable, credible

individual and doesn't have any functional overlays." He added, "so now she has motor weakness, she has objective pathology in her MRI, by the way, almost completely on the right side, not on the left, and yet we now say that her symptoms cannot in any way be associated with the objective pathology which correlates with the subjective complaints and physical examination. That is illogical." He later added, "this C6 or C7 nerve root often may be a different component of how much C5, C6, C7 depending on that patient's individual anatomy." He later testified, "only thing I can say is that her objective pathology, which is so obvious on the image nine of 13 which I presented to you, I have made two black marks up to the large herniation at C5-6, it's essentially obliterating her foramen."

The Arbitrator notes that the testimony of Dr. Gornet is supported by the objective evidence presented in Petitioner's exhibits four and five. Those exhibits are large, blowups of the MRIs taken on 6/2/15. Dr. Gornet has marked each vertebrae and has indicated where there is cord compression evidenced on the films. In reviewing the films, it is plainly apparent to the Arbitrator that there is objective indication of cord interruption and nerve root compromise as evidenced on the films. These markings are consistent with the subjective complaints expressed to Drs. Gornet, Mall and Weimer.

<u>Conclusion:</u>

The Arbitrator must weigh the medical evidence along with the credibility of the Petitioner. To that and, the Petitioner's testimony cannot be imputed. In fact, the Respondent's physician agreed that she had no evidence of false findings or exaggeration. She testified that her right arm symptoms began consequential to the assault that occurred at work. The only defense to medical causation is Dr. Bernardi's assertion that her symptom pattern expressed on the day of his examination was not wholly consistent with what is later seen on the MRI. It must be noted that during his first examination he did not have an opportunity to review the detailed MRI ordered by Dr. Gornet. Dr. Bernardi's opinion on whether there was objective indication of injury seemed affected by the subsequent MRI. Essentially, he agreed that there was an indication of cervical abnormality but would not give causal connection because the complaints expressed during the independent medical examination would not normally be expected to be produced by the injured areas reflected in the MRI. However, the doctor noted that it could be anatomical crossover/variance which would explain the inconsistency.

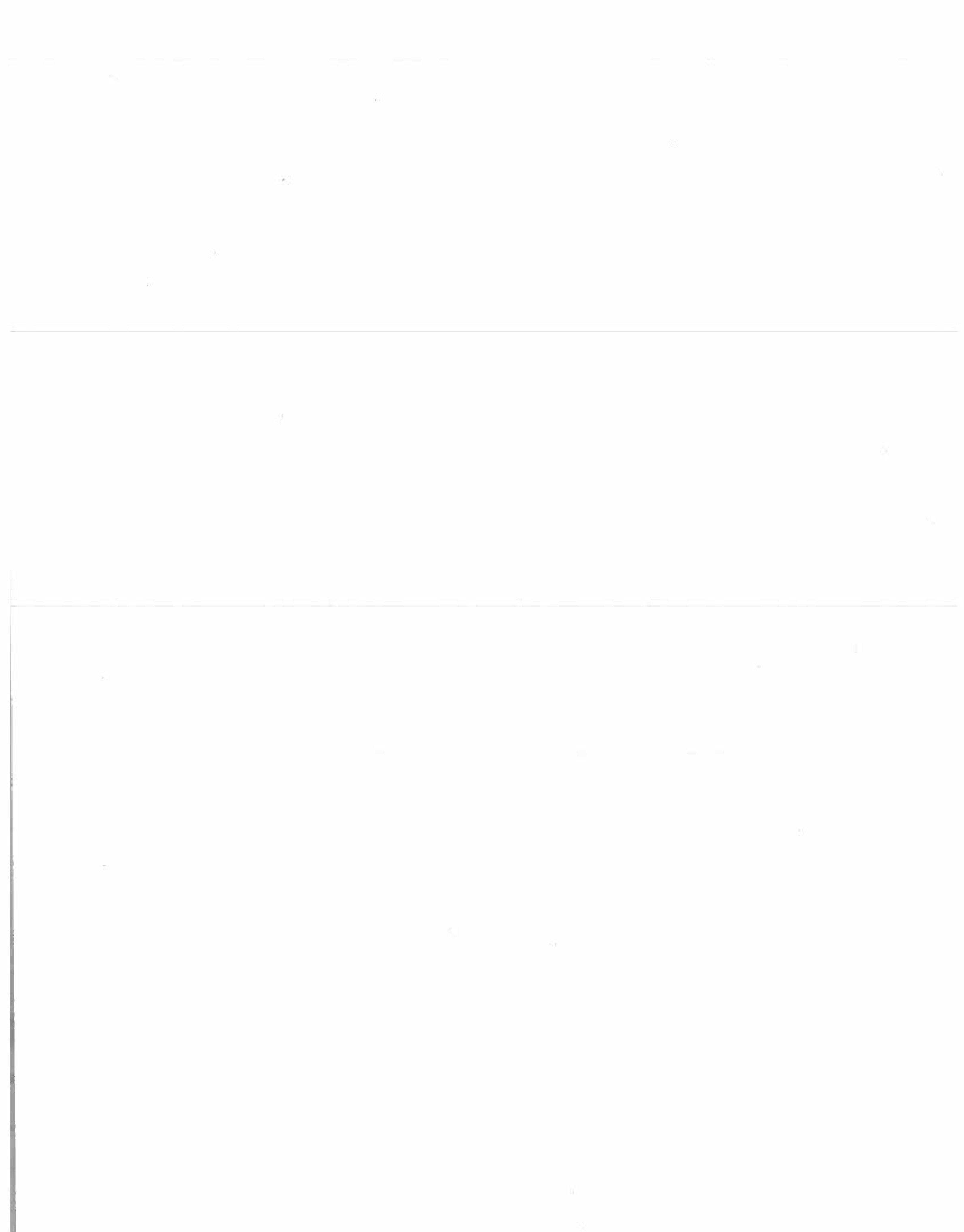
As indicated above, there is no basis for questioning the veracity or truthfulness of the Petitioner. She testified that she has never had pain, numbness or tingling into her right arm and hand until after the assault at work. The assault she described would reasonably be expected to cause the right shoulder injury she suffered. All of the doctors agreed that there would be transfer of force through the shoulder into the cervical spine. There is no indication Petitioner had any injury to the cervical spine prior to the assault. There is also no evidence that Petitioner had any complaints or work

limitations regarding her neck prior to the assault. Accordingly, the only issue is whether the assault has caused or aggravated an injury to her neck such that surgery is the only viable option.

The primary difference between their examinations was the assessment of the precise nerve distribution pattern complained of by Petitioner. In looking at the films, considering the testimony of Petitioner and weighing the respective opinions of the experts, it is the determination of the Arbitrator that the Petitioner has suffered an injury to C-5 – C6 and to C6 – C7 that will require surgical repair. The Petitioner has exhausted all reasonable conservative measures. She participated in physical therapy, received cervical injections and has cooperated with all recommendations from all treating physicians. The fact that she has worked throughout the years since the accident only bolsters her credibility.

AWARD:

1. The Arbitrator finds that Petitioner has proved that she injured her cervical spine in the course of her employment.
2. The Arbitrator finds that Petitioner has proved that her cervical spine injuries are causally connected to the work-related assault and that surgery proposed by Dr. Gornet is reasonable and necessary and is hereby awarded.
3. For the reasons stated above Petitioner is here in awarded medical bills in the amount of $77,928.54 as set forth in Petitioner's exhibits 14 through 27. Respondent is entitled to a credit for all amounts previously paid.



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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Johnathan K. Campbell,

Petitioner,

vs. NO. 17WC 017947

Metro Transit,

Respondent.

19IWCC0137

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 14, 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.

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

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

No bond is required 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 28 2019
SJM/sj
o-2/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

CAMPBELL, JOHNATHAN K
Employee/Petitioner

Case# **17WC017947**

METRO TRANSIT
Employer/Respondent

19IWCC0137

On 6/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

0384 NELSON & NELSON
ROBERT C NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

5263 HARRIS DOWELL FISHER & HARRIS
J BRADLEY YOUNG
15400 S OUTER FORTY SUITE 202
CHESTERFIELD, MO 63017

STATE OF ILLINOIS)

)SS. 19IWCC0137

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)

Jonathan K. Campbell
Employee/Petitioner

Case # **17 WC 017947**

v.

Consolidated Cases: N/A

Metro Transit
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 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. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **05/06/17**, 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 **$70,200.00**; the average weekly wage was **$1,350.00**.

On the date of accident, Petitioner was **46** 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 ***is*** entitled to a credit for any medical bills it may have paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$900.00/week for 16 5/7ths weeks** commencing **05/06/17** through **06/01/17** and **01/05/18** through the present **(04/13/18)**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 6, except the CEP America Illinois bill for $1460.00 and Dr. Mahmood's bill for $30.00, pursuant to the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical expenses that have previously been paid by it and shall hold Petitioner harmless and agree to indemnify and defend Petitioner from any claims by group carriers for subrogation for the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for additional medical treatment related to Petitioner's recovery from his total knee replacement as may be recommended by Dr. Stephen Horner.

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

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

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

Nancy Lindsay
Signature of Arbitrator

June 10, 2018
Date

ICArbDec19(b)

JUN 14 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges that he sustained injuries to his right hand (fourth and fifth fingers) and left knee as a result of a work accident occurring on May 6, 2017. Respondent originally disputed whether Petitioner sustained an accident on May 6, 2017 and whether his current condition of ill-being in his left knee is causally related to the alleged accident. However, after proofs were closed (as will be discussed herein) Respondent stipulated to accident. Liability for Petitioner's left total knee replacement procedure remained in dispute. Related issues include liability for medical expenses, temporarily total disability, and prospective medical care.

The Arbitrator find:

Petitioner was examined at Belleville Memorial Hospital on May 6, 2017. The history notes an altercation and ground level fall at work resulting in pain to the left knee and right hand. There was a superficial abrasion to the left leg and it was painful to palpation. X-rays were taken of both Petitioner's right hand and left knee. On the right hand, Petitioner had ulnar subluxation of the middle phalanx on the proximal phalanx of the fifth digit. No acute fracture was identified. Petitioner's left knee, compared to findings from a March of 2015 x-ray, showed signs of moderate to severe osteoarthritis of the medial central weightbearing compartment and moderate osteoarthritis of the patellofemoral, lateral central weightbearing compartments. Petitioner's right pinky finger was buddy taped to the fourth digit. He was referred to Dr. Crowe, Dr. Horner, and Dr. LeeBurton. Petitioner was taken off work for five days. (PX 3)

As instructed, Petitioner presented to Dr. LeeBurton on May 22, 2017 regarding his right finger injury. His finger complaints included swelling and dull pain along with a feeling of instability. On examination, Petitioner's gait was within normal limits. Dr. Lee Burton felt Petitioner had sustained a radial collateral ligament injury to the small finger. He was advised it could take up to three months to recover and he could still be left with some swelling and stiffness at the PIP joint. He was to remain buddy taped for five weeks and then return. Work status was not addressed. (PX 2)

Petitioner presented to Dr. Horner on May 23, 2017 regarding his left knee. According to the history noted by Dr. Horner, Petitioner's left knee was immediately painful upon his getting up off the ground following the altercation. Petitioner described himself as hitting the ground "hard" and landing on the knee. Petitioner had been limping reportedly and was now feeling somewhat better than he had initially. There was no history of any prior knee surgeries or injuries. The doctor noted mild swelling and he was ambulatory bearing full weight. He had slight varus mal-alignment but no redness, warmth or joint effusion. His knee was tender directly anterior at the lateral half of the patellar tendon. There was a mild amount of swelling and a small lump in the area. There was no medial or lateral joint line tenderness. Range of motion was full. All other aspects of the exam were normal. X-rays demonstrated marked degenerative changes in the left knee. Dr. Horner's impression was that of an anterior left knee contusion from his recent fall with pre-existing radiographic evidence of rather severe osteoarthritis. Dr. Horner reported at the first visit that, "the arthritis is not caused by the injury but certainly could be aggravated by it. This may or may not need additional treatment in the future." (PX 2)

Petitioner signed his Application for Adjustment of Claim in this matter on June 1, 2017. (AX 2)

Petitioner remained off work until he was released to return to work for Respondent on June 1, 2107 on a light duty basis. (PX 2)

Petitioner followed up with Dr. LeeBurton on June 19, 2017 reporting ongoing debilitating pain to both the pinky and ring finger. On examination, Petitioner's gait was within normal limits. There was swelling and tenderness along the small and ring finger. His hand was warm to touch. The doctor ordered an MRI. Work status was not addressed. (PX 2)

Petitioner returned to see Dr. Horner on June 20, 2017, for continued significant left knee pain. Petitioner located the area on the lateral side of the patella and down the lateral side of the tibial tubercle as the source of the majority of his symptoms. He also reported some popping and catching in his knee along with pain after prolonged standing or walking. Petitioner was walking with a slight limp but not using a cane or crutch. His knee revealed some varus mal-alignment. Range of motion was well-preserved with some mild discomfort. Crepitus was present and the joint was tender at the lateral side of the patellofemoral joint with a little "pop" noticeable in the area. Dr. Horner's impression was that of continued left knee pain post injury. Dr. Horner ordered an MRI and injected Petitioner's left knee with Kenalog. Work status was not discussed. (PX 2)

Petitioner underwent another MRI of his right upper extremity on June 28, 2017. It revealed fifth digit proximal interphalangeal joint low-grade edema in the distribution of the proximal phalangeal attachment of the volar plate and centered at the joint capsule circumferentially without evidence of volar plate injury. There was also mild volar proximal phalanx bone marrow edema, probably most likely related to low grade hyperextension from the recent dislocation. There was also a low to intermediate grade sprain of the radial collateral ligament and joint capsule of the proximal interphalangeal joints of the fourth digit. (PX 2)

Petitioner also underwent a left knee MRI on June 28, 2017. It revealed: medial femoral and tibial subchondral sclerosis and edema that could be related to end state osteoarthritis and/or a developing insufficiency fracture; severe osteoarthritis of the patellofemoral compartment and moderate osteoarthritis of the lateral compartment; free edge fraying; and degeneration of the body and posterior horn of the medial meniscus and moderate knee joint effusion with synovitis. (PX 2)

Petitioner followed up with Dr. LeeBurton on July 3, 2017. They reviewed the MRI with the doctor recommending an ulnar gutter brace for mobilization along with a Medrol Dosepak. He was to continue with work restrictions of no lifting more than six pounds for the next five weeks. Petitioner's gait was noted to be within normal limits. (PX 2)

Petitioner returned to Dr. Horner's office on July 14, 2017 with continued difficulties, albeit milder. The doctor felt the cortisone shot might have helped. On physical examination there was some mild swelling and tenderness over the medial and lateral compartments. They discussed Petitioner's MRI findings and treatment options for osteoarthritis including Synvisc injections and, ultimately, a knee arthroplasty. Petitioner was aware that his was bone on bone in his knee. He was to call for further treatment if needed. Work status was not addressed. (PX 2)

Dr. LeeBurton re-examined Petitioner's hand on August 7, 2017. His gait was, again, noted to be within normal limits. Petitioner reported that since his last visit he had been involved in an incident where he needed to perform manual labor with his right hand and he sustained a repeat injury of the small

finger. He reiterated that he his little finger had never stopped hurting since the original injury and that the most recent one resulted in increased swelling. Moderate swelling was noted on exam along with tenderness. The ligament had good stability. A repeat prescription for a Medrol Dosepak was ordered along with physical therapy. He was to continue his work restrictions. (PX 2)

Petitioner returned to see Dr. LeeBurton on September 11, 2017 reporting ongoing dull pain in his right small finger. If he would bump his finger it would aggravate his symptoms. His gait was noted to be within normal limits. Dr. LeeBurton was concerned enough to order a new MRI and prescribed Ultram for pain. Work restrictions continued. (PX 2)

Petitioner underwent an MRI of his right little finger on September 21, 2017. It showed improved signal of the collateral ligaments and volar plate of the PIP joint of the right little finger indicative of a healing sprain injury. No radial collateral ligament tear was noted. The fourth finger also indicated a healing sprain. (PX 2)

On October 31, 2017 Dr. Horner re-examined Petitioner for continued severe left knee pain with developing varus deformity. Petitioner denied any new injury. Petitioner reported he was struggling at home and at work because of knee pain. Nonsurgical treatment had not been successful with the doctor noting "He has terrible arthritis of the left knee." Petitioner was limping with every step he took and examination showed varus malalignment and mild swelling. Range of motion had crepitus and pain. Prominent medial compartment tenderness was seen. The doctor's impression was severe primary osteoarthritis of the left knee for which he recommended a total knee replacement. Work status was not addressed. (PX 2)

Dr. LeeBurton re-examined Petitioner on November 20, 2017 at which time Petitioner reported 2/10 pain and dull pain that was resolving. Petitioner had been going to physical therapy and making increases with range of motion. His gait was noted to be within normal limits. His small finger had a slight flexion lag and mild swelling at the PIP. His motor strength stability was within normal limits. Petitioner was doing significantly better and the doctor ordered ongoing therapy for another month and released him to full duty with no restrictions. He was to return as needed. (PX 2)

At Respondent's request, Petitioner was examined by Dr. Milne on November 28, 2017. Dr. Milne took a complete history from Petitioner, reviewed all of the medical records, and performed a physical examination of Petitioner. Afterwards, he then reached the following conclusions in his report regarding the relationship between the incident at work on 5/6/17 and Petitioner's need for knee replacement surgery:

> I do not believe any structural change occurred in his knee as a result of this injury that would necessitate a knee replacement from the perspective of workers compensation...If he does elect for total knee replacement, it is my opinion this would fall outside the auspices of workers compensation and I do not believe there is any structural change that occurred in his knee as a result of the reported work injury that would have caused, aggravated or accelerated his knee to the point of needing total knee replacement from a structural perspective. (RX 2)

Dr. Milne was also asked to address Petitioner's current complaints. In addition to degenerative conditions, the doctor listed "left knee acute onset of pain" and "moderate joint effusion with synovitis –

acute". He was asked "whether Mr. Campbell is capable of returning to his regular job duties." The answer in the 11/28/17 report was that "From the perspective of his work injury, I believe he needs alternated sitting and standing work." When asked if Petitioner were at MMI, he responded that "I believe the work injury caused or aggravated symptoms and I believe he needs temporary restrictions at this time" (RX 2).

In his addendum report dated December 8, 2017, Dr. Milne further expounded on his opinions, stating:

> To be clear, it is my opinion, based on a reasonable degree of medical certainty, that if anything, this patient temporarily aggravated his symptoms only and the work related injury did not cause any structural change to his knee. Also to be clear, based on a reasonable degree of medical certainty, I do not believe he needs any work restrictions for any alleged work injury itself. His temporary symptom aggravation may cause him some discomfort in working his regular job duties, however, for some period of time....If he elects to proceed (with total knee replacement surgery), I feel this would be most appropriate under his private medical insurance, as I believe the need for total knee replacement would be due to his longstanding degenerative changes and not to the acute exacerbation of his symptoms only from any alleged work injury." (RX 2)

Petitioner underwent a physical therapy evaluation on January 31, 2018. He explained to the therapist that he had injured his knee in a work-related accident. He stated that he had had some osteoarthritis prior to the injury and was now getting ready for a total knee replacement in a couple of weeks. He was not sleeping well due to knee pain and noticed an increase in his pain with weightbearing activity. (PX 2)

Petitioner underwent a total left knee replacement procedure on February 15, 2018. (PX 2)

Petitioner's first post-op visit with Dr. Horner was held on March 2, 2018. Petitioner's staples were removed. Pain medication was prescribed. He was to return in two weeks. Petitioner's first therapy visit was held on March 2, 2018. (PX 2)

Dr. Horner's deposition was taken on April 4, 2018 (PX 4) Dr. Horner is board certified in orthopedic surgery. Dr. Horner testified consistent with his office notes. Dr. Horner testified that the trauma was a cause of symptoms Petitioner suffered from on May 23, 2017. (PX4, page 7) Dr. Horner testified that Petitioner's symptoms when first examined included mild swelling, a tender lump in the anterior part of the knee and a contusion to the patella tendon (PX4, page 8). X-rays were taken that showed evidence of pre-existing rather severe osteoarthritis. After reviewing x-rays the doctor concluded that Petitioner had arthritis which could have been aggravated (PX4, pp. 8-9). Dr. Horner agreed that the arthritis was not caused by the accident. Dr. Horner also testified that he thought Petitioner would get better with time and that he didn't need any direct treatment. He stated, "I certainly didn't want to replace a knee for a guy who'd had symptoms for two weeks." (PX 4, p. 9) Dr. Horner testified that Petitioner's contusion itself did not need any treatment; however, Petitioner was restricted from squatting, kneeling or exercise due to pain. (PX 4, p. 9). Dr. Horner felt the restrictions were a result of the trauma (PX4, page 10).

Dr. Horner testified that when Petitioner returned to see him on June 20, 2017 he still had pain in the area subjected to trauma and he also reported some popping and catching in his knee. He had not improved any since the earlier visit. He was limping a little bit when he walked and his range of motion and alignment were unchanged. He was still tender anteriorly around his kneecap and patellar tendon. The doctor noticed some popping but found no instability or joint effusion. The doctor injected Petitioner's knee and continued the same restrictions (PX4, pp. 10-11).

Dr. Horner further testified that Petitioner returned to see him on July 14, 2017 and reported that the shot had helped but only a little (PX4, page 11). An MRI was ordered. Dr. Horner testified that he saw nothing on the MRI requiring surgery other than the arthritis and the bone edema and swelling from it. He discussed treatment options with Petitioner including injections or surgery if he failed to improve. (PX 4, p. 11)

Dr. Horner also testified that Petitioner again returned to see him on October 31, 2017 with reports of severe knee pain and little success with the injections previously done (PX4, p. 12). Petitioner reported struggling with home activities and work activities. Petitioner denied any new injury. The doctor testified that the symptoms hadn't stopped since May and included pain worse when being up on the leg and trying to move around and with squatting, lifting, and climbing (PX4, pp. 12 – 14). Dr. Horner testified that "the whole thing hasn't stopped since May." (PX 4, p. 12)

Dr. Horner testified that he has seen patients with severe x-ray changes but very little symptoms in the past and did not suggest operations on such people (PX4, page 13). He thought, though, that the trauma in May was a contributing factor to the development of symptoms (pain worse with being on it and trying to move around and squat, lift and climb) which, ultimately, lead to his surgical management (PX4, page 13).

Dr. Horner testified that he re-examined Petitioner in November and they discussed scheduling surgery. (PX 4, p. 14)

Dr. Horner further testified that he performed a left total knee arthroplasty on February 15, 2018. He would not have performed it but for Petitioner's symptoms. He felt that conservative treatment had failed and that Petitioner was not going to get better without total knee replacement surgery (PX4, pp. 14-15). Petitioner had rested his knee, undergone a steroid injection and was using medications but not getting significant improvement in function or pain control. (PX 4, p. 15) While Petitioner might have undergone another injection he didn't think it would be successful given the result from the first injection. Dr. Horner explained that there just was no reasonable likelihood that Petitioner would have spontaneous relief of his symptoms without the surgery that he ultimately performed. According to the doctor, the surgery was absolutely necessary given the severity of Petitioner's disease. (PX4, pp.15 - 16)

Dr. Horner believed that Petitioner would not be recovered from the surgery until June or August (PX4, page 18). He described Petitioner's current condition as a little bit stiff and noted he was working with physical therapy. (PX 4, p. 16)

Dr. Horner was asked whether the work accident accelerated the need for Petitioner's total knee replacement and he replied:

> I think he would have required it sometime. I think the

> aggravating injury sustained earlier that we discussed was sort of a 'straw that broke the camel's back' sort of effect that brought him to have symptoms that we were unable to control and ended up doing the knee replacement. (PX 4, p. 17)

Dr. Horner testified that he knew of no prior treatment or problems that Petitioner had regarding his left knee and he had been working with no prior knee injuries or surgeries. Dr. Horner testified that he initially saw Petitioner as an emergency room follow-up. (PX 4, p. 18)

On cross-examination Dr. Horner was asked about the initial x-ray findings. He explained that "varus malalignment' refers to bow leggedness and that would have pre-existed Petitioner's work accident. Dr. Horner attributed Petitioner's bow leggedness to the osteoarthritis but it can also increase a person's risk of getting osteoarthritis. He also acknowledged that Petitioner had bone spurs in his knee which develop because of osteoarthritis. They, too, predated Petitioner's work accident. Dr. Horner also agreed that the joint space narrowing of the patellofemoral compartment was present before the work accident and that the x-rays also showed bad arthritis in the weight-bearing part of the medial compartment, mostly on the inside which also pre-dated the work accident. He had less pronounced arthritis in the lateral part of the joint but it, too, pre-dated the accident. He agreed that there was no objective evidence on the x-ray that any of the aforementioned findings were the result of acute trauma. Everything, according to Dr. Horner, was degenerative in nature and pre-dated the work accident. (PX 4, pp. 20 – 23)

Dr. Horner was asked if the only actual injury Petitioner sustained as a result of the work accident was a contusion to the left knee and he replied, "Yes, sir." (PX 4, p. 24) He further testified that with regard to the work accident he initially only recommended rest, light duty, and restriction of activities. Dr. Horner also agreed that Petitioner's BMI of 31 would put him in the mildly obese category and obesity can aggravate and cause osteoarthritis of the knee. He also agreed that Petitioner had an unusually high level of osteoarthritis given his age. He felt that in light of the high level of pre-existing osteoarthritis in Petitioner's knee, his obesity contributed to cause it. (PX 4, pp. 24 – 27)

Dr. Horner agreed that as of the second visit on June 20, 2017 his diagnosis for Petitioner's knee as it related to the work accident remained unchanged. Petitioner had only temporary partial relief of pain from the injection. He would have only expected a few months of relief at best. (PX 4, pp. 27 – 28)

Dr. Horner was asked several questions about the MRI findings and acknowledged that the findings therein all pre-dated the work accident. (PX 4, pp. 28 – 39) Included in those findings was evidence of remodeling which would be the result of bone alterations over time to meet the mechanical demands of the knee and would have pre-dated the work accident and can be causally related to obesity and the additional stresses on the knee every time the person takes a step or walks. Dr. Horner further explained that full thickness loss of the articular cartilage, as found on the MRI, referred to Petitioner's knee cartilage wearing away and going down to the bone. Petitioner was bone-on-bone which is as bad as one can get. Dr. Horner further testified that "more than likely" Petitioner was bone-on-bone and had no articular cartilage at the time of his accident. He hadn't seen any older x-rays but the appearance on the ones he saw "sure looked like it was chronic and old osteoarthritis." (PX 4, pp. 33 – 34)

Dr. Horner testified that by July 14, 2017 the contusion had most probably resolved. (PX 4, p. 40) Dr. Horner agreed that he recommended the knee replacement due to the arthritis and not the contusion. He further testified that he thought Petitioner would need a replacement eventually. He was 46 years old

with a severely arthritic, actually "deformed knee", that eventually was going to give enough problems where he was going to have surgery. "I think his surgery was accelerated because he had an injury." (PX 4, p. 42) He also agreed that Petitioner's obesity was a partial cause in the knee's severe degenerative changes. (PX 4, pp. 42-43)

Dr. Horner acknowledged that he never saw the IME report from Dr. Milne. (PX 4, p. 43) He also acknowledged that Petitioner's surgery was absolutely necessary given the pre-existing osteoarthritis in his knee and he was going to need it sometime. (PX 4, pp. 43-44) Dr. Horner had no idea when Petitioner would have needed the knee replacement in the absence of the work accident. (PX 4, p. 45)

Dr. Horner also testified on cross-examination that kneeling if often difficult after a knee replacement as is running and jumping and high-level athletic activities. However, he felt Petitioner would be able to resume his regular full-duty activities for Respondent. (PX 4, p. 46)

On redirect examination, Dr. Horner testified that it would have been difficult to determine when Petitioner could have returned to work had he not had the surgery. He explained that Petitioner was not doing very well. Shock, rest, time, nothing was helping. It looked like he was going to struggle indefinitely as far as the doctor could tell. He also explained that he took him off his regular job because of the pain. (PX 4, p. 48)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on April 13, 2018 pursuant to Petitioner's 19(b) Petition. The disputed issues included accident, causal connection, medical bills, prospective medical care, temporary total disability benefits, and penalties and attorney fees. (AX 1) Petitioner was the sole witness testifying at the hearing. It should be noted that during the hearing an issue came up regarding whether Respondent had filed a response to the penalties petition. Respondent was granted leave to submit its response with its proposed decision and it would be marked as RX 4 and included in the record.

Petitioner testified that on May 6, 2017 he was employed as a transit service manager for Respondent, a light rail public transportation system providing service to metro St. Louis. He had worked for Metro for eleven years and seven months.

Petitioner testified that prior to May 6, 2017 he had no health difficulties with his right hand or left knee. He exercised regularly riding a bicycle, jogging, etc. and without trouble with either his left or right knee. He had lost no time from work due to knee problems. His leg had never been swollen. He had no issue at all with either of his legs prior to the accident discussed hereafter. No physician had told him that he had arthritis in his knee before. He had no pain or difficulties in the left knee prior to the incident on 05/06/17. Petitioner's right hand had never been injured prior to the accident.

Petitioner testified that his physical job duties included a lot of walking, riding trains, walking the ballast and generally being on his feet a lot. He was required to monitor the train operators, monitor the activity on trains and make sure passengers were safe. He was required to assist with anything dealing with Metro on or off Metro property. His job was to make sure the trains were as secure as possible.

In carrying out his responsibilities, Petitioner explained that he was required to assist security when necessary to apprehend trespassers. Petitioner had had prior experience with dealing with unruly

passengers as did nearly all other managers. Several times in his work tenure he was called upon to assist in stopping passengers engaged in improper activities. He was over Bi-State (Metro) security personnel who typically apprehended subjects engaged in criminal activity on and off Bi-state property. If a subject runs off Metro property five yards or a quarter mile a manager is still required to pursue. Upon hearing of a problematic incident, a manager is required to respond without being further specifically told.

Petitioner testified that on May 6, 2017 he was in a Metro vehicle approximately a mile from Jackie Joyner-Kersee Center in East St. Louis, Illinois when he heard on his portable radio the report of an unruly passenger on a train. At the time, all trains were stopped. Any time the trains are stopped the manager in the area, at that time Petitioner, must assist with the problem. He drove the Metro vehicle to the station and was hailed by the deputy who had confronted the offending passenger walking down the alignment. The deputy stated that the subject had gotten away after fighting with and injuring the deputy and his sergeant. The deputy entered Petitioner's company car to locate and pursue the subject. After driving only half a block the deputy saw the subject, exited the Metro vehicle and attempted to subdue the subject passenger. Another altercation ensued. The subject, 6'2" or 6'3" and weighing 280 pounds, started "yanking towards his gun" trying to get the gun away from the deputy. The deputy begged Petitioner for help. Petitioner then exited the Bi-State vehicle and pulled the offending passenger from the deputy. Both the subject passenger and the deputy fell on Petitioner's left leg. Petitioner testified that his leg went backwards. Petitioner's knee was badly swollen immediately, his right little finger was dislocated and his right ring finger was swollen and bruised.

Respondent introduced an employee injury statement signed by a supervisor concerning the injury. Petitioner had never spoken to the supervisor and the form was not filled out in his presence. His name was misspelled. Petitioner testified that he was unable to write at the time so he could not prepare his own report.

Petitioner testified that ever since the accident his leg has been swollen. It has never felt well since the injury. Petitioner has had difficulties with limping, squatting, and stairs since the injury.

Petitioner testified that he has been off work for his hand, per Dr. LeeBurton, since the date of accident through June 1, 2017. During this time, he was also having trouble with his leg and it was swollen.

Petitioner also testified that since his first visit with Dr. Horner on May 23, 2017, the surgeon has never released him to return to his regular duties. Petitioner testified that since the injury he has never been able to walk sufficiently to perform his old job.

Petitioner testified that he returned to work light duty beginning on June 1, 2017 when he was given a light duty job consisting of driving a company vehicle and monitoring the alignment. He did not write reports, though, because of the difficulty with his hand. He did not sit in the car for long periods of time or stand because he wasn't allowed to do so.

Petitioner testified that while he was off work until June 1, 2017 he received some type of payment but wasn't sure what it was. At that point in the proceedings the attorneys for both parties agreed to provide the Arbitrator with a stipulation post-hearing regarding the benefits Petitioner received while off work. That document was to become a part of the record so that an amount, if appropriate, could be credited against any potential TTD award.

Petitioner also testified that he worked light duty from June 1, 2017 through January 5, 2018, including overtime. After January 5, 2018 Respondent would no longer allow Petitioner to work light duty. While working light duty Petitioner was riding in a vehicle and assisting with calls, if needed. Petitioner wasn't able to get out on the alignment, walk or ride trains or anything of that nature due to his knee. Petitioner met with his boss, Martin Gulley, on January 4th who told him he didn't feel comfortable with Petitioner being there anymore since he was injured. Petitioner testified that he could have continued light duty if it was simply riding in a vehicle but walking was difficult because his knee hurt so much.

Petitioner testified that since he couldn't work he needed to get his knee fixed. He underwent a total knee replacement with Dr. Horner. Up until the surgery he was in pain and couldn't walk to perform his job. Petitioner testified that there was never a time after the accident when he wasn't limping and he couldn't squat either. Prior to the accident he could do so and engaged in a spin class three times a week.

Petitioner identified photographs of his knee taken in October of 2017 and about a week after his surgery. (PX 1) At the time of hearing Petitioner's knee was still swollen and disfigured. Petitioner testified that he has not been released to return to his regular duties yet. He next sees his physician on April 2, 2018. He is currently undergoing physical therapy at Memorial Hospital East in O'Fallon, Illinois.

Petitioner testified that conservative treatment, including modification of activities and injections, did not relieve the pain and limitations. Up until the time of the knee replacement procedure, Petitioner's leg was never pain free. Petitioner testified that he is slowly improving since his surgery.

Petitioner testified that he has used all of his paid time off. After last working on January 4, 2018 he was paid his last two weeks of pay and claimed all his paid time off was paid nothing further. He has had great difficulty paying his rent and relied on friends and credit cards through the time of the hearing.

Petitioner testified that he would like Respondent to pay for his medical treatment and benefits since January 5, 2018.

On cross-examination Petitioner was asked many questions about the circumstances surround the accident and his preparation of the injury report.

Petitioner further testified that he was a police officer from 1994 through 2001. In 2001 he went to work for Union Pacific Railroad. He then went to work for Respondent. His current job with Respondent is called a "transit service manager." His position covers an array of things pertaining to MetroLink and the train tracks.

Petitioner testified that Dr. Horner never discussed the fact he was bow legged with him. He also testified that prior to seeing Dr. Horner no other doctor had ever told him he had bone on bone arthritis in his left knee. He also testified that, other than being sore from a workout or something like that, he never had any pain or difficulties with him left knee prior to his work accident. Petitioner also testified that Dr. Horner recommended injections for pain but he didn't know if that was for the contusion or just what.

Proofs were closed.

After proofs were closed but prior to the issuance of the Arbitrator's Decision, the parties reached an agreement regarding two issues in the case and submitted emails to the Arbitrator confirming their

agreement/stipulation. A copy of that email has been included in the record as AX 6. Per that agreement, Respondent agreed to stipulate that Petitioner sustained an accident on May 6, 2017 that arose out of and in the course of his employment with Respondent and Petitioner agreed to waive his Petition for Penalties and Attorney's Fees. It should also be noted that there is no RX 4 contained in the record (Respondent's response to the penalties petition) given the stipulation of the parties.

The Arbitrator also needs to address RX 3 -- the deposition of Dr. Milne. According to Respondent's Exhibit List, the deposition of Dr. Milne was to be included as RX 3. The Arbitrator's set of Exhibits does not contain this. Instead, RX 3 is the deposition of Dr. Milne taken in a totally different case. By email dated May 30, 2018 this Arbitrator brought the issue to the attention of both attorneys. Petitioner's attorney responded in his June 1, 2018 email that he was agreeable to the late submission of the correct deposition transcript. This Arbitrator then emailed the attorneys that she needed the transcript asap as the decision's deadline was looming. (See AX 6 for emails). On the morning of June 8, 2018, the Arbitrator received an email from Respondent's attorney attaching Dr. Milne's deposition transcript. The Arbitrator has printed the email, deposition transcript, and exhibits. They have been marked as RX 5.

The deposition of Dr. Milne was taken on March 5, 2018. (RX 5) Dr. Milne is an orthopedic surgeon who was retained by Respondent to examine Petitioner. He did so on November 28, 2017, issued a report, and then issued an addendum on December 8, 2017. As part of the exam, he reviewed an ambulance report, emergency room visit report, x-ray report from the ER of both the hand the knee, lab work, etc. He reviewed records of Dr. LeeBurton, and a note from Dr. Horner dated 5/23/17, 6/20/17, 7/14/17, 10/13/17. He also reviewed an MRI from 6/28/17. Dr. Milne's examination was focused on Petitioner's left knee.

As part of the exam, Petitioner provided Dr. Milne was a history of his accident and treatment thereafter. At the time of the exam, Petitioner had undergone no physical therapy. His complaints included intermittent aching and dull pain with occasional sharp pain, worse in the morning but increased with weight-bearing activity. He also had feelings of instability, popping, grinding and decreased strength and range of motion as well as intermittent swelling. Petitioner, according to Dr. Milne, denied any prior injuries, surgeries or injections to his left knee before his accident. Petitioner's examination was positive for McMurray's test with pain on deep flexion. X-rays showed severe end stage arthritis.

Dr. Milne testified that the x-ray taken of Petitioner's left knee in the ER after the accident was compared to an x-ray from March of 2015 which meant the radiologist had the benefit of seeing a previous x-ray. The 2017 x-ray showed nothing acute. (RX 5, pp. 1 – 29)

Dr. Milne took no exception to Dr. Horner's diagnosis of a contusion. He concurred that Dr. Horner recommended no further treatment for the contusion as of May 23, 2017. He further testified that there was nothing about the work incident of May 6, 2017 that caused or contributed to the advanced degenerative changes in Petitioner's left knee. Dr. Milne's diagnosis was that of pre-existing left knee severe medial patellofemoral compartment osteoarthrosis, an acute onset of pain, and a medial meniscus extrusion of the left knee with moderate joint effusion and synovitis. The doctor believed that Petitioner would need a total knee replacement but it was not the result of his work accident. He felt the work accident might have caused an acute exacerbation of pain and effusion which could be addressed through conservative treatment, including aspiration, therapy, and an unloader brace (although Petitioner had already tried the unloader brace). Dr. Milne felt Petitioner was too young to proceed straight to surgery for the arthritis but felt he might be able to get back to his pre-injury level of function with the more

conservative means. He did not believe there was any structural change that occurred in Petitioner's knee as a result of the work accident that would have caused, aggravated or accelerated his knee to the point of needing a total knee replacement from a structural perspective. (RX 5, pp. 29 – 38) Dr. Milne was asked if the accident at work did anything more than a temporary aggravation of Petitioner's pre-existing arthritis to which he responded, "I don't even know if it aggravated his pre-existing knee arthritis, if it aggravated his symptoms." (RX 5, p. 39) Dr. Milne was also asked if Petitioner's overall knee condition returned to his pre-accident baseline after the temporary aggravations subsided and he replied, "Well, I don't know, you know again it's based on his subjective complaints of pain from a structural perspective. I believe that he returned to his pre-injury level of function." (RX 5, pp. 39-40)

On cross-examination Dr. Milne agreed that Petitioner was involved in a traumatic event that led to the acute onset of left knee pain. (RX 5, p. 44) He acknowledged that when he examined him, Petitioner still had subjective complaints of pain ranging from a 6 – 8/10. When asked if there was ever a time that Petitioner's pain subsided back down to baseline, the doctor responded that he didn't know if he got to baseline. He did recall Petitioner reporting that he received improvement from the two injections that lasted one to two months. Dr. Milne was also aware that Petitioner was working on a light duty but full-time basis. Dr. Milne was asked if Petitioner had come to see him because of problems with his other knee and the doctor had determined that he had the arthritis in his left knee that he does have but was working full-time with no pain whatsoever and no treatment he would not have determined that Petitioner was in prompt need of a knee replacement. (RX 5, p. 48) Dr. Milne agreed that a factor to be considered in determining whether surgery might be appropriate would be if the patient was symptomatic. He testified, "So the main factor in anyone requiring a total knee replacement is pain that does not respond to any other treatment, in light of their overall medical condition." (RX 5, p. 52) He agreed that Petitioner's pain was reportedly from the work accident as Petitioner had relayed to him. He agreed that the work injury caused or aggravated Petitioner's current symptoms. He agreed that Petitioner needed temporary restrictions in light of those symptoms. Dr. Milne was asked, "…did you feel that those aggravated symptoms caused the need for light duty?" and he responded "Again, it's based on his subjective complaints, yes." (RX 5, p. 55)

Dr. Milne testified that he didn't know for a fact that Petitioner had no symptoms before the work accident that could be aggravated. While Petitioner told him he had none, the doctor also had to consider the radiology report showing an x-ray was taken in 2013 [sic] and no one would take an x-ray for no reason. The doctor further testified that the only evidence he had to suggest any prior left knee problems was the x-ray taken four years [sic] earlier and the appearance on the x-ray from 2017 when he examined him. Dr. Milne acknowledged that he had no evidence provided to him that Petitioner was having any trouble on his job or had been on light duty in the four years prior to his exam of Petitioner. He was unaware of any information indicating Petitioner had any long-time chronic knee problems prior to his work accident.

Dr. Milne went on to testify that he believed Petitioner fell on his knee and had a contusion to the anterior knee or patellar tendon and had pain from that contusion as well as abrasions on the anterior aspect of his knee, neither of which requires a total knee replacement. Dr. Milne acknowledged that he had no medical records from before the work accident. He also acknowledged that Petitioner told him he wasn't having any problems before the work accident. He did not think Petitioner was dishonest or magnifying any symptoms.

During further cross-examination the following exchange occurred:

19IWCC0137

Q. You felt that he had an exacerbation of symptoms from the work injury, correct?

A. Yes.

Q. You felt that was still causing symptoms, seven, eight months later at the time of your exarn [sic]?

A. That's what he reported to me.

Q. Is that what reported in your report also?

A. Yes.

Q. Did you feel that those symptoms were likely to continue for some period of time?

A. There's no way for me to know that. (RX 5, p. 69)

Dr. Milne agreed that at some point in time Petitioner's best chance for relief of his symptoms would be a total knee replacement. He felt Petitioner was too young for a total knee replacement but, if all else failed, it would be a reasonable idea. He also agreed that the presence of pain is a factor in a patient's accepting to proceed with total knee replacement surgery. He also agreed that a person's restrictions, limitations, and inability to do things, particularly work, if he needed to, would be a factor to consider in proceeding with surgery. Dr. Milne testified that he was not critical of Dr. Horner's decision to proceed with surgery. He also agreed that the total knee replacement was the best chance for Petitioner's complete relief of symptoms. (RX 5, pp. 69 – 85)

On redirect examination Dr. Milne testified that he didn't think Petitioner needed any work restrictions or additional treatment relative to the work injury as of December 8, 2017. (RX 5, p. 86)

On further cross-examination Dr. Milne was asked if he felt Petitioner needed further treatment to resolve his symptoms and he responded that since he had not seen him since November he didn't know what his symptoms were. If the symptoms persisted, surgery could be discussed but, again, he is young. Dr. Milne was asked to assume that if Petitioner's subjective symptoms were indeed present and that Petitioner did not have them before the accident, did he feel they came from the event and he replied, "Based on him giving me a full and honest answer, yes." (RX 5, pp. 88 – 91) Dr. Milne also acknowledged that he had no reason to suspect that Petitioner's answers were not honest. He also agreed that the injury caused or aggravated Petitioner's current symptoms. (RX 5, p. 91)

The Arbitrator Concludes:

Issue (C) Accident

This issue was waived after proofs were closed. See AX 6. Petitioner sustained an accident on May 6, 2017 that arose out of and in the course of his employment with Respondent.

Issue (F) Causal Connection

Petitioner's current condition of ill-being in his left knee is causally connected to his undisputed accident of May 6, 2017. In so concluding the Arbitrator relies upon a chain of events, and the more persuasive opinions and testimony of Dr. Horner.

At the outset, the Arbitrator notes that she found Petitioner to be a credible witness during the hearing. He was very believable and direct in his manner of testimony. However, upon reviewing the record in its entirety some contradictions/questions came to light given Petitioner's testimony and the records:

First, Petitioner testified and/or represented to the doctors that he had been limping since the accident. This is not corroborated by the medical records. Petitioner did give a history of limping immediately after the accident. However, by the time he was seen in the emergency room those records don't reflect any complaint or observation of limping. Furthermore, Dr. LeeBurton's office notes document that during all of their visits Petitioner's gait was within normal limits. When Dr. Horner initially examined Petitioner on May 23, 2017 Petitioner was in no distress and was ambulating with full weight bearing ability. He made no note of limping. It was not until Petitioner returned to see Dr. Horner on June 20, 2017 that one finds the first reference to limping and it was described as "slight." Thus, whether or not Petitioner, indeed, was limping since the accident isn't certain.

Second, Petitioner denied any prior problems with his left knee or that he had ever been told he had bone on bone osteoarthritis in his left knee. In contrast, however, is the May 6, 2017 x-ray report from the ER indicating that the radiologist compared it to an earlier one taken in March of 2015. As Dr. Milne pointed out, something had to have occurred to prompt the taking of the x-ray in 2015. No one addressed this during the arbitration hearing. Neither party tried to obtain the earlier x-ray report itself. Additionally, Petitioner presented for physical therapy on January 31, 2018. According to the history, Petitioner reported injuring his knee in a work-related incident. "States he had some OA prior to the injury and will now have a TKA in a couple of weeks." (PX 2) This history can be interpreted one of two ways. Either Petitioner knew he had osteoarthritis in his knee before his accident or Dr. Horner may have told him (after the accident) that he clearly had osteoarthritis before his accident. There is also a troubling statement from Petitioner referenced in Dr. Milne's initial written report. On page four of his initial report, Dr. Milne addressed possible conservative treatment modalities for Petitioner including, inter alia, an unloader brace. Dr. Milne wrote, "He reports he has already tried the unloader knee brace." It is unclear when that may have occurred. Neither the ER records, Dr. Horner's records, or Dr. Horner's bills include any reference to an unloader brace. While Petitioner denied any prior injuries, injections, or surgeries to his left knee, he was never specifically asked about any prior treatment. He did deny being ever told he had bone on bone arthritis in his knee prior to the work accident and it is possible to undergo treatment for symptoms or complaints regardless of an accident.

Based upon the record as a whole, as well as the foregoing comments, the Arbitrator reasonably infers that Petitioner may have very likely had some issues with his left knee before the work accident. More significantly, however, is the fact Petitioner was able to work full duty in a physical job and engage in physical recreational pursuits (such as spinning classes). No evidence was presented that he had lost time from work or had restrictions at work due to a left knee issue before the work accident herein. Respondent produced no evidence showing any prior treatment for Petitioner's left knee. Neither Dr. Milne nor Dr. Horner questioned Petitioner's honesty. No one inquired of Petitioner regarding prior treatment to his knee or why an x-ray was taken in 2015 so the Arbitrator cannot conclude that Petitioner tried to cover anything up or was being dishonest. The most that can be said is that he may have somewhat exaggerated the extent of any limping he experienced immediately after the accident.

Furthermore, when Dr. Horner noted the limping (June of 2017) Petitioner had just returned to light duty work, having previously been off work altogether.

The Arbitrator has also considered Petitioner's mechanism of injury. While the Injury Report stated he fell (and he did), that was not entirely how Petitioner described it. He testified that two people fell on him and his leg went backwards. Thus, a great amount of force landed on him and his leg went backwards. He didn't simply fall on his knee. Petitioner's testimony regarding his description of the accident was unrebutted. He also told Dr. Milne that when he fell he twisted his knee.

In Steak N Shake v. IWCC, 2016 IL App (3d) 150500WC, the Appellate Court considered the case of a restaurant manager who was injured by simply wiping down tables on a busy day. She had pre-existing arthritis of her thumb. The sole doctor's opinion claimed that the activity caused "manifestation of symptoms" but that her current symptoms were not related to her movement. Despite Dr. Wysocki's ultimate opinion regarding causation the Arbitrator, Commission, Circuit and Appellate Court all found for Petitioner based on the sequence of events theory. The Commission noted she was asymptomatic before the event but had extensive symptoms and treatment thereafter. That sequence was sufficient to support a finding of causation. Her medical evidence showed an ongoing condition that began the day of the incident and therefore was inconsistent with Dr. Wysocki's opinion that the incident was not a causative of claimant's condition. Since she was asymptomatic before and had immediate onset of symptoms after that was sufficient to establish a causal relationship. The Court noted it as well settled that the Commission can infer causation from a sequence of lack of symptoms prior to an industrial accident with symptom manifestation immediately following. It cited Freeman United Coal Min. Co. v. Industrial Comm'n, 318 Ill. App.3d 170, 175, 251 Ill. Dec. 966. The employer pointed out that Dr. Wysocki's opinion was the only medical opinion about causation but the court disagreed with his conclusion since Wysocki admitted that she was pain free before the incident and wiping tables caused "symptom manifestation".

In Corn Belt Energy Corp v. IWCC, 56 N.E.3d 1101, 404 Ill.Dec. 688 (2016) an employee twisted his back while exiting a truck. He denied experiencing any similar problems in the week before the injury but had seen his chiropractor eight times in the year of the injury, the last being approximately one month prior.

In Jeffery Howard III v. St. Clair County Highway Department (16 IWCC 0187) the Commission considered whether a claimant's need for new knee was compensable. Petitioner had had an extensive pre-existing arthritic condition. Petitioner stepped in a hole twisted and fell injuring his knee. Thereafter he sought treatment. The medical testimony concluded that Petitioner had additional pain that accelerated the need for surgery. The Section 12 examiner agreed the accident caused pain resulting in Petitioner seeking medical treatment. Petitioner had six prior orthoscopic surgeries but the last was 28 years before the accident but, despite the arthritic condition and recent treatment he was able to perform his relatively heavy labor job before the accident. The Commission felt that the work accident accelerated the need for surgery and found it compensable.

In Taylor v. Alpha (16 IWCC 0170) Petitioner was in good health relative to her knee for more than three years before the accident. After the accident the knee problems were consistent ongoing and undebated. Again, the Commission referred to a "chain of events analysis" pointing to the causal connection but really was just confirming the Arbitrator, Arbitrator Carlson who decided that "To say that Petitioner may have sustained a knee strain as a result of the work accident which should have resolved three to four weeks after the accident

and that Petitioner's present condition of ill-being is due solely to a pre-existing condition disregards the 'chain of events' analysis".

In Navistar, Inc. v. IWCC, 22 ILWCLB 117, Ill.App.2d (2014) the Commission found a causal relationship between Petitioner's knee injury and his work accident. The Respondent claimed that Petitioner had serious arthritis before the injury but he had had no symptoms. After twisting his knee, however, Petitioner had a medial meniscus tear and underwent total knee arthroscopy. The Commission found the claimant credible in stating that he had no symptoms prior to the work accident, worked full duty and never received treatment for his knee prior. Further he had immediate and consistent knee pain thereafter. Petitioner's doctor said the injury was the straw that broke the camel's back; causing the underlying arthritic conditions to be symptomatic; the defendant's experts conceded that a twisting injury could have caused the preexisting tear to worsen.

See also Peabody Coal v. Industrial Comm'n, 571 N.E.2d 1182, 213 Ill.App.3d 64 (Ill. App. 5 dist. 1991) wherein the Court noted that "casual connection between work duties and condition of ill-being maybe established by chain of events including workers' compensation claimant's ability to perform job duties before date of accident and inability to perform said duties following that day".

While it is true that Petitioner's left knee has evidence of severe pre-existing osteoarthritis, Petitioner never injured his left knee before the accident, never underwent any surgery or injections for his knee, and had never been told he needed a total knee replacement. He was also working full duty and was very physically active prior to the accident herein. No evidence was presented that Petitioner was having any symptoms in his left knee before the work accident. As such, causation herein can be established through a chain of events.

The Arbitrator has also considered the opinions and testimony of Dr. Horner, Petitioner's treating surgeon, and Dr. Milne, Respondent's examining physician. The Arbitrator finds the opinions of Dr. Horner to be more persuasive than those of Dr. Milne. Dr. Horner has been treating Petitioner since the accident and has had more interaction with Petitioner than Dr. Milne, whose report and opinions was based upon just one visit. Dr. Milne did not disagree with Petitioner's need for surgery, only its causal relationship to the accident. While he recommended conservative measures for Petitioner's osteoarthritic condition, those conservative measures were not successful. Dr. Milne did not re-examine Petitioner prior to the knee replacement surgery. Dr. Horner persuasively testified that Petitioner's need for the total knee replacement surgery was accelerated by the accident herein as his symptoms became so great that there was no other option if Petitioner was going to get better and return to work. No other doctor had ever recommended to Petitioner that he undergo a total knee replacement prior to this work accident. Since his accident Petitioner has either been off work or on light duty. He never returned to his pre-accident level of activity prior to the knee replacement procedure being recommended. While Petitioner's contusion had most likely resolved by July 14, 2017 Petitioner was not asymptomatic and he was working on a light duty basis and on his leg. He was still in significant pain and limping, two problems he did not have prior to the work accident. Additionally, the Arbitrator notes substantial concessions made by Dr. Milne on cross-examination regarding the issue of causation, including the fact that he found a causal connection between the work accident and Petitioner's symptoms at the time of the examination. He also agreed that one could be asymptomatic in one's knee despite evidence of osteoarthritis on an MRI or x-ray. Petitioner's accident has remained a cause of his need for the total knee replacement and, as such, causation is established under current Illinois law. As Dr. Horner explained, the accident accelerated the need for the surgery, a surgery which had never been recommended prior to the work accident herein.

The Arbitrator further finds that Petitioner also sustained an injury to his right fourth and fifth fingers as a result of his accident on May 6, 2017. It appears, however, that he reached maximum medical improvement

for those injuries on November 20, 2017 when he was released by Dr. LeeBurton to return to full duty with no restrictions and to return as needed. (PX 2)

Issue (J) Medical Bills

Consistent with her causation determination set forth above, and incorporated herein by reference, the Arbitrator finds that Petitioner's care and treatment has been reasonable, necessary and causally related to his work accident of May 6, 2017. As a result, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 6, except the CEP America Illinois bill for $1460.00 and Dr. Mahmood's bill for $30.00, pursuant to Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving his credit, as provided in Section 8(j) of the Act. There is a charge of $30.00 from Dr. Mahmood for cardiology care shortly before the surgery. There are no records attached nor did Petitioner address it in his testimony. Therefore, the charge was denied. There is also a charge from CEP America Illinois for $1,460.00 for treatment on the very day of the emergency visit. No record in support of the bill was admitted into evidence. Therefore, it is also denied although the Arbitrator also notes a zero balance.

Issue (K) Prospective Medical Care

Consistent with her causation determination set forth above, and incorporated herein by reference, the Arbitrator finds that Respondent shall authorize and pay for any ongoing treatment recommended by Dr. Horner as Petitioner continues to recover from his left knee surgery.

Issue (L) TTD

Petitioner is entitled to received temporary total disability benefits for 16 5/7ths weeks from 05/06/17 through 06/01/17 and 01/05/18 through the present (04/13/18). Respondent did not dispute the dates of temporary total disability only liability for the benefits. Consistent with her causation determination set forth above, and incorporated herein by reference, the benefits are awarded.

The Arbitrator further notes that despite the intent of the parties to provide her with a stipulation regarding any payments Petitioner received while off work, no stipulation (to be marked as AX 5) was ever received. This, too, was discussed in emails. (AX 6) Therefore, she cannot award any credits.

Issue (M) Penalties

This issue was waived after proofs were closed. See AX 6.

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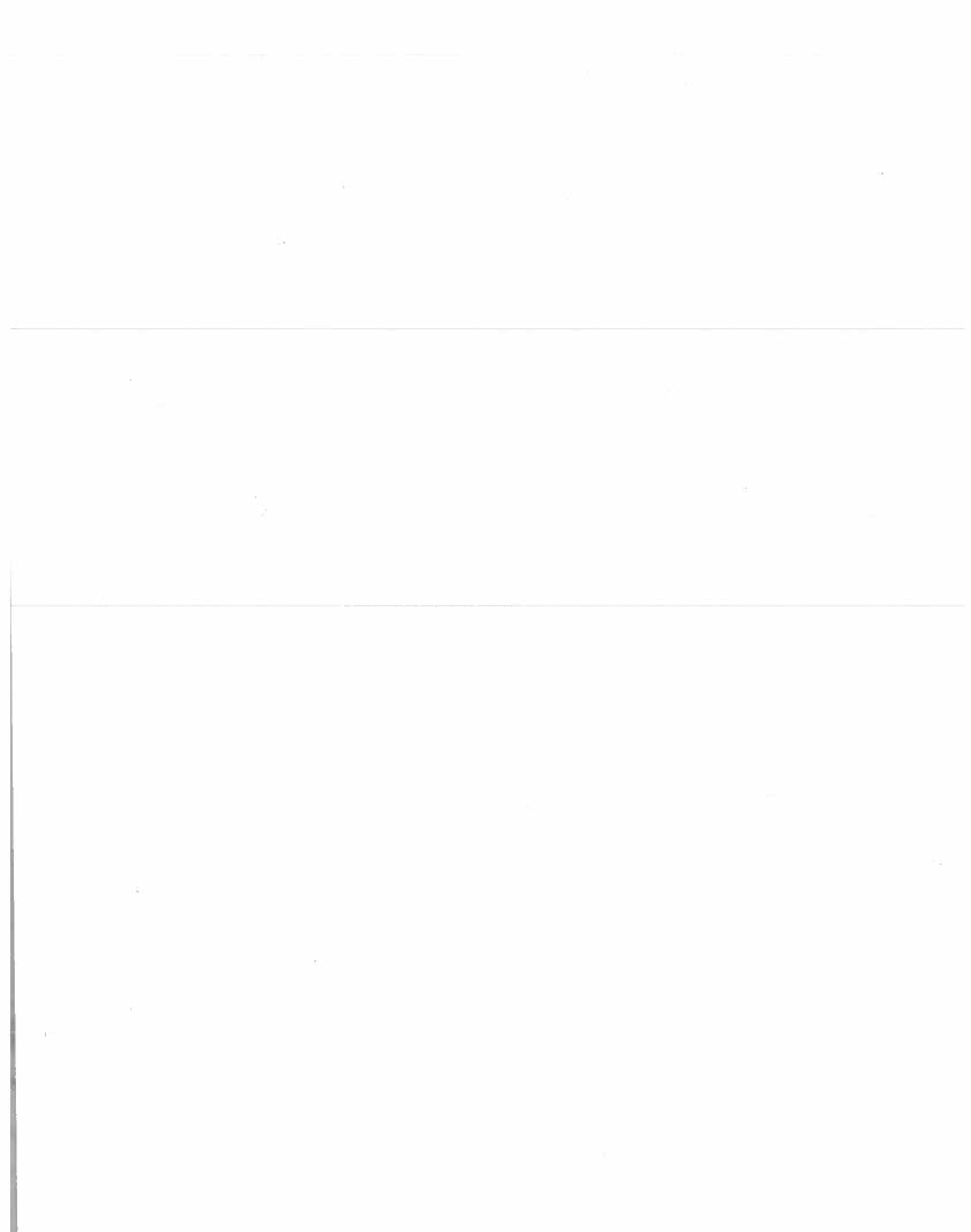


STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Todd Werneburg,

Petitioner,

vs. NO: 15WC 30793

George Young & Sons,

19IWCC0138

Respondent.

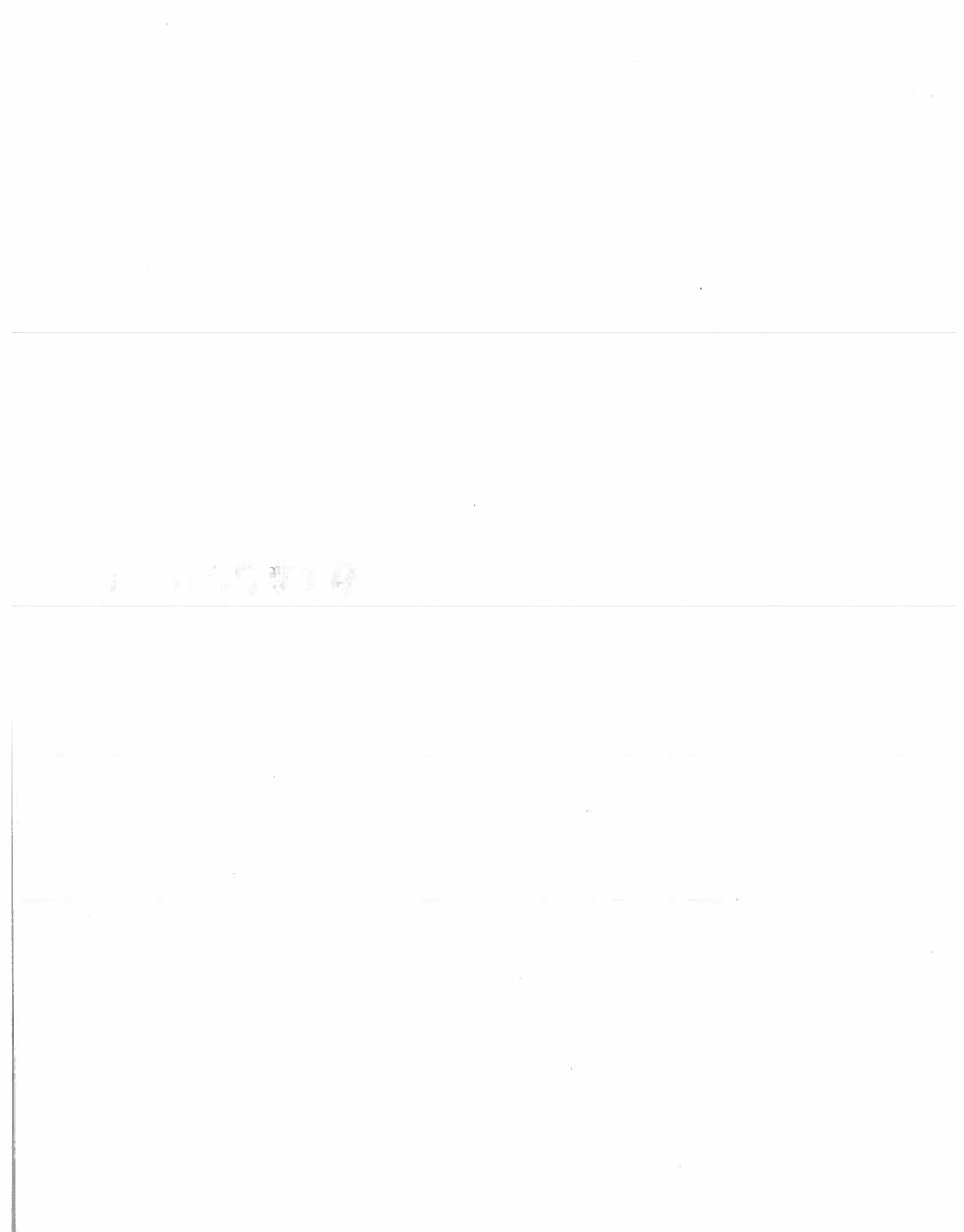
DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2018 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.



19IWCC0138

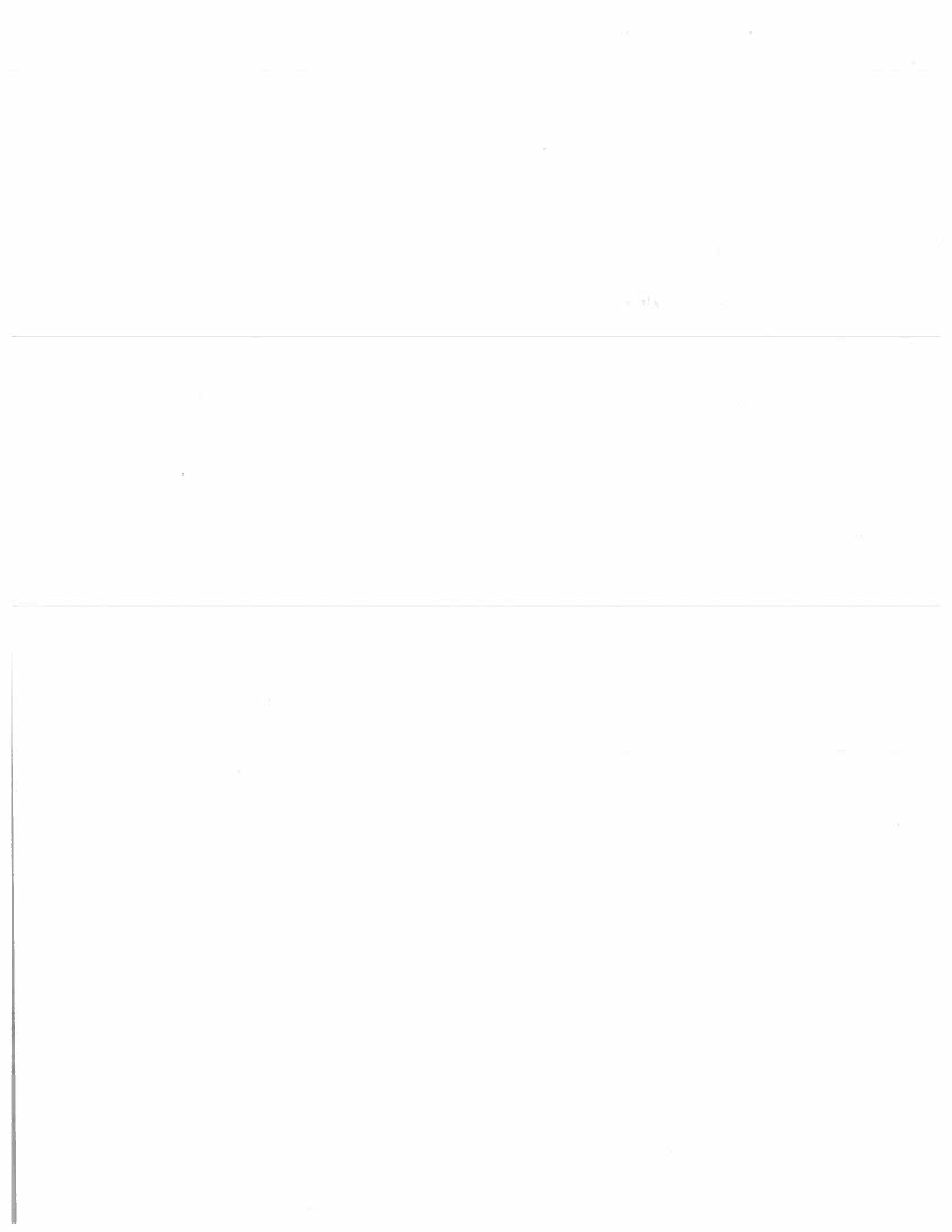
No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 28 2019
SJM/sj
o-2/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson



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

WERNEBURG, TODD
Employee/Petitioner

Case# **15WC030793**

GEORGE YOUNG & SONS
Employer/Respondent

19IWCC0138

On 6/5/2018, 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 2.07% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

1454 THOMAS & PORTELLA
ROBERT HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Todd Werneburg
Employee/Petitioner

v.

George Young & Sons
Employer/Respondent

Case # 15 WC 30793

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **April 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. [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 [x] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [x] Other Vocational Rehabilitation

FINDINGS

On the date of accident, **May 12, 2015,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Per the stipulation of the parties, in the 32 weeks preceding the injury, Petitioner earned **$26,440.56**; the average weekly wage was **$826.27.**

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$40,522.54** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$40,522.54.**

Respondent shall be given a credit of **$0** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent and, 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 **$40,522.54** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$40,522.54.**

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

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

5/31/18
Date

ICArbDec19(b)

JUN 5 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Todd Werneburg
Employee/Petitioner

Case # 15 WC 30793

v.

Consolidated cases: N/A

George Young & Sons
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified he was a union painter and was working for Respondent in Bloomington on the alleged date of accident. He testified that on May 12, 2015, he was sandblasting cooling units at State Farm and reached down to pick up a piece of steel which he estimated weighed anywhere from 300-400 pounds. He testified that when he tried to flip it, he developed back pain, groin pain, left abdomen pain and left thigh pain.

In addition to outlining various medical treatment that he received, Petitioner testified that after the date of accident he worked until May 20th but could no longer perform the job duties as requested of him. He testified that after he failed conservative care he ultimately had surgery in August of 2016, which was that of a lumbar fusion at L5-S1. He testified that he continued to follow-up with Dr. O'Leary, who sent him for an FCE. He testified that he was then given permanent restrictions and was released. He testified that he is now treating at Illinois Regional Pain Institute. He testified that in June of 2017, he started looking for work and has not yet found a job.

On cross examination, Petitioner agreed that he went to a doctor with hip or groin pain on April 23, 2015. On additional cross examination, Petitioner was unable to remember a multitude of things, including whether or not he told Dr. Bernstein that he did not have any prior back problems; whether or not he was involved in a motor vehicle accident in 2006; whether or not he went to Dr. Johnson in 2011 with complaints of back pain; whether or not he was in an altercation with his neighbor; and whether or not in 2010 he plead guilty to a theft charge.

George Eric Young, III ("Eric") was called as a witness by Petitioner at the time of the arbitration. He testified that in May of 2015, he was a foreman with Respondent and that he worked for Local 157 District Council 30, which was a painter's union.

Mr. Young testified that on the alleged date of accident, he was working with Petitioner as his direct supervisor. He testified that they were sandblasting the ends of tanks and that there were heavy plates that were pulled out. He testified that it was a two-man lift and that a fork truck should have been used. He testified that Petitioner lifted more than he did and that after they were finished, Petitioner said that he hurt himself with the heavier plate. He testified that they had a hard job, but that he did not worry about it.

On cross examination, Mr. Young testified that he worked for Respondent until June of 2015, which was when he last worked there. He testified that he has issues with his femur and has had surgery, and that he had not been back to work for Respondent since then.

On cross examination, Mr. Young testified that the next morning after the alleged accident, he met Petitioner and they drove to work together. He testified that Petitioner continued to work for the next several days.

The medical records of UnityPoint Health/Methodist Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on November 18, 2014, at which time it was noted that he was seen for his annual appointment. The assessment was noted to be that of generalized osteoarthrosis, headache and low back pain, among other issues. Petitioner was instructed to continue his current medications and was instructed to return in one year. It was noted that Petitioner was taking Neurontin, Mobic and Prilosec. At the time of the April 23, 2015 visit, it was noted that Petitioner was seen for rectal bleeding. In addition to having made complaints of blood in his stool, it was noted that Petitioner stated that he had begun a workout regimen in which his left hip had started to ache and that he had been taking Ibuprofen four times daily for his hip discomfort. The assessment was noted to be that of blood in stool and left hip pain. Petitioner was given a prescription for Anusol and Mobic and was instructed to limit the use of NSAIDs such as Ibuprofen while taking Meloxicam. (PX1).

The records of UnityPoint Health reflect that Petitioner was seen on May 20, 2015, at which time it was noted that he was complaining of lower abdominal pain and burning in the left thigh. It was noted that Petitioner was complaining of suprapubic pain with radiation across the lower abdomen, worse on the left side, and that it radiated down the left groin. It was noted that the onset was a few days ago and that it had been worsening the past 1-2 days. It was noted that Petitioner denied injury, that he did tell "rooming staff" that he had lifted some metal and denied it was at work, and that he noticed swelling. It was noted that Petitioner appeared uncomfortable and was unable to remain in any position for long and that his suprapubic/left lower quadrant abdomen was soft, swollen and tender. Petitioner was recommended to undergo a stat sonogram. It was also noted that Radiology called back to report that Petitioner had bilateral hernias (inguinal and femoral) and that a surgery appointment had been scheduled for the next day. It was noted that when Petitioner was notified of the appointment, he mentioned that he injured himself at work. It was noted that there was conflicting information and that Petitioner told the nurse that he hurt himself on May 12th and had informed his foreman that day. It was noted that the surgery appointment was cancelled and that Petitioner would be scheduled to go to IWIRC. (PX1).

Included within the records of UnityPoint Health was an interpretive report for x-rays of the left hip dated May 13, 2015, which were interpreted as revealing minimal osteoarthritic change; no acute abnormality. It was noted that the indication was that of left hip pain that radiated to the groin for the last week. Included within the records of UnityPoint Health was an interpretive report for x-rays of the lumbosacral spine also dated May 13, 2015, which were interpreted as revealing advanced degenerative disk disease at L5-S1; multilevel endplate depression of mild severity; MRI may be helpful for further evaluation of these findings. It was noted that the indication was that of left hip pain radiating to the groin for the last one week, possible radiculopathy, no trauma. The records reflect that Petitioner underwent an ultrasound on May 21, 2015 for diagnoses of abdominal pain, suprapubic pain and difficulty voiding, which was interpreted as revealing (1) likely right femoral hernia containing non-obstructed and reducible loop of bowel; patient did demonstrate tenderness in the region of the hernia; (2) probable small left inguinal hernia. Petitioner also underwent an MRI of the lumbar spine on May 29, 2015 for an indication of chronic low backache, pain in the left upper inner thigh since May 12, 2015; advanced degenerative changes noted on the spinal radiograph. According to the interpretive report, the films were interpreted as revealing (1) mild multilevel degenerative changes in the spine most prominent at L5-S1 where there is disc extrusion with severe left neural foraminal stenosis; (2) incidental note of prominent retrocrural lymph nodes. (PX1).

The records of UnityPoint Health reflect that Petitioner was seen on April 8, 2014 for a sore throat and head congestion. At the time of the June 26, 2012 visit, it was noted that Petitioner complained of joint discomfort throughout the body, worse with the knees and hands, with an onset of months ago. It was noted that Petitioner worked as a painter, that he was frequently on ladders and used a sprayer and that sometimes his hands fell asleep at night. It was noted that Petitioner had Tramadol and Flexeril from a prior injury more than one year ago and was not effective with his current pain. The assessment was noted to be that of carpal tunnel syndrome and generalized osteoarthritis. Petitioner was prescribed Mobic and was recommended to use wrist braces at night. At the time of the June 22, 2011 visit, it was noted that Petitioner had nausea, among other issues. Petitioner's Tramadol was refilled as requested. At the time of the April 8, 2011 visit, it was noted that Petitioner had back pain that continued since an altercation, among other issues. It was noted that Petitioner was being seen for a recheck of back pain following a fall nearly one month ago, that he had been seeing a chiropractor without relief and that he was planning to return to work the next week. It was noted that Petitioner's pain had improved some since the injury and that he requested refills on pain medication and muscle relaxer. The assessment was noted to be that of lumbago, among other issues. Petitioner was prescribed Flexeril and Tramadol and it was noted that he could consider a referral to physical therapy. At the time of the March 18, 2011 visit, it was noted that Petitioner was seen for headaches, neck and back pain after being involved in an altercation on March 14th. It was noted that four days prior Petitioner was involved in a dispute with his neighbor over property lines, that the neighbor pulled a stake out of the ground by wire, that it was attached to cause the wire to hit him across the neck and that the weight of the stake caused him to fall backwards on concrete, injuring his head, neck and low/mid back. It was noted that the following morning Petitioner awoke with a headache from the posterior neck radiating up over his head to his forehead and that he also had light sensitivity. It was noted that Petitioner had been taking Ibuprofen and using heat without headache/back improvement, that he had seen a chiropractor, that his x-rays were normal and that he was told he had a whiplash injury. The assessment was noted to be that of low back pain, neck strain, accidental fall and headache. Petitioner was recommended to continue with the chiropractor if he wished, was prescribed Tramadol and Flexeril and was given a back and neck exercises handout. (PX1).

The medical records of Midwest Orthopaedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on May 18, 2017, at which time it was noted that he had been seen by the pain doctor, Dr. Feather. It was noted that Petitioner was nearly a year out from an L5-S1 anterior lumbar interbody fusion. It was noted that Dr. O'Leary believed that Petitioner was healed and that he had a functional capacity evaluation which demonstrated that he could work at the Medium category of work and that it was a valid test. It was noted that Dr. O'Leary was recommending that Petitioner return to work at a Medium functional capacity that was 20-50 pounds lifting occasionally, 10-25 pounds lifting frequently, and up to 10 pounds lifting constantly and that the remainder of the restrictions were as per his FCE. The assessment was noted to be that of lumbar intervertebral disc disorder with displacement. It was noted that Petitioner was instructed to follow-up as needed and that he was at maximum medical improvement. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on April 25, 2017, at which time it was noted that his anterior lumbar interbody fusion, L5-S1, was to treat a symptomatic disk herniation with foraminal stenosis. It was noted that Dr. O'Leary believed that it was a work injury and that Petitioner had to see an independent evaluator the month prior and that it was recommended that he undergo a CT of the lumbar spine. It was noted that Petitioner stated that he had good days and bad days but that there were some things where if he was doing something, he would have little shocks or jolts in his back and that it went away when he stopped doing it. It was noted that Petitioner wanted something to manage the pain, but that he was frustrated by the opioid epidemic and the press that was covering that. The impression was noted to be that of (1) lumbar foraminal stenosis, status post anterior lumbar interbody fusion, L5-S1; (2) ongoing low back pain. It was noted that Petitioner was informed that there was not going to be more surgery in the future and that to Dr. O'Leary he had a solid fusion. It was noted that with

lack of motion on flexion-extension, Dr. O'Leary did not feel that a CT scan was going to be very beneficial. Petitioner was referred for chronic pain management to Dr. Feather. It was noted that with regard to his work capacity, Petitioner could lift 20 pounds frequently and up to 40 pounds occasionally and that Dr. O'Leary wanted an FCE. Petitioner was instructed to follow-up after the FCE. (PX2).

The records of Midwest Orthopaedic Center 'reflect that at the time of the January 10, 2017 visit, it was noted that Petitioner called before the holidays saying that his pain had escalated quite severely and that he was carrying 4-gallon buckets of paint. It was noted that Petitioner only did that four times and could barely take it. It was noted that Petitioner's injury was back in May of 2015 and that he had not done normal work since that time. It was noted that Petitioner had a constant achiness in his low back which he rated as a 3-4, that it never went away and that he had had it since he was taken off narcotics. It was noted that Petitioner took narcotics chronically prior to the surgery, that Tramadol and Norco made him ill and that his current level of pain was unacceptable. It was noted that Petitioner was very concerned because he felt like he should be able to do more and should be able to return to work, that at that point there was no work because it was the light season and that he wanted to be ready come the spring. The impression was noted to be that of lumbar spondylosis, foraminal stenosis and disc displacement status post L5-S1 anterior lumbar interbody fusion. It was noted that it was very difficult for Dr. O'Leary to identify exactly where the pain generation was coming from, that the exam did not lead him in one direction or another and that the x-rays showed stable alignment. It was noted that Dr. O'Leary did not want to start Petitioner back on any kind of narcotic regimen and that he thought they should do a topical agent for his back pain with anti-inflammatories, muscle relaxants and pain medication instead. It was noted that Dr. O'Leary also wanted Petitioner to try physical therapy again and that he would be kept on a 20-pound limit and anticipated raising it in 2-3 months. It was noted that prior to return to work full-time, Petitioner was to undergo a CT of the lumbar spine to make sure that the spine was completely healed. Petitioner cancelled his appointment scheduled for December 22, 2016 due to being in a lot of pain. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen in physical therapy on December 19, 2016, at which time it was noted that he was quite sore and had done a lot of work over the weekend which involved crawling, bending and lifting 50-60# carpet rolls. It was noted that Petitioner felt that some of the discomfort was due to the weather and the increase in activity and that he noted that it was hard for him to get up occasionally and that he noted a lot of left leg weakness which took a while to walk out. It was noted that Petitioner was walking with a very pronounced limp in the left lower extremity. At the time of the December 16, 2016 physical therapy session, it was noted that Petitioner continued to need a little more strengthening of the core prior to returning to job duties of heavier lifting and squatting activities. It was noted that Petitioner did not show up for his scheduled physical therapy session on December 9, 2016 and that he cancelled his physical therapy session scheduled for December 6, 2016 due to not feeling well. At the time of the December 2, 2016 physical therapy session, it was noted that Petitioner reported needing to go back to work due to finances and that the doctor had released him. It was noted that Petitioner stated that he would like to continue with therapy until he found a company to hire him due to being unsure his old company would take him back. It was noted that Petitioner stated that he was sore on that date, but had no real pain. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on December 1, 2016, at which time it was noted that he was doing okay and just had an ache in his back. It was noted that Petitioner stopped taking Vicodin and that he took a little bit of Tramadol. It was noted that Petitioner told Dr. O'Leary that he was not getting payments anymore and really wanted to go back to work and that he was "between a rock and a hard place." The impression was noted to be that of lumbar spondylosis with foraminal stenosis, status post anterior lumbar interbody fusion L5-S1, condition improving. It was noted that the issues that Petitioner had with his stomach were very common taking narcotics and that the Tramadol was helping his headaches, which was telling Dr. O'Leary that it may be some withdrawal symptoms. It was noted that Petitioner was encouraged to taper slowly. It was noted that Petitioner was

good to return to work and that he was to be given a return to work without restriction effective December 2, 2016. (PX2).

The records of Midwest Orthopaedic Center reflect that at the time of the November 30, 2016 physical therapy session, Petitioner noted that he could tell if he lifted or did too much around the house. At the time of the November 28, 2016 physical therapy session, it was noted that Petitioner reported that his exercises were going well, that he was eager to get back to work and that he was doing all that he could in therapy to help with that. At the time of the November 17, 2016 physical therapy session, it was noted that greater hip weakness was noted in the left hip, that Petitioner tolerated the increase in resistance fairly well and that he was eager to do all he could to get back to work. At the time of the November 15, 2016 physical therapy session, it was noted that Petitioner was an industrial sandblaster, that he was sandblasting on May 12, 2015 while working with coolants, that he picked up a steel plate to flip it and injured his back, that he tried to finish the job and consulted with the doctor for an MRI which progressed to surgery, and that he originally thought he strained his left groin. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on October 13, 2016, at which time it was noted that he was doing very well and had had a significant improvement in his condition. It was noted that Petitioner was taking a minimal dose of Norco, that he wanted to get back to work, that his job was that of an industrial sandblaster and that he had to be capable of lifting hundreds of pounds at a time. The impression was noted to be that of status post L5-S1 anterior lumbar interbody fusion, condition improved. It was noted that Dr. O'Leary believed that Petitioner was well on his way and looked very good overall. It was noted that Petitioner was to be given a 25-pound lift with occasional lifting up to 50 pounds for work restrictions at that point, and that he was going to do physical therapy. It was noted that Petitioner was told that it was time to diminish the intake of narcotics completely and that he was to taper to a non-narcotic dose. At the time of the August 30, 2016 visit, it was noted that Petitioner was readmitted on the 21st for acute pericarditis and that he felt okay following his ALIF. It was noted that Petitioner had a little bit of soreness in his abdomen and a little bit of soreness in his back, but otherwise his legs felt very good. It was noted that Petitioner was going to be following up with his cardiologist. The impression was noted to be that of status post L5-S1 anterior lumbar interbody fusion. Petitioner's pain medication was refilled. It was noted that Petitioner was to stay off work. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on December 22, 2015, at which time it was noted that he injured himself while working on May 12, 2015. It was noted that Petitioner was working and sandblasting, that he had his whole garb and was going to lift a cooling plate that weighed 300-400 pounds, that he lifted it just to gently move it, that he felt a tug and lifted the rest of the way and that he felt excruciating pain in his back and then going down his leg. It was noted that Petitioner ended up having acute hernia surgery, but developed some significant low back pain as a result of this as well. It was noted that Petitioner was initially referred for some epidural injections and therapy and that he was being seen at the request of Dr. Sureka to see if there was something that could be done from a surgical perspective. It was noted that Petitioner had mostly low back pain and shooting pains, more on the left leg than the right leg, and that the pains had calmed down in the legs but that he still got them from time to time. The impression was noted to be that of (1) lumbar disk disease, L5, S1; (2) lumbar foraminal stenosis, L5-S1; (3) back and lower extremity pain. It was noted that Petitioner had more of a discogenic back pain component with foraminal symptoms and that the mechanism of lifting the cooling plate was believed to have caused the condition with regard to the low back and left leg complaints and had necessitated his care. It was noted that Dr. O'Leary indicated that Petitioner was probably best served with an anterior lumbar interbody fusion at L5-S1 and that he did not think a microdiskectomy/micro cleanout procedure was going to be of long-term benefit to him. It was noted that Petitioner was going to consider his options and that he was to remain on his 40-pound lifting restriction. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on September 29, 2015 by Dr. Sureka, at which time it was noted that he had undergone two epidural steroid injections. It was

noted that Petitioner's leg pain had been eliminated but that he continued to have left-sided low back pain. It was noted that Petitioner noted that this was problematic while working and that lifting and bending forward would worsen his pain. The assessment was noted to be that of (1) low back pain; (2) history of facet disease. The plan was noted to be that of (1) left L5 transforaminal epidural steroid injection #3; (2) follow-up in two weeks; (3) consider a facet injection if there was not adequate relief with the epidural steroid injection. According to the Procedure Note dated September 29, 2015, Petitioner underwent left L5 transforaminal epidural steroid injection #3 under fluoroscopic guidance on that date for a diagnosis of degenerative spine disease. At the time of the September 11, 2015 visit with Dr. Sureka, it was noted that Petitioner had undergone two epidural injections so far and that he felt that his pain was significantly improved. It was noted that Petitioner's back pain was improved and his leg pain was no longer merely as sharp as it once was. It was noted that bending forward would worsen Petitioner's pain and that sitting would relieve it. The assessment was noted to be that of (1) lumbar radicular pain; (2) L5-S1 foraminal stenosis. Petitioner was recommended to increase his home exercise program and consider a third epidural injection if he did not have adequate relief with the increased home exercise program alone. According to the Procedure Note dated August 27, 2015, Petitioner underwent left L5 transforaminal epidural steroid injection #2 under fluoroscopic guidance on that date for a diagnosis of degenerative spine disease. According to the Procedure Note dated August 13, 2015, Petitioner underwent left L5 transforaminal epidural steroid injection #1 under fluoroscopic guidance on that date for a diagnosis of degenerative spine disease. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on August 5, 2015, at which time it was noted that he had successfully had his hernia repaired, that he continued to have back pain, back stiffness and leg pain and that the pain was on the inside of his left leg mainly, down the entire leg. It was noted that Petitioner was working light duty and that he continued to feel that his back was bothersome. The impression was noted to be that of (1) L5-S1 disk herniation; (2) left L5-S1 radiculopathy. It was noted that Petitioner had been doing therapy that was not helping him as much, that he continued to have some symptoms and that Dr. O'Leary thought that it would be worthwhile to try an epidural steroid injection at L5-S1 to see if they could calm down the pain and break the pain cycle. It was noted that Petitioner was given work restrictions and instructed to return in six weeks. It was noted that Dr. O'Leary opined that lifting the plate aggravated and potentially even caused the disk herniation at L5-S1 and led Petitioner to be symptomatic and that prior to this, he had not significant symptoms of back or leg pain. At the time of the July 1, 2015 visit, it was noted that Petitioner described an injury at work on May 12, 2015, that he was sandblasting cooling units at State Farm in Bloomington, that he reached down to pick up a piece of steel to flip it and that when he lifted it, he felt a pull in his back, lower groin and severe low back pain. It was noted that Petitioner tried to keep working but that he was continuing to have groin pain, back pain and shooting pains and that through the process, he was diagnosed with a hernia and an undescended testicle on the left side. It was noted that Petitioner had pretty significant pain in both groins and his back. The impression was noted to be that of (1) L5-S1 disk disease; (2) left L5-S1 disk herniation; (3) leg pain, left greater than right, with back and groin pain. It was noted that Dr. O'Leary opined that it was a work-related condition and that Petitioner had a degenerative disk that probably pre-existed, but that he suspected that he may have an acute disk finding at L5-S1. It was noted that Petitioner would require physical therapy and possibly an epidural steroid injection and that he was placed under work restrictions. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner underwent bilateral L5 and S1 facet joint injections under fluoroscopic guidance on December 27, 2012 and October 15, 2012 by Dr. Sureka for a diagnosis of degenerative spine disease. Included within the records of Midwest Orthopaedic Center was an interpretive report for a total body bone scan and lumbar SPECT performed at OSF St. Francis Medical Center on October 8, 2012, which was interpreted as revealing (1) low grade degenerative osteoblastic activity throughout the lower thoracic spine and lumbar spine most marked at the L5-S1 level; correlation with lumbar radiographs is suggested; (2) degenerative changes in other areas as discussed; specifically, there is intense activity in the left AC joint compatible with severe arthritis, however infection

is not excluded on this study; (3) probable post-traumatic activity in the distal right clavicle possibly related to the non-unionized fracture; if clinically indicated, right shoulder radiographs may be helpful. The history noted was that of a history of chronic low back pain, bilateral shoulder arthritis, cortisone injection in the left shoulder last week and previous right clavicular fracture; no history of cancer or recent trauma. The Radiology note as authored by Dr. Sureka noted that the imaging revealed increased uptake noted at the right L5-S1 facet joint and some facet arthropathy at the left L5-S1 facet joint as well. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on October 5, 2012 by Dr. Sureka, at which time it was noted that he complained of a one-year history of neck pain and low back pain. It was noted that Petitioner denied any leg symptoms and that he graded his pain as 9/10 with occasional worsening 10/10. It was noted that bending forward tended to worsen his pain, that lying down tended to relieve his pain and that he had been doing some exercises on his own. The assessment was noted to be that of (1) low back pain; (2) neck pain. Petitioner was recommended to start physical therapy to address back and abdominal strengthening as well as range of motion exercises. Petitioner was also prescribed medication for symptomatic pain relief and he was recommended to undergo a lumbar bone scan with SPECT to determine the etiology of his symptoms. The records further reflect that in 2007, Petitioner underwent non-operative treatment by Dr. Levine for a right ankle fracture after a slip and fall on the ice. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was issued a Return to Work slip on May 18, 2017, which indicated that he was allowed to return to work on May 18, 2017 with restrictions in accordance with FCE recommendations and a Medium category of work with occasional 20-50 pound lift, frequent 10-25 pound lift and constant up to 10 pound lift. Petitioner was issued a Return to Work slip dated April 27, 2017, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 20 pounds frequently/40 pounds occasionally and light duty only and were to apply until follow-up after the FCE. Petitioner was issued a Return to Work slip dated January 10, 2017, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 20 pounds and were to apply until follow-up in 2-3 months. Petitioner was issued a Return to Work slip dated December 1, 2016, which indicated that he was able to return to work with no restrictions or limitations starting December 2, 2016 and were to apply until follow-up in four months. (PX2).

The records of Midwest Orthopaedic Center reflect that Petitioner was issued a Return to Work slip dated October 13, 2016, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 25 pounds frequently/50 pounds occasionally and light duty only and were to apply until follow-up in eight weeks. Petitioner was issued a Return to Work slip dated August 30, 2016, which indicated that he was totally unable to return to work until his six-week follow-up visit. Petitioner was issued a Return to Work slip dated December 22, 2015, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 40 pounds. No timeframe was indicated as to how long the restrictions were to remain in effect. Petitioner was issued a Return to Work slip dated August 5, 2015, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 20 pounds frequently/40 pounds occasionally and were to apply until his follow-up appointment in six weeks. Petitioner was issued a Return to Work slip dated July 1, 2015, which indicated that he was able to return to work with restrictions of not lifting/pulling/carrying more than 20 pounds, light duty only, no repetitive bending or twisting from the waist and allowance of a 5-minute break for every hour of work to stand, sit or change positions and were to apply until his follow-up in six weeks. (PX2).

The medical records of Mid Illini Surgical Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that on July 2, 2015, Petitioner underwent laparoscopic bilateral groin (inguinal) exploration by Dr. Salimath for pre-operative diagnoses of (1) chronic recurrent lower abdominal pain and bilateral groin pain with activity, ultrasound suspicious for femoral hernia and also bilateral inguinal hernia; (2) left cryptorchidism and a post-operative diagnosis of

no inguinal hernia noted. Included within the records of Mid Illini Surgical Associates was an interpretive report for a CT of the abdomen and pelvis performed on June 8, 2015 at UnityPoint Health Methodist, which was interpreted as revealing (1) small left-sided inguinal hernia; (2) soft tissue material in the right inguinal canal which based on the patient's history could represent atrophied undescended testicle. Also included within the records of Mid Illini Surgical Associates was an interpretive report for an ultrasound bilateral limited extremity for hernia performed on May 20, 2015 at UnityPoint Health Methodist, which was interpreted as revealing (1) likely right femoral hernia containing non-obstructed and reducible loop of bowel; patient did demonstrate tenderness in the region of the hernia; (2) probable small left inguinal hernia. The history noted that Petitioner had suprapubic pain of 12 days and voiding problems. (PX3).

The records of Mid Illini Surgical Associates reflect that Petitioner was seen on May 29, 2015, at which time it was noted that he had complaints of left groin and suprapubic pain. It was noted that Petitioner stated that on May 12, 2015 he felt a pull in his left groin/thigh area while picking up/moving a piece of steel at work, that he noted that since that time he had had an increase of pain and that the pain was associated with increased frequency of urination, pain and nausea. The assessment was noted to be that of bilateral inguinal hernia ? right one being femoral based on ultrasound findings; right femoral hernia reducible; prostatitis ?; left cryptorchidism ? the source of his abdominal pain. Petitioner was recommended to undergo a CT of the abdomen and pelvis to locate his left testicle and he would be empirically treated for urinary tract infection and prostatitis. At the time of the June 26, 2015 visit, it was noted that Petitioner noted shooting pains down his left leg, a pulling sensation in the groin when lifting and testicular achiness and pain in the bilateral groin area with activity. It was noted that Petitioner was convinced that his pain was due to hernia. Petitioner was recommended to undergo laparoscopic bilateral groin exploration with possible bilateral inguinal hernia repair with mesh. Petitioner was advised not to lift anything over 40 pounds for 4-6 weeks. It was noted that Petitioner was given the option of observation, but that he wanted to undergo surgery since he was having a lot of pain in the groin area every time he lifted anything. (PX3).

The records of Mid Illini Surgical Associates reflect that Petitioner was seen on July 17, 2015 visit, at which time it was noted that he noted no groin pain or tenderness, that he had some umbilical redness and tenderness and that there had not been any bleeding or drainage from the umbilicus, but that he was concerned about possible infection. It was noted that since Petitioner's pain had completely resolved and he did not want to see the urologist to get the undescended testicle removed, he was advised to avoid lifting over 40 pounds for another two weeks and to return on an as needed basis. A "To Whom It May Concern" letter dated July 17, 2015 was issued by Dr. Salimath, noting that Petitioner was totally incapacitated during the dates of July 2, 2015 to present, that he was unable to lift more than 40 pounds for two weeks and that he would have no lifting restrictions as of July 31, 2015. (PX3).

The transcript of the deposition of Dr. Patrick O'Leary was entered into evidence at the time of arbitration as Petitioner's Exhibit 4.[1] Dr. O'Leary testified that he is a board-certified orthopedic spine surgeon and that his practice is dedicated to the treatment of spinal disorders. (PX4).

Dr. O'Leary testified that he first saw Petitioner on July 1, 2015, at which time he stated that he was working as a painter and sandblaster and that on May 12, 2015, he was sandblasting cooling units at State Farm in Bloomington. He testified that Petitioner indicated that he reached down to pick up some type of piece of steel, that the records revealed that the piece weighed 300-400 pounds, that he had to flip it "or something like that" and that in doing that he developed back pain, groin pain and felt a pull in his back. He testified that on physical examination, Petitioner had some subjective tenderness in his low back, that there was no weakness in any motor groups and that he had a little bit of pain when his left hip was moved but that mostly the hip exam was benign. He testified that he reviewed the MRI of May 29, 2015, which showed a degenerative disc at L5-S1 with a left paracentral disc protrusion and some foraminal

[1] The deposition was taken on May 19, 2016.

stenosis, left more than right, at L5-S1. He testified that his diagnosis was that of L5-S1 disc disease, a left L5-S1 disc herniation, and leg pain with back and groin pain, left side more than right. (PX4).

Dr. O'Leary testified that he believed that there was some connection in the work accident having aggravated an underlying condition. He testified that he wanted to prescribe some physical therapy and give work restrictions. He testified that he next saw Petitioner on August 5, 2015. He testified that Petitioner stated that his pain was on the inside of his left leg going down the entire leg and that he continued to have back pain. He testified that Petitioner had been in physical therapy and that it was not helping very much, so he suggested an epidural steroid injection. He testified that Petitioner followed up on December 22, 2015 after the injections were performed, at which time he stated that he felt it gave him a little bit of relief but was not really anything that lasted. He testified that he thought that Dr. Sureka was out of conservative options and that he referred Petitioner back to him to see if he was a candidate for surgery. He testified that Petitioner's symptoms overall throughout were relatively consistent and that he seemed to have back pain and left leg pain with a pretty substantial finding at the L5-S1 level. (PX4).

Dr. O'Leary testified that in his opinion he had found that a laborer that was going to have to push or pull a number of pounds did not usually very well with a simple laminectomy alone and that he found that stability was provided with an anterior lumbar interbody fusion, so he recommended that Petitioner have a one-level lumbar fusion. He testified that the need for the surgery was related to the May 12, 2015 accident. He testified that Petitioner had a preexisting back disorder and that the accident did not cause his L5-S1 disc to wear out to the degree that it had, but that something in the process of his lifting caused him to become symptomatic and continue to seek treatment. He testified that he thought it was an unusual case in that Petitioner did not have a hernia after surgery was performed and that, to him, Petitioner's pain was consistent throughout the time that he evaluated him and seemed to not be abated despite preventive conservative measures. He testified that the mechanism of lifting a substantial plate could "tweak" a low back condition and aggravate it, so he thought that the rationale for recommending the treatment was related to that injury. (PX4).

Dr. O'Leary testified that there was no way to compare the findings on an MRI in 2015 to a bone scan in 2012. He testified that there was some correlation, though, in the sense that the study in 2012 suggested that Petitioner had degenerative changes at L5-S1 and that he was not surprised by that. He testified that the bone scan did not change his opinion if Petitioner was treated three years ago, had an injection and got better and then did not have a path of care, ongoing treatment or a surgical recommendation at L5-S1. He testified that the office note from April 23, 2015 at UnityPoint Health by nurse practitioner Candy Johnson had no affect on his causation opinion. He testified that the treatment he performed, including the steroid injections and physical therapy, was reasonable and necessary medical treatment and that he would like to perform a single level fusion at L5-S1. (PX4).

On cross examination, Dr. O'Leary testified that he did not know before the deposition that Petitioner had treated at Midwest Orthopaedic Center in 2012 and that he was not aware that he had had spinal injections before. He agreed that his opinions on causation were based solely on the history that Petitioner provided to him. When asked if Petitioner was going to the doctor on multiple occasions in the month of May and did not complain of back pain or radicular complaints and whether that would be an indicator that the incident on May 12, 2015 was not the cause of the disc herniation, Dr. O'Leary responded that if Petitioner had six weeks with no documented complaints of back or any kind of pain like that and that he then showed up six weeks later and stated that it all started 6-7 weeks ago, he would "scratch [his] head a little bit." He admitted that he had not reviewed any of the records from Petitioner's treaters who saw him for what they thought was a hernia and testified that he believed that Petitioner told him that he went to IWIRC. He testified that he had not reviewed any of the records initially right after the injury and that he did not review of any Dr. Salimath's records. (PX4).

On cross examination when asked if the medical records were silent on the subject of back pain or radicular pain and whether that would be an indicator to him that the accident might not be the cause of the disc herniation that he diagnosed, Dr. O'Leary responded that he did not think that Petitioner's predominant problem was a disc herniation and that he thought his predominant problem was severe disc degeneration at L5-S1. He testified that there may be a component of an acute herniation, but that Petitioner had foraminal stenosis and degenerative disk disease at L5-S1. He testified that it would be unusual for someone to be seeking care and then not really have any complaints of back pain or leg pain in terms of a sciatica documented, so it would raise suspicion for him. He further testified that not every medical record would raise suspicion for him, such as that from a surgical subspecialist who did not specialize in back disorders. (PX4).

On cross examination, Dr. O'Leary agreed that Petitioner's issues were degenerative in nature and pre-dated the alleged accident. He testified that after reviewing the MRI, he could assure that the vast majority of findings on the MRI were chronic and likely present for years. He agreed that he could not tell whether the possible disc herniation was something of three or four weeks' duration as opposed to a year. (PX4).

On redirect, Dr. O'Leary testified that radiating thigh pain could illustrate an issue with the low back. He testified that not everyone would develop symptoms immediately. He testified that the left hip x-ray report dated May 13, 2015 noted a reason of hip and thigh pain on the left side and that the lumbar x-ray report dated May 13, 2015 noted left hip pain radiating to the groin, possible radiculopathy. He testified that these records would be consistent with the accident history that he was given and the injuries that he would suspect after the accident. He further testified that thigh pain or radiating thigh pain right after the accident would be consistent with the low back injury that he treated Petitioner for, and that Petitioner had those symptoms when he came the first time and continued to have many of those same symptoms throughout the course of treatment given. He testified that he believed that in this case it was consistent with the low back etiology, particularly given the fact that Petitioner had a surgery to fix a hernia that was not found. (PX4).

On redirect when asked to assume that Petitioner was having the left thigh pain radiating down his leg right after the accident and did not have a hernia and whether this was consistent with a low back injury to L5-S1 even if the low back complaints were not initially in the records, Dr. O'Leary responded affirmatively. (PX4).

On further cross examination, Dr. O'Leary testified that L5-S1 could herniate for any number of reasons. He agreed that accidents as trivial as sneezing could cause a herniation. He agreed that he has had patients come into his office and say that their back started to hurt and that they did not know what happened and that he had found a herniated disc. (PX4).

On further redirect, Dr. O'Leary denied that Petitioner in this case ever said he did not know what happened or thought that the herniated disc happened because of sneezing. He agreed that Petitioner's history was consistent every time that he saw him regarding the work accident. (PX4).

The medical records of IWIRC were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on August 21, 2015, at which time it was noted that he returned for evaluation of his bilateral groin strain and degenerative disease of the lumbar spine. It was noted that Petitioner stated that his symptoms had improved, that he rated his current pain level at 5/10 and described it as intermittent soreness, that he was currently taking Vicodin and bought a back brace to wear when doing activities, that he was on Medium work restrictions and that he stated that his employer was compliant with the restrictions that were given. It was noted that Petitioner stated that he was feeling better in the lower abdomen, groin areas with no real pain but some soreness/sensitivity at times. It was noted that Petitioner had been released to regular duty by his surgeon, that he continued to work on restrictions

and had been seeing Dr. O'Leary and had had an epidural steroid injection. It was noted that Petitioner continued to have back pain and was taking Vicodin. The assessment was noted to be that of (1) bilateral groin strains; no hernia noted per Dr. Salimath during surgical exploration; released to regular duty by the surgeon; (2) degenerative disease of the lumbar spine, not work-related, for which he was undergoing treatment by Dr. O'Leary. Petitioner was instructed to follow-up with Orthopedics/primary care physician as directed for the non-work issue, was restricted to no safety sensitive duties (due to a medication for a non-work-related issue), and was released from care. It was noted that Petitioner was recommended a fitness for duty evaluation prior to return to regular duty without restrictions. (PX5).

The records of IWIRC reflect that Petitioner was seen on July 22, 2015, at which time it was noted that he returned for evaluation of his right femoral hernia and left inguinal hernia. It was noted that Petitioner stated that his symptoms had improved for his stomach/hernia area rating at 0/10 as far as pain. It was noted that Petitioner stated that his back was still bothering him, that he went to physical therapy two times per week at Midwest Orthopaedic and that certain movements could cause him to have pain rating 10/10 that went down his left leg. It was noted that Petitioner was currently taking Vicodin in the morning as needed and Meloxicam daily. It was noted that Petitioner was on sedentary, minimum bending and twisting of the back, frequent position changes and no safety sensitive duties work restrictions which he stated his employer was compliant with. It was noted that Petitioner continued his treatment for non-work related degenerative joint disease of the spine with his primary care physician. The assessment was noted to be that of (1) bilateral groin strains; no hernia noted per Dr. Salimath during surgical exploration; remains on restrictions until July 31, 2015 at which point may return to unrestricted duty for this injury; (2) degenerative disease of the lumbar spine, not work-related. Petitioner was recommended to continue his medications as prescribed by his primary care physician and to return to work with restrictions of Medium duty (maximum lifting of 40 pounds) and no safety sensitive duties (due to a medication for a non-work-related issue) and follow-up in 3-4 weeks. (PX5).

The records of IWIRC reflect that Petitioner was seen on July 8, 2015, at which time it was noted that he returned for evaluation of his right femoral hernia, left inguinal hernia. It was noted that Petitioner stated that his symptoms had improved since his last office visit and that he rated his current pain level at 5/10 with constant soreness due to surgery on July 3, 2015. It was noted that Petitioner was on sedentary work restrictions and that he stated that his employer was compliant with the restrictions that were given. It was noted that Petitioner was taking Norco as needed and Meloxicam. The assessment was noted to be that of (1) right femoral hernia, work-related; post-surgical repair; (2) left inguinal hernia; work-related; post-surgical repair; (3) lumbar spine degenerative changes; not work-related and persistent; (4) left cryptorchidism; not work-related. Petitioner was instructed to follow-up with his surgeon and was prescribed medications. Petitioner was also allowed to return to work with restrictions of lifting 10 pounds occasionally, sitting mostly; minimal bending or twisting of the back; frequent position changes for comfort; no safety sensitive duties. At the time of the June 16, 2015 visit, it was noted that Petitioner stated that his symptoms had not improved and that he was going to Midwest Illini on June 26th and Midwest Orthopaedics on July 7th. It was noted that Petitioner stated that he was still having pain shooting down both of his legs, that he rated his current pain level at 8/10 and that he was currently taking Vicodin. It was noted that Petitioner was on light, no safety sensitive work restrictions and that he stated that his employer was compliant with the restrictions that were given. The assessment was noted to be that of (1) right femoral hernia; work-related; stable; awaiting surgery; (2) left inguinal hernia; work-related; stable; awaiting surgery; (3) lumbar spine degenerative changes; not work-related; (4) left cryptorchidism; not work-related. It was noted that Petitioner was awaiting surgery on June 26, 2015 and that he was prescribed medications. Petitioner was also issued work restrictions of sedentary duty (lifting 10 pounds occasionally, siting mostly), frequent position changes, minimal bending and twisting of the back and no safety sensitive duties. (PX5).

The records of IWIRC reflect that Petitioner was seen on June 9, 2015, at which time it was noted that he returned for evaluation of his right femoral hernia and left inguinal hernia. It was noted that Petitioner stated that his symptoms had remained the same since his last office visit and that he stated that he still had pain that shot down both of his legs. It was noted that Petitioner rated his current pain level at a constant, sharp, burning 5/10 and that he was currently taking Vicodin. It was noted that Petitioner was on sedentary work restrictions with minimum bending and twisting of his back and no safety sensitive duties and that he stated that his employer was compliant with the restrictions that were given. It was noted that Petitioner stated that he felt a pulling in the bilateral groin with bending and lifting and that it made his stomach upset. The assessment was noted to be that of (1) right femoral groin strain per CT; (2) left inguinal hernia; work-related; (2) lumbar spine degenerative changes; chronic; not work-related; (4) left cryptorchidism; not work-related; (5) diverticulosis; not work-related. Petitioner was instructed to follow-up with Mid Illini and to continue Vicodin. Petitioner was allowed to return to work with restrictions of light duty (lifting 20 pounds occasionally, 10 pounds frequently) and no safety sensitive duties. Petitioner was also instructed to follow-up with his primary care physician for diverticulosis and the right inguinal density seen on the CT scan, which were not work-related. (PX5).

The records of IWIRC reflect that Petitioner was seen on June 2, 2015, at which time it was noted that he returned for evaluation of his right femoral hernia and left inguinal hernia. It was noted that Petitioner stated that his symptoms had worsened since his last office visit, that he stated he had shooting pain in the lower back that went up and down both legs as well and that he stated that the pain woke him up at night. It was noted that Petitioner had had an MRI done on May 29, 2015 and that it showed a herniated disc in the lower back and that he rated his current pain level at 10/10. It was noted that Petitioner was on sedentary work restrictions and that he stated that his employer was compliant with the restrictions that were given. The assessment was noted to be that of (1) right femoral hernia; work-related; surgery pending; (2) left inguinal hernia; work-related; surgery pending; (3) lumbar spine degenerative changes; not work-related; (4) left cryptorchidism; not work-related. Petitioner was instructed to follow-up with surgery and was prescribed Vicodin. It was noted that Petitioner was able to return to work with restrictions of sedentary duty (lifting 10 pounds occasionally, sitting mostly); frequent position changes; minimal bending and twisting of the back; no safety sensitive duties. Petitioner was instructed to return in 5-7 days. (PX5).

The records of IWIRC reflect that Petitioner was seen on May 26, 2015, at which time it was noted that he stated that his symptoms had not improved, that he was having constant pain in the groin area and that it was very difficult to sleep, stand and sit for any length of time. It was noted that Petitioner rated his current pain level at 8/10 and was currently taking Vicodin. It was noted that Petitioner was on sedentary work restrictions and that he stated that his employer was compliant with the restrictions that were given. It was noted that Petitioner was scheduled for surgery on May 29, 2015 and that he also had left inner thigh pain that was being worked up by his primary care physician. It was noted that Petitioner stated that the pain was so bad sometimes that he needed to urinate or have a bowel movement, but that he denied incontinence of bowels or bladder. The assessment was noted to be that of (1) right femoral hernia, surgery pending; (2) left inguinal hernia, surgery pending. Petitioner was instructed to continue Hydrocodone as directed per his primary care physician and to return to work with restrictions of sedentary duty (lifting 10 pounds occasionally, sitting mostly); frequent position changes for comfort; minimal bending or twisting of the back; no safety sensitive duties. Petitioner was also instructed to return in three weeks. At the time of the May 21, 2015 visit, it was noted that Petitioner presented for initial evaluation of his double hernia. It was noted that Petitioner stated that his injury occurred on May 12, 2015 at 1100 hours, that he stated that he went to pick up a piece of steel to flip it and that when he got it about a foot in the air, he felt a tear in his hernia. It was noted that Petitioner rated his pain at 10/10 at initial onset and was now 8/10. It was noted that Petitioner described his symptoms as constant pressure and that he had been taking Vicodin for symptom relief. It was noted that Petitioner stated that he was sandblasting on May 12, 2015 when he bent to pick up a heavy piece of steel when he felt a sharp pain in the right lower groin and in the left lower groin

with shooting pain down the left leg. It was noted that initially Petitioner thought that it was a pulled muscle and that he continued working, that each day the pain increased and encompassed the lower abdomen and that position changes were painful. The assessment was noted to be that of (1) right femoral hernia with protruding bowel per ultrasound from Methodist; (2) left inguinal hernia, small, per ultrasound from Methodist. Petitioner was recommended a surgical consult with Midwest Illini for bilateral hernias with bowel involvement and was instructed to continue Hydrocodone as directed per his primary care physician. Petitioner was allowed to return to work with restrictions of sedentary duty (lifting 10 pounds occasionally, sitting mostly); frequent position changes for comfort; minimal bending or twisting of the back; no safety sensitive duties. Petitioner was instructed to return for a recheck in 3-5 days. (PX5).

The Operative Report dated August 14, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Operative Report noted that Petitioner underwent (1) anterior interbody lumbar fusion, L5-S1; (2) application of a PEEK cage by Medtronic; (3) crushed spinal allograft in the form of one small kit of bone morphogenic protein by Dr. O'Leary for pre-operative diagnoses of (1) lumbar disk displacement, L5-S1; (2) lumbar foraminal stenosis, L5-S1; (3) back and lower extremity pain and post-operative diagnoses of (1) lumbar disk displacement, L5-S1; (2) lumbar foraminal stenosis, L5-S1; (3) back and left more than right lower extremity pain. (PX7).

The medical records of Restore Medical/Koch Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on May 30, 2017 by Dr. Cummings for follow-up of low back pain. It was noted that Petitioner was feeling the same as he was since the last visit and that he had back pain many times per day, which limited his movement. It was noted that the pain did not radiate into his legs, that he had no numbness in his legs and that he still felt some weakness in his left leg, especially his hip area. It was noted that Petitioner was at maximum medical improvement and had permanent work restrictions. It was noted that Petitioner was referred to Illinois Regional Pain Clinic for continued management. The Physical Therapy Discharge Note dated May 8, 2017 noted that Petitioner was no longer receiving authorized visits and just underwent an FCE to determine possible return to work. At the time of the April 24, 2017 visit, it was noted that Petitioner reported having a work injury when lifting a steel beam at work back in May of 2015, that he had a lumbar fusion in 2016 and that he only went through a couple of physical therapy visits and was doing fairly well until he had an incident at home when he was lifting something while painting back in December of 2016 which seemed to re-injure his back. At the time of the April 19, 2017 visit, it was noted that Petitioner reported that he was definitely getting stronger and that he stated that the strength was resulting in higher endurance levels with activities, but that his pain level remained fairly steady. At the time of the March 31, 2017 visit, it was noted that Petitioner reported a constant achy feeling in his lower back, 3/10, and that he still needed to take medication for the intensity of back pain, but that he was taking it less often and not every day. (PX8).

The records of Restore Medical/Koch Physical Therapy reflect that Petitioner was seen by Dr. Cummings on March 28, 2017, at which time it was noted that he stated that he felt like physical therapy was making significant improvement in his strength and that he felt like it was helping him deal with the pain. It was noted that Petitioner stated that as to the pain his lower back, it was about the same and constant and that it was worse if he did a lot of activities or sat too long. It was noted that Petitioner stated that he felt like he was walking with less of a limp but still felt he was waddling to a degree, that he was having no new weakness in his legs and that he felt like they were much stronger. It was noted that there was no pain or numbness going down at the legs. It was noted that Petitioner had an IME in Chicago a few days ago and that a CT was being ordered of his back. It was noted that Petitioner was doing well and making good improvements from the physical therapy and that it would continue for at least another month. At the time of the March 17, 2017 visit, it was noted that Petitioner stated that he had good days and bad days in regard to his pain. At the time of the March 16, 2017 visit, it was noted that Petitioner reported that he had to drive

from Texas from a family event, that it was a 16-hour drive and that it was very uncomfortable in the car with increased back pain. (PX8).

The records of Restore Medical/Koch Physical Therapy reflect that Petitioner was seen on February 27, 2017, at which time it was noted that the therapist believed that he may benefit from pool therapy or getting a gym membership to get into a pool to normalize his gait pattern and that he would continue to benefit from skilled land-based therapy to further improve strength and core stability. At the time of the February 17, 2017 visit, it was noted that Petitioner stated that prior to December he still had some nagging pain with prolonged activities but since then he had noticed a decline in function. It was noted that Petitioner stated that sitting in one place or without moving for too long was very hard for him to do and that he said both with static positions and with prolonged walking or with weightbearing he would have pain in his back and significant weakness into both legs, but left greater than right. At the time of the February 16, 2017 visit with Dr. Cummings, it was noted that on May 12, 2015 Petitioner was at work sandblasting in an enclosed space and that he had a helmet on. It was noted that they had moved two pieces of steel, that Petitioner went to move the piece of steel back and that as he squatted down and began to pick it up, he got about halfway and suddenly had a terrible pain in his lower back. It was noted that Petitioner had undergone a spinal fusion by Dr. O'Leary, that after surgery he had had limited physical therapy and that there was an incident where it flared up the pain and made it worse. It was noted that Petitioner felt that his legs were not as strong as they used to be, that when the back pain flared up his legs felt even weaker, that if he walked too far and aggravated the back pain his legs felt weak and that it usually started in his left leg. It was noted that Petitioner felt the low back pain essentially every day, that it was mostly in the middle of his back but could go down lower and to the sides of his back also, that he stated that the pain went into his posterior hip areas and was usually worse on the left side and that he felt it when he woke up in the morning. The assessment was noted to be that of acute low back pain, muscle pain and weakness of the leg. It was noted that Petitioner had a tender trigger point in his left lower lumbar area and that he had a significant antalgic gait with significant leaning to the left. Petitioner was recommended to undergo physical therapy, to keep the same work restrictions of 20 pounds that he had from Dr. O'Leary and that he would continue to see his primary care physician for non-work-related issues. It was noted that Petitioner requested Norco for his back pain and that a script would be provided while he was working to get back to baseline with physical therapy. Petitioner underwent lumbar trigger point injections on that date. (PX8).

The records of Restore Medical/Koch Physical Therapy reflect that Petitioner was seen on March 2, 2017 by Dr. Cummings, at which time it was noted that he had been able to get back into physical therapy and felt that this was movement in the positive direction. It was noted that Petitioner could see that his body mechanics were off and that he still felt that he was having some weakness, especially in his left leg. It was noted that the trigger point injections Petitioner had had the last time helped with some of the muscle pain but that he felt it was temporary and did not last even a whole day. Petitioner was prescribed anti-inflammatory pain medication as well as a muscle relaxer, and his narcotic pain medication was refilled. It was noted that Petitioner was to phase-out of the narcotics and did not need them, and that he understood and agreed. (PX8).

The medical records of Illinois Regional Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on November 1, 2017 for a medication refill. It was noted that Petitioner had been using only two Norco per day with minimal pain relief, that he did not want to increase his narcotics as he was waiting for his MC card and that he stated he was interested in the spinal cord stimulator. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome, spondylosis without myelopathy or radiculopathy, lumbosacral region, and long-term (current) use of methadone for pain management. At the time of the October 2, 2017 visit, it was noted that Petitioner was there to discuss his psychology report and plan of care with Dr. Feather. It was noted that Petitioner wanted to get off the opiates and was interested in the spinal cord stimulator. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome, spondylosis without

myelopathy or radiculopathy, lumbosacral region, and long-term (current) use of methadone for pain management. It was noted that Petitioner would continue the Norco until he got his medical cannabis card. At the time of the September 11, 2017 visit, it was noted that Petitioner was to undergo an evaluation for medical marijuana. It was noted that Petitioner was questioning his script refill and that he was sent to "David" for psychological testing due to testing positive for cocaine. It was noted that Petitioner had failed back syndrome and continued with pain that impacted his activities of daily living and function and that he had failed conservative therapy and surgery. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome and spondylosis without myelopathy or radiculopathy, lumbosacral region. It was noted that Dr. Feather thought that Petitioner had qualified for the medical cannabis program and had exhausted conservative therapy. (PX9).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on August 30, 2017, at which time it was noted that he was seen for evaluation and medication refill. It was noted that Petitioner stated that he continued to have low back pain, that he described his pain as aching, stabbing and nagging in nature and that he stated that bending over worsened his pain. It was noted that Petitioner stated that he did have a visit with "pain psych" a few weeks ago to evaluate for narcotic dependence. It was noted that Petitioner was still not interested in any interventions at that point, that he stated that he had had a lot done and that he did not think anything would help. It was noted that Petitioner was interested in "MMJ" and had a consult with Dr. Feather on September 11th. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome, spondylosis without myelopathy or radiculopathy, lumbosacral region, and long-term (current) use of methadone for pain management. It was noted that Petitioner would be notified of the decision to prescribe narcotics after the report. At the time of the July 31, 2017 visit, it was noted that Petitioner was considering medical cannabis but could not afford it at that time. It was noted that his pain to the low back was rated 4/10 with a daily average 4/10 that was stabbing, nagging, sharp, worse in the afternoon and aggravated by bending or lifting. It was noted that lying down helped alleviate Petitioner's pain and that his pain medications helped him become more active at home with chores. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome and spondylosis without myelopathy or radiculopathy, lumbosacral region. It was noted that a Norco script was not given, that a discussion was had regarding a positive cocaine test, that Petitioner denied using cocaine and that he was saving money for a medical cannabis visit. (PX9).

The records of Illinois Regional Pain Institute reflect that Petitioner was seen on June 30, 2017, at which time he was seen for a medication refill. It was noted that Petitioner was considering medical cannabis. It was noted that Petitioner's pain remained at 3-4/10, that it was stabbing and nagging and that it was worse with bending and walking. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome, spondylosis without myelopathy or radiculopathy, lumbosacral region, and long-term (current) use of methadone for pain management. Petitioner's Norco was refilled and it was noted that he could make an appointment for medical cannabis if he wished to pursue the program. At the time of the May 30, 2017 visit, it was noted that Petitioner was referred by Dr. O'Leary for low back pain that started back in 2015 with a job injury and then after having a spinal fusion in 2016, the pain had gotten worse. It was noted that the pain was sharp, shocking and constant and that he had a daily pain average of 3/10. The assessment was noted to be that of other chronic pain, post-laminectomy syndrome, spondylosis without myelopathy or radiculopathy, lumbosacral region, and long-term (current) use of methadone for pain management. Petitioner was given prescriptions for Norco and Gabapentin. (PX9).

Included within the records of Illinois Regional Pain Institute was an evaluation from Psychology Specialists dated November 9, 2017 pertaining to a diagnostic interview to assist in the decision-making process as a candidate for a spinal cord stimulator. It was noted that Petitioner reported a history of chronic pain in his back and legs subsequent to an injury at work. It was noted that Petitioner reported that he had a spinal fusion in 2016 and developed pericarditis twice within two weeks after the surgery. It was noted that Petitioner was assessed to be low level of risk for poor outcome. Also included within the records of

Illinois Regional Pain Institute was an evaluation from Psychology Specialists dated August 30, 2017 pertaining to a psychological interview to assist in the decision-making process for his medication protocol. It was noted that Petitioner reported currently being prescribed Vicodin and Gabapentin. It was noted that based on Petitioner's SOAPP-R scores, his responses placed him in the moderate risk category for opioid misuse. It was noted that treatment recommendations included periodic urine screens, among others. (PX9).

The FCE Report dated May 8, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that Petitioner demonstrated the ability to perform within the Medium Physical Demand Category and that he was presently able to work full time for up to eight hours per day while taking into account his need to alternate sitting and standing. It was noted that during objective functional testing, Petitioner demonstrated consistent effort throughout 100% of the test which suggested that he put forth full and consistent biomechanical and evidence-based effort during the evaluation. It was noted that Petitioner presented with a Waddell score of 0/4 which suggested a negative Waddell sign and the potential for reliable pain reports during functional testing. (PX10).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen in the emergency room on August 29, 2016, at which time it was noted that he was seen for chest pain. It was noted that Petitioner while sitting at home six hours ago developed left-sided sharp chest pain 9/10 with radiation into the left jaw and shoulder. It was noted that Petitioner was recently treated for carditis. The diagnosis was noted to be that of acute pericarditis. The records reflect that Petitioner was seen on August 12, 2016, at which time it was noted that he was admitted for L5-S1 anterior lumbar interbody fusion with instrumentation and C-arm. The Ortho Discharge Summary noted that Petitioner's discharge diagnoses were that of lumbago – sciatica due to displacement of lumbar intervertebral disc and lumbar stenosis with neurogenic claudication. (PX11).

The records of OSF St. Francis Medical Center reflect that Petitioner was seen in the emergency room on August 20, 2016, at which time it was noted that he had complaints of chest pain. It was noted that Petitioner stated that he had a spinal fusion surgery done eight days ago and that he had been healing well since that time. It was noted that Petitioner had progressively improving abdominal and back pain. The assessment was noted to be that of acute pericarditis, likely AKI and bibasilar post-operative atelectasis, likely post-operative from L5-S1 spinal fusion on August 12, 2016 per the History and Physical from Heartcare Midwest. (PX11).

Job Search Documentation was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Arbitrator points out that while many of the job search logs were very difficult to read, the Arbitrator notes that Petitioner applied for a variety of positions as documented in the logs including that of Assistant Director to Accounting, CEO, Finance Manager, Controller, Court Advocate, HR Generalist, Eye Technician, Pilot, Meteorologist, News Anchor, Psychologist, Pharmacy Tech and Jewelry Store Manager, among others. (PX12).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The TTD Advancement was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

Various medical records of Midwest Orthopaedic Center were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were duplicative of those as contained in Petitioner's Exhibit 2. (RX3; PX2).

The transcript of the deposition of Dr. Avi Bernstein was entered into evidence at the time of arbitration as Respondent's Exhibit 4.[2] Dr. Bernstein testified that he is board-certified in orthopedic surgery and that he limits his practice to the spine. (RX4).

Dr. Bernstein testified that he examined Petitioner on March 27, 2017, at which time he gave a history that on May 12, 2015 he was flipping a piece of steel which was very heavy (weighing up to 200-300 pounds) and that he began to experience low back pain and left lower extremity sciatica. He testified that Petitioner indicated that he went through a course of physical therapy, took multiple medications, tried epidural steroid injections and had continued pain. He testified that Petitioner indicated that he had a pain level of 10/10 with severe pain in the left buttock radiating down the left leg. He testified that Petitioner had an MRI scan and then underwent a spinal fusion in August of 2016 through an anterior approach. He testified that Petitioner indicated that he had a physical therapy program post-operatively and that he indicated that he was definitely improved following surgery, but still had some persistent complaints. He testified that Petitioner complained of low back pain to a level of 3/10 and that when he was active, his pain would increase up to 5/10 or 7/10. He further testified that Petitioner indicated that his symptoms were aggravated by activity, that he was generally comfortable when he was inactive and that he was using Vicodin for pain control as needed. (RX4).

Dr. Bernstein testified that Petitioner did not indicate to him during the exam that he was initially diagnosed with a hernia. He testified that on physical examination, Petitioner had some slight pain guarding during the evaluation. He testified that neurologically, Petitioner was completely normal and intact. He testified that his diagnosis was that of status post anterior lumbar L5-S1 spinal fusion and that he had looked at x-rays and felt that they demonstrated a clinically-healed fusion. When asked whether he formulated an opinion as to whether or not Petitioner had any restrictions at the time of the examination, Dr. Bernstein responded that he felt that Petitioner could at least perform in a light duty capacity with a 20-pound lifting restriction and that he was at a point where he could pursue unrestricted physical therapy to increase his functional ability and then transition to a work conditioning or hardening program. He testified that based on the history that Petitioner gave him, he believed that Petitioner had aggravated a pre-existing degenerative condition of the low back as the result of his work injury, necessitating his care, treatment and surgery. (RX4).

Dr. Bernstein testified that subsequent to his examination he received additional medical records pertaining to care and treatment of Petitioner, including records from Dr. Salimath. He testified that what he found of significance was that Petitioner's complaints were abdominal and groin pain and no complaints of low back pain or radicular pain. He testified that as a result of the medical records that he reviewed, he revised his opinion on causation and believed that Petitioner did not suffer a low back injury as a result of his work-related accident. When asked to assume that Petitioner had a hernia repair on July 2, 2015 which revealed no hernia and that subsequent to the hernia repair he reported low back pain to his treating physicians and whether he had an opinion as to what, if any, significance that additional history gave to him, Dr. Bernstein responded that it indicated that the patient developed back pain following his abdominal or hernia surgery and not directly as a consequence of an injury on the job. (RX4).

Dr. Bernstein testified that from the medical records that he reviewed, Petitioner had a prior history of back complaints leading to care of the low back. He testified that Petitioner had facet injections to L5-S1 in October of 2012, that he had an x-ray following the work incident of the low back that revealed an advanced degenerative disk at L5-S1 and that the MRI obtained on May 29, 2015 described an indication of chronic low back pain and pain in the left upper inner thigh since May 12th. He testified that the indication on the MRI scan report suggested the chronic history of low back pain, not an acute injury to the low back.

[2] The deposition took place on November 29, 2017.

He testified that he would not use the term "chronic" for someone who was complaining of back pain for a period of two or three weeks. (RX4).

Dr. Bernstein testified that he believed that the degenerative changes shown on the MRI of May 29, 2015 pre-dated the alleged incident on May 12, 2015. He testified that he did not think that if Petitioner initially had hernia-like complaints they would have masked or hidden low back pain or complaints. He testified that he thought that if a patient had a significant injury to the low back such that they had a fusion, then he would expect them to have pain at the time of the event or within a few days of the event and that the pain would be significant. He testified that he did not believe that the back surgery that Petitioner had was caused or aggravated by the alleged incident of May 12, 2015. (RX4).

On cross examination, Dr. Bernstein testified that he met with Petitioner about 15-20 minutes. He testified that he did not believe that he had medical records from IWIRC. He testified that he did not have the treating doctor's records that recommended the MRI. He agreed that since he did not have the records, he was not able to review the histories that were given. He agreed that the only history that he had at that time was from the hernia surgeon and, in fact, he only had his operative report. He testified that he did not have any other history then around the time of the accident other than Petitioner's history that he gave him. (RX4).

On cross examination, Dr. Bernstein agreed that Petitioner did not mention a hernia to him. He testified that he did not recall if he asked Petitioner about the hernia, but that he referred to a hernia scar so there was probably some discussion. He testified that he did not find Petitioner to be malingering. He agreed that because there was a history issue, it would be important to review the medical records at or around the time of the accident as for causation. He agreed that if Petitioner did have radicular symptoms or low back pain starting right after the accident, it would be one of the factors that would allow him to causally connect the low back condition to the accident. (RX4).

On cross examination, Dr. Bernstein agreed that in his first report he causally connected the low back injury to the work accident based on Petitioner's history. When asked if the initial medical reports mirrored his history and whether he would still relate it, Dr. Bernstein responded that he might and that it depended on how it was written and what was said. (RX4).

On cross examination, Dr. Bernstein testified that if one damaged an L5-S1 disc and pinched the left SI or L5 nerve root, one would expect posterior lateral buttock, thigh and lateral radiation down the calf into the foot. He testified that one did not expect left medial groin pain or left medial thigh pain and that it did not really correlate with the L5-S1 level. He agreed that the May 13, 2015 x-ray report stated that there were radicular symptoms. He agreed that the history that Petitioner gave him was that he was having radicular symptoms. He testified that that it did not tell him, however, that they were the same symptoms that constituted radiculopathy. He agreed, however, that the report was one day after the accident. He testified that term "radiculopathy" was very subjective to whoever wrote it in the record and was typically accompanied by a description. (RX4).

On cross examination, Dr. Bernstein testified that he agreed with the surgery that was performed and thought it was a reasonable option. He testified that he did not have any opinions as to permanent restrictions as he did not know Petitioner's current status. He agreed that in his first report he had discussed some prior medical treatment that Petitioner had received and that he still causally connected it to the work accident and testified that it was based on the history that he gave him. He testified that in addition to the history given to him by Petitioner, he also had the history of Dr. Salimath from May 29, 2015 describing the symptoms that Petitioner experienced at the time of the injury and subsequent to it. He agreed that Dr. Salimath was the doctor treating Petitioner's hernia and not the low back. He agreed that just based on the hernia doctor's opinion, he changed his causal connection opinion. He testified that it could be an issue

that the hernia doctor did not put anything in about the low back because he was not treating the low back. (RX4).

On redirect, Dr. Bernstein testified that the March 13th [*sic*] x-ray report indicated possible radiculopathy and also indicated chronic low backache and no trauma and that the combination did not imply or indicate a new back injury. When asked of the significance of the May 29th note from Dr. Salimath that led him to change his opinion, Dr. Bernstein responded that there was no discussion of any other symptoms except for abdominal pain, groin pain, inguinal pain and medial thigh pain, none of which should be associated with a disk problem at L5-S1. When asked whether he would expect Dr. Salimath to comment on whether there were radicular complaints and low back complaints, Dr. Bernstein responded that he could not speak for him, but that he would expect doctors to describe "kind of a global condition" of someone if they had other dominating complaints. (RX4).

On further cross examination when asked whether based on Dr. Salimath's abdominal complaints he would have ever ordered an MRI for the lumbar spine, Dr. Bernstein responded that he did not think so. He agreed that he probably would not have done an x-ray of the lumbar spine but that both of those were done after the accident in question. He agreed that he did not have the treatment records that based the ordering of the MRI or x-ray. (RX4).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on May 12, 2015.

At the outset, the Arbitrator finds Petitioner not to be a credible witness, as he did not appear to be candid and forthcoming in his testimony at arbitration. While Petitioner easily answered questions on direct examination from his counsel, on cross examination Petitioner was unable to remember a number of things, including whether or not he told Dr. Bernstein that he did not have any prior back problems; whether or not he was involved in a motor vehicle accident in 2006; whether or not he went to Dr. Johnson in 2011 with complaints of back pain; whether or not he was in an altercation with his neighbor; and, perhaps most significantly to the Arbitrator, whether or not in 2010 he plead guilty to a theft charge. This, when coupled with some of the types of positions that Petitioner (a self-described union painter) applied for during his self-directed job search as contained in Petitioner's Exhibit 12 (*e.g.*, CEO, Controller, Court Advocate, Pilot, Meteorologist, News Anchor and Psychologist, among others) causes the Arbitrator to place no evidentiary weight on his testimony.

Furthermore, the Arbitrator finds that there are numerous inconsistencies in this case, including those as contained in the testimonial evidence as well as those as contained in the medical evidence. For example, Petitioner testified that on May 12, 2015 while he was working with his foreman and fellow union member, he injured himself lifting a sheet of steel. Petitioner testified that he had an immediate onset of groin, abdominal and back pain. His co-worker and direct supervisor, Eric Young, testified that Petitioner began to limp and complain of abdominal/groin pain on the date of the alleged accident. While Petitioner testified that he sought medical care the following day, Mr. Young's testimony was that he picked Petitioner up the following morning, that he drove him to work and that he worked for several days before Mr. Young told him to go the doctor.

Additionally, there are inconsistent histories as contained in the medical records as well. For example, the interpretive report for x-rays of the left hip dated May 13, 2015 noted that the indication was that of left hip pain that radiated to the groin for the last week. (PX1). Similarly, the interpretive report for

x-rays of the lumbosacral spine also dated May 13, 2015 noted that the indication was that of left hip pain radiating to the groin for the last one week, possible radiculopathy, no trauma. (PX1). Furthermore, the records of UnityPoint Health reflect that Petitioner was seen on May 20, 2015, at which time it was noted that he was complaining of lower abdominal pain and burning in the left thigh. It was noted that Petitioner was complaining of suprapubic pain with radiation across the lower abdomen, worse on the left side, and that it radiated down the left groin. It was noted that the onset was a few days ago and that it had been worsening the past 1-2 days. It was noted that Petitioner denied injury, that he did tell "rooming staff" that he had lifted some metal and denied it was at work, and that he noticed swelling. Petitioner was recommended to undergo a stat sonogram. It was also noted that Radiology called back to report that Petitioner had bilateral hernias (inguinal and femoral) and that a surgery appointment had been scheduled for the next day. It was noted that when Petitioner was notified of the appointment, he mentioned that he injured himself at work. It was further noted that there was conflicting information and that Petitioner told the nurse that he hurt himself on May 12th and had informed his foreman that day. (PX1). Similarly, the interpretive report for the lumbosacral MRI dated May 29, 2015 noted that the indication was that of chronic low backache, pain in the left upper inner thigh since May 12, 2015 and advanced degenerative changes noted on the spinal radiograph. (PX2).

Having considered and reviewed the entirety of the evidence in this matter and having placed no evidentiary weight on Petitioner's testimony, in light of the multitude of inconsistences in the evidence the Arbitrator finds that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on May 12, 2015.

All benefits are denied. The Arbitrator finds that the remaining issues of notice, causation, medical bills, temporary total disability benefits, maintenance benefits, and vocational rehabilitation are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Kleich,

Petitioner,

vs. NO: 17WC 02146

GM Sign, Inc.,

Respondent.

19IWCC0139

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19b having been filed by the parties herein and proper notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, all issues raised at trial, and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 24, 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.

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 28 2019
SJM/sj
o-2/21/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

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

KLEICH, JASON
Employee/Petitioner

Case# **17WC002146**

GM SIGN INC
Employer/Respondent

19IWCC0139

On 7/24/2018, 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 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
JEANMARIE CALCAGNO
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jason Kleich
Employee/Petitioner

v.

G.M. Sign, Inc.
Employer/Respondent

Case # **17** WC **2146**

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 **Michael Glaub**, Arbitrator of the Commission, in the city of **Waukegan**, on **5/24/2018**. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, **7/26/2016**, 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 **$35,334.00**; the average weekly wage was **$702.74**.

On the date of accident, Petitioner was **44** 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 **$15,802.96** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$15,802.96**.

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

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $468.49/week for 29 weeks, commencing 8/4/2016 through 2/23/2017, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $15,802.96 for temporary total disability benefits that have been paid.

Prospective Medical Care
Petitioner is hereby awarded prospective medical care in the form of a right carpal tunnel release surgery as recommended by Dr. Kelly Holtkamp along with all associated reasonable and necessary post-operative medical care.

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

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

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

Signature of Arbitrator

July 23, 2018
Date

JUL 24 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Kleich,	)	
	)	
Petitioner,	)	
	)	
v.	)	**No. 17 WC 2146**
	)	
G.M. Sign, Inc.,	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

Testimony of Petitioner, Jason Kleich

Petitioner worked for Respondent as a fabricator/welder for a period of 23 years. Transcript of Arbitration, hereinafter referred to as "R", 8. As a fabricator/welder Petitioner's responsibilities included welding signs, pulling materials such as steel and aluminum, cutting metal, and drilling. R 8-9. These pieces of metal were typically pieces of sheet metal approximately 5 feet by 8 feet that he would manually move in order to fabricate a sign. R 10. Petitioner would utilize tools such as rivet guns, drills, saws, welders, and hand clamps. R 9, 12. Petitioner worked this job for eight hours per day with overtime, 5 days per week, for 23 years. R 9. Petitioner was working for Respondent as a sign fabricator on July 26, 2016. R 10-11. At approximately 3:00 PM on that date Petitioner was using a hand clamp and applying gripping force with his right hand when his right hand curled in and cramped. R 11-12. Petitioner is right handed. R 12. Petitioner would use hand clamps "almost all day". R 26. Petitioner testified that he had prior issues with both hand being "asleep" when he had woken up, but that he was able to perform his full duty job prior to this date. R 13-14. Petitioner did not receive medical care on that date. R 14.

Petitioner testified that the next day he still could not operate his hand and he attempted to make an appointment with Dr. Kelly Holtkamp. R 15. A medical note contained in Petitioner's medical records dated August 3, 2016 indicates that Petitioner had telephoned the doctors' office and reported sudden right wrist pain from a July 26, 2016 work injury when tightening a clamp. Pet. Ex. #1. Petitioner saw Dr. Kelly Holtkamp on August 4, 2016. *Id.* Petitioner's medical records indicate that Petitioner had injured his right hand while tightening a clamp at work on July 26, 2016. *Id.* Petitioner hand had "cramped up and experienced pain." *Id.* It was noted to be a sudden onset of an "electrical shock" and some numbness in the finger tips. *Id.* Dr. Holtkamp noted a positive Tinel's sign at the right wrist, a positive carpal tunnel compression test, and a positive Phalen's test. *Id.* Dr. Holtkamp recommended an EMG and placed Petitioner off work. *Id.*, R 16.

An EMG performed on September 3, 2016 at Greenleaf EMG revealed mild right carpal tunnel syndrome (Px 2).

Petitioner saw Dr. Holtkamp on September 15, 2016 (Px 1). Dr. Holtkamp noted pain that waxed and waned between 2 and 7 on a scale of 10. *Id.* After reviewing the EMG Dr. Holtkamp recommended an open carpal tunnel release and prescribed Petitioner to be off work for 3 days, then to return to work with a restriction of no lifting greater than 5 lbs. *Id.* Dr. Holtkamp noted in the medical record that, "It is my opinion within a reasonable degree of medical and surgical certainty that the right carpal tunnel syndrome is causally related to work secondary to history of injury." *Id.* Petitioner testified that there was never light duty offered to him by Respondent. R 17. Petitioner physically presented for light duty to his supervisor, Garrett, but was not accommodated. R 68.

Respondent sent Petitioner for an IME with Dr. Craig Phillips at the Illinois Bone and Joint Institute on December 6, 2016. Resp. Ex. #3. Dr. Phillips noted that Petitioner injured his right hand on July 26, 2016 while tightening a clamp at work. *Id.* He further notes that he reviewed a Form 45 that noted that Petitioner's right hand cramped up while tightening a claim on July 26, 2016 at work. *Id.* Dr. Phillips also reviewed a job description forwarded by Respondent. *Id.* Dr. Phillips diagnosed Petitioner with right-sided carpal tunnel syndrome, but opined that it was a long-standing condition that was not an acute injury. *Id.* He believes that the July 26, 2016 incident only caused Petitioner pain. *Id.* He further opined that Petitioner requires surgery for his carpal tunnel syndrome, but does not believe that it is related to his July 26, 2016 work injury. *Id.*

Petitioner last saw Dr. Holtkamp on February 23, 2017 (Px)1. Dr. Holtkamp noted pain in Petitioner's left hand that was from a work injury nearly 1.5 years prior but that treatment was being pursued through personal health insurance. *Id.*

On June 26, 2017 Dr. Holtkamp authored a narrative report answer certain questions from Petitioner's counsel (Px 3). Dr. Holtkamp wrote that she believes that Petitioner's current condition is related to his job duties. *Id.* She wrote that she believes that the injury from 7/26/2016 was an aggravation of an underlying condition. *Id.* She confirmed that she believes that Petitioner requires an open right carpal tunnel release. *Id.*

Petitioner testified that he did received TTD benefits initially but that they were delayed. R 20. He further testified that his medical bills have been paid. R 20. Petitioner wishes to have surgery and would have it performed immediately if the Arbitrator were to award it. R 21-22. Petitioner testified that he was terminated by Respondent in February 2017. R 22. Petitioner has not worked since the accident and has been on State medical insurance and was receiving food

stamps for a period of time. R 23. Petitioner denies any other accidents to his right hand since July 26, 2016. R 22-23. Petitioner admits that prior to July 26, 2016 he had some bouts of numbness, but was able to fully perform his job duties. R 24. Petitioner was wearing wrist splints as recommended by Dr. Holtkamp on the day of trial. R 25.

Petitioner testified on cross-examination that he had previously sought emergency room treatment when he was unable to get his "hand awake." R 29 Petitioner testified that he underwent a cardiac work up and was discharged without follow up. R 31. Petitioner testified that despite having previous issues, he had never had feelings like what was experienced after this accident. R 73. Petitioner testified that he used to lift weights in his home. R 43. He testified that he has not worked out since approximately 2010. R 76. Petitioner applied for unemployment benefits subsequent to being terminated, but those benefits were denied and no appeal was taken. R 39.

Petitioner testified that he owns two guns and used to shoot at a gun range in Waukegan prior to his accident. R 57-58. When Petitioner went to the range he would fire twenty rounds as he would split a box of ammunition with his girlfriend. R 66. Petitioner has been unable to fire a weapon since his work accident. R 77. Petitioner had a car accident in 1993 in which he sustained cracked ribs, but no injury to his right hand. R 72.

Testimony of Mr. George Matiasek

Respondent called Mr. George Matiasek to testify. R 82. Mr. Matiasek is President of the Respondent, G.M. Sign, Inc., and has been with the Respondent for 37 years. R. 83. Mr. Matiasek testified that the Respondent's business is custom sign manufacturing. R 84-85. Mr. Matiasek that Petitioner was employed as a sign fabricator. R 85. Mr. Matiasek testified that the

clamp that Petitioner was using was force dependent, or held as hard as someone squeezed. R 104, 108. He testified that using a clamp as a sign fabricator is reasonable. R 102. Mr. Matiasek testified that Petitioner's job did not require repetitive work, repetitive forceful gripping, and repetitive heavy gripping. R 93-94. Mr. Matiasek reviewed and signed off on a job description for Respondent. R 100.

On cross-examination Mr. Matiasek testified that he received a form for Petitioner's light duty, but that light duty was not available. R 102-103. Mr. Matiasek confirmed that Petitioner was terminated by Respondent. R 103.

Testimony of Ms. Denise McNicholas

Respondent called Ms. Denise McNicholas to testify. R 110. Ms. McNicholas is employer by Comp Alliance Managed Care in vocational case management. R 113-114. Ms. McNicholas performed a job analysis in conjunction with Petitioner's job. R 116. Ms. McNicholas testified that she performed measurements related to the job of sign fabricator and measured forces involved with the job duties. R 119-120. Ms. McNicholas also videotaped work activities related to the position of sign fabricator and the video was admitted as Respondent's Exhibit #10. R 123. In conjunction with the video analysis, Ms. McNicholas also issued a written job analysis, admitted as Respondent's Exhibit #6. R 125. Ms. McNicholas played part of the video job analysis for the Court and the Arbitrator noted that he observed a device being used that looked like "an oversized vice grip." R 131. Ms. McNicholas testified that according to her measurements the force required to open/close the clamp in question was between 10 and 20 pounds. R 134. She testified that the range was due to individuals' build and strength. R 134-135.

On cross-examination Ms. McNicholas testified that it is possible to use over 20 pounds of force when using the vice clamp in question. R 142. Ms. McNicholas testified that she referred to the use of vice grips as "frequently" in her report, but testified that sign fabricators only "occasionally" use the vice clamps. R 145. She clarified this point by testifying that her narrative report is less accurate. R 145-146.

Deposition of Dr. Kelly Holtkamp

Dr. Kelly Holtkamp testified by way of evidence deposition (Px 4). Dr. Holtkamp testified that she is a board certified hand surgeon. *Id.* at 4-5. Dr. Holtkamp testified that Petitioner reported to her that he had injured his right hand while using a clamp at work on July 26, 2016. *Id.* at 7-8. Her physical examination of Petitioner on that date revealed a positive carpal tunnel compression test and a positive Phalen's test, both indicative of carpal tunnel syndrome on the right. *Id.* at 8-9. After recommending an reviewing an EMG, Dr. Holtkamp diagnosed Petitioner with carpal tunnel syndrome and recommended an open right carpal tunnel release. *Id.* at 9-11. She testified that she is familiar with the Petitioner's job duties and understands that Petitioner was forcefully gripping a clamp when he was injured. *Id.* at 13-14. She testified that Petitioner is not female and does not have any conditions that would result in a predisposition of developing carpal tunnel syndrome. *Id.* at 14-15. She testified that she believes that Petitioner's current condition is causally related to his work injury as that incident was an aggravation of his pre-existing carpal tunnel syndrome. *Id.* at 16. She believes that Petitioner had carpal tunnel syndrome and then had a work injury that caused it to manifest itself. *Id.* at 16-17. On cross-examination Dr. Holtkamp testified that she had not seen a formal job description. *Id.* at 27.

Deposition of Dr. Craig Phillips

Dr. Craig Phillips testified by way of evidence deposition (Rx 1). Dr. Phillips is a board certified orthopedic surgeon with an added qualification in hand and upper extremity surgery. *Id.* at 7-8. Dr. Phillips performs approximately 150 IMEs per year. *Id.* at 10. Dr. Phillips reviewed Petitioner's prior medical records, injury report, EMG, a job analysis report, and job video. *Id.* at 13. Dr. Phillips took a history from Petitioner and interviewed him, revealing that Petitioner enjoys shooting a gun and shoots about 1000 rounds at a time, and that Petitioner likes to work out but has not done so in 2 years. *Id.*at 18. Dr. Phillips related that Petitioner reported that he injured his right hand while turning and tightening a clamp on Jily 26, 2016 at work. *Id.* at 20. Dr. Phillips then described the job duties of a sign fabricator based on the job description provided to him. *Id.* at 23-28. Dr. Phillips testified that the examinations and tests that he performed on Petitioner had results that he could not explain, and caused him to believe that Petitioner was exaggerating his condition. *Id.* at 30-36. Dr. Phillips diagnosed Petitioner with bilateral carpal tunnel syndrome and symptom magnification. *Id.* at 40. He does not believe that the tightening of the clamp by Petitioner on July 26, 2016 played any role in Petitioner's condition. *Id.* at 41. He believes that Petitioner's carpal tunnel is pre-existing and was not aggravated by the July 26, 2016 work accident. *Id.* at 42-43. He felt Petitioner was capable of returning to work full duty. *Id.* at 49.

On cross-examination Dr. Phillips testified that Petitioner had pre-existing carpal tunnel syndrome, by he reviewed no medical records pre-dating the work accident. *Id.* at 49-50. Dr. Phillips confirmed that Petitioner did have a positive Tinel's sign on examination. *Id.* at 54.

CONCLUSIONS OF LAW

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

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, are generally deemed to have been received "in the course" of the employment. *Caterpillar Tractor Co. v. Indust. Comm'n.*, 129 Ill.2d 52, 57 (1989) The "arising out of" component refers to the origin of cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.* at 58. There is no dispute that Petitioner was working as a sign fabricator for Respondent on July 26, 2016. On that date he was using a hand clamp when his right hand cramped up and froze. There is also no dispute and ample evidence from every witness in this case that the use of this claim is reasonable and foreseeable in the position of sign fabricator. This is an action that arises out and in the course of Petitioner's employment by Respondent.

The inquiry in this case is therefore whether the accident occurred. The Arbitrator finds that it did. Petitioner testified credibly that he was squeezing and tightening a clamp with his right hand at work on July 26, 2016 when his hand cramped up and he was unable to use it. R 11-12. Petitioner's telephone call to his doctor's office on August 3, 2017 records the exact same history and mechanism of injury (Px 1). Petitioner's initial medical record from Dr. Holtkamp on August 4, 2016 records the exact same history and mechanism of injury (Px 1). The From 45 injury report (that was not offered into evidence at trial) that Dr. Craig Phillips

reviewed in conjunction with his IME records the exact same history and mechanism of injury. (Rx 3).

Based on the above, the Arbitrator finds that the preponderance of credible evidence establishes that Petitioner injured his right hand and wrist in an accident that arose out of and in the course of his employment by Respondent on July 26, 2016 while tightening a clamp.

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

Dr. Holtkamp and Dr. Phillips agree that Petitioner's right carpal tunnel condition pre-existed the July 26, 2016 work accident. The doctors have differing opinions regarding whether or not the July 26, 2016 accident aggravated Petitioner's pre-existing condition. Dr. Holtkamp believes that the accident of July 26, 2016 manifested and aggravated Petitioner's right carpal tunnel syndrome. Dr. Phillips believes that the July 26, 2016 "incident", as he describes it, did not play any role in Petitioner's condition. He opines that Petitioner could not have used an amount of force sufficient to have caused injury. However, the evidence at trial shows that the amount of force used on the clamp in question is determined by the user. Dr. Phillips could not possibly know the amount of force used by Petitioner on the day of accident. This medical opinion is not supported by the facts of this case. Immediately following the July 26, 2016 work accident Petitioner telephoned Dr. Holtkamp's office and related what had occurred and Petitioner's medical records establish that his right hand condition manifested immediately after the accident. Dr. Phillips's opinion is not supported by the evidence in this case.

Further, a causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform the duties before the date of the

accident, and inability to perform the same duties following that date. Pulliam Masonry v. Industrial Comm'n., 77 Ill.2d 469, 471 (1979). In this case, Petitioner had pre-existing carpal tunnel in his right wrist that was asymptomatic. Petitioner did seek emergency medical care once in the years prior due to both of his hands being asleep, but never received ongoing medical care or any diagnostic testing for carpal tunnel syndrome. Prior to the accident of July 26, 2016, petitioner was pain and symptom free in his right hand and wrist and was not receiving any active medical treatment for this condition. Further, petitioner was able to perform all of his job functions prior to July 26, 2016. Petitioner had a quiescent condition that was rendered symptomatic on July 26, 2016 when he was using a clamp. Following that accident Petitioner was unable to perform his job duties, a diagnostic test confirmed a diagnosis of moderate carpal tunnel syndrome and surgery was recommended.

Based on all of the above, the Arbitrator finds a causal relationship between the petitioner's right hand condition and his accidental injuries of July 26, 2016.

(K) Is Petitioner entitled to any Prospective Medical Care?

Dr. Holtkamp and Dr. Phillips, both board certified orthopedic hand surgeons agree that Petitioner requires a right carpal tunnel release. There is no medical evidence to the contrary.

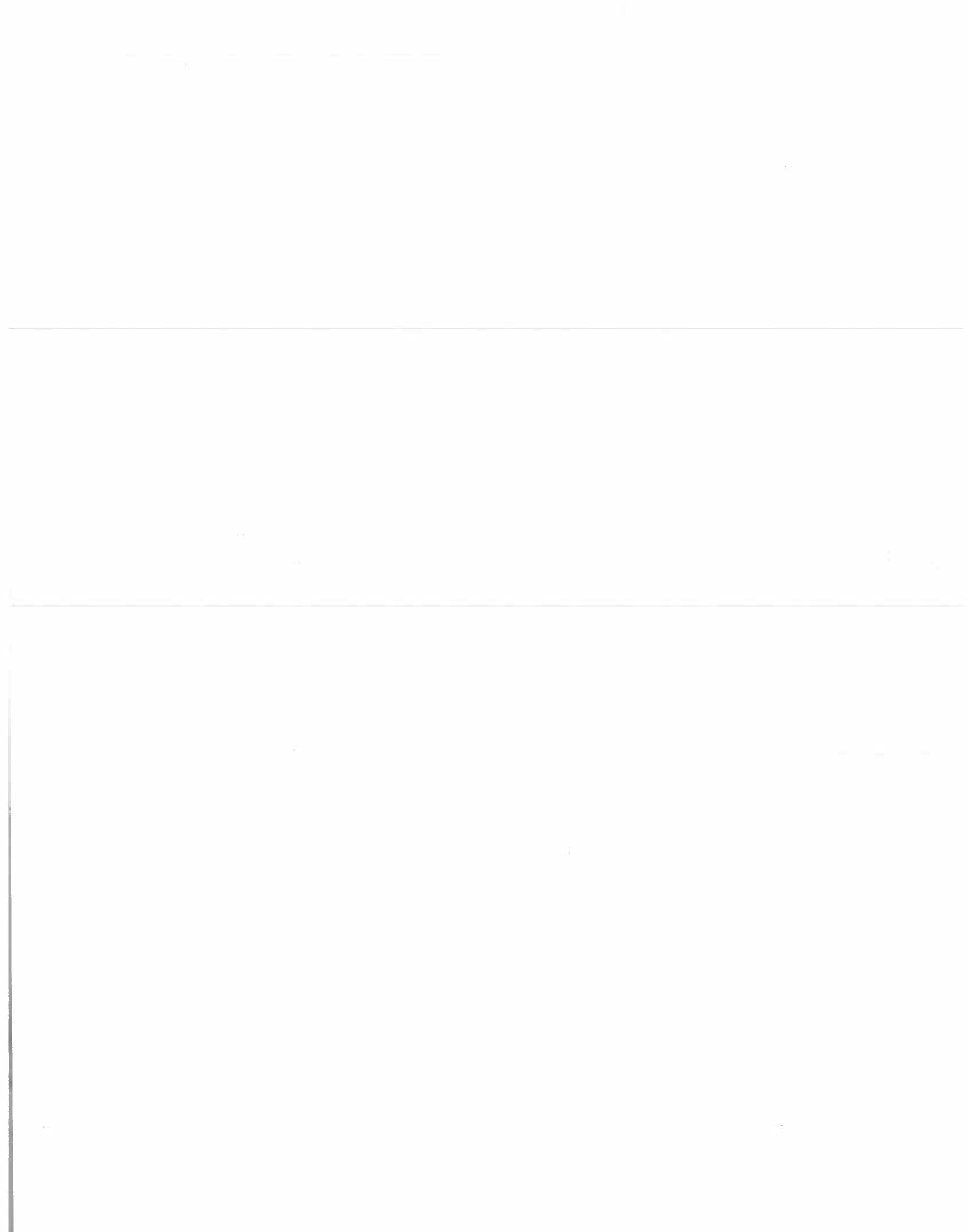
Based on the above including the Arbitrator's findings on the issue of causal relation, the Arbitrator finds that Petitioner is entitled to prospective medical care in the form of a right carpal tunnel release as recommended by Dr. Kelly Holtkamp along with all associated reasonable and necessary post-operative rehabilitative care.

(L) What Temporary Total Disability Benefits are in dispute?

Petitioner is claiming that he entitled to TTD from August 4, 2016 through the date of trial of May 24, 2018, a period of 94 1/7 weeks. Petitioner was initially taken off work by Dr. Holtkamp following his initial visit on August 4, 2016. On September 15, 2016 Dr. Holtkamp released Petitioner to return to work light duty with a 5 pound lifting restrictions. Petitioner testified that Respondent was unable to take him back to work. R 68. Further, Mr. Matiasek testified that he received a form for Petitioner's light duty, but that light duty was not available.

The Arbitrator notes the narrative report of Dr. Holtkamp of June 26, 2017. In that report, Dr. Holtkamp opines that the petitioner's "work capability is within his tolerance of activity" (Px 3). The Arbitrator further notes that petitioner last medical treatment of any kind was on February 23, 2017. The Arbitrator reviewed the progress notes of petitioner's visits with Dr. Holtkamp in February 2017. The Arbitrator finds no reference to Dr. Holtkamp's medical opinion in those progress notes regarding the petitioner's ability to work. In fact, under a section labeled "Current Work Status" are the words: "not working due to another problem". The Arbitrator notes there was no evidence offered by petitioner as to "his tolerance of activity". The Arbitrator believes that Dr. Holtkamp altered her opinion regarding the initial work restrictions she imposed. The Arbitrator further believes that the change in Dr. Holtkamp's opinion was likely based on her most recent medical examinations of the petitioner, the last of which occurred on February 23, 2017. The Arbitrator also notes the medical opinion of Dr. Philips who opined that petitioner could work without restrictions based on his independent medical exam of December 6, 2016.

Based on all of the above including the Arbitrator's findings on causal relation, the Arbitrator finds that the Petitioner proved he is entitled to TTD benefits from August 4, 2016 through February 23, 2017, a period of 29 weeks less the Respondent's stipulated credit of $15,802.96 for TTD benefits paid. Based on all of the above, the Arbitrator further finds that the petitioner failed to prove he is entitled to temporary total disability benefits after February 23, 2017.



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

Craig Ullrich,
Petitioner,

vs.

NO: 12 WC 37617

19IWCC0142

CST Storage,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 9, 2017 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 1 - 2019

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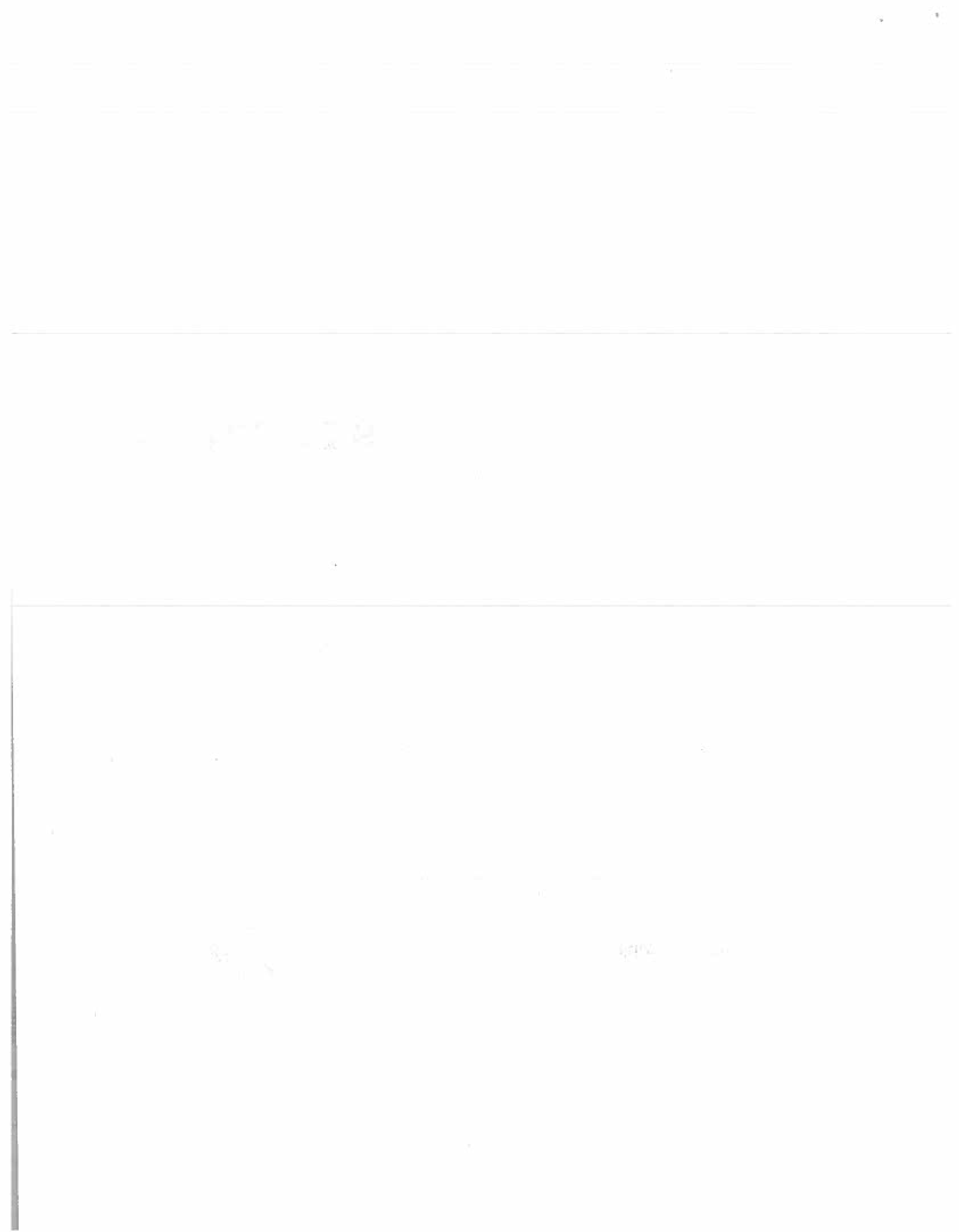
CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

ULLRICH, CRAIG
Employee/Petitioner

Case# **12WC037617**

CST STORAGE
Employer/Respondent

19IWCC0142

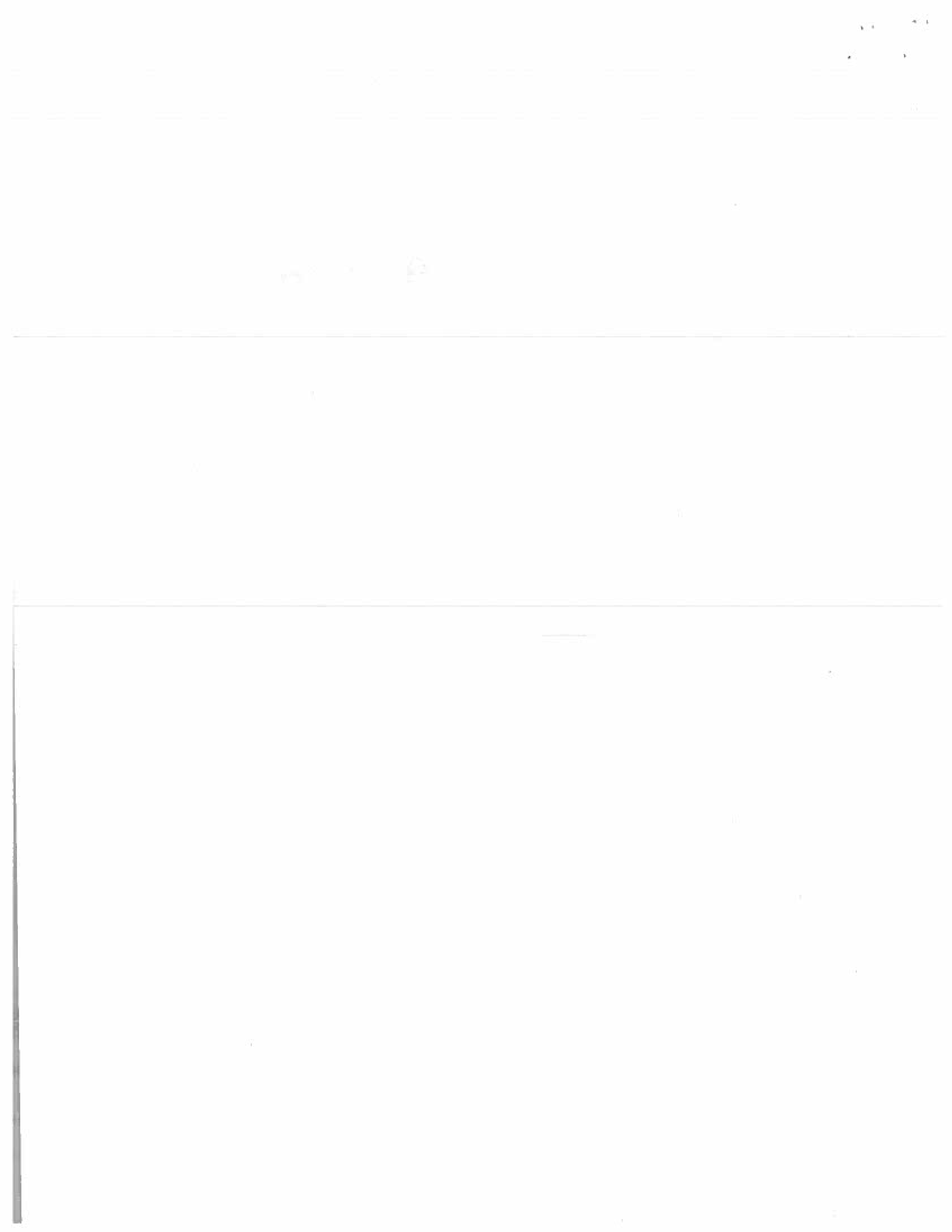
On 2/9/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

2097 GRANT & FANNING
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606



STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION

Craig Ullrich
Employee/Petitioner

v.

CST Storage
Employer/Respondent

Case # 12 WC 37617

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **December 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 28, 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 as explained *infra*.

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

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

In the year preceding the injury, Petitioner earned **$45,344.00**; the average weekly wage was **$872.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*..

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,857.14** for other benefits (i.e., non-occupational indemnity disability benefits), for a total credit of $**1,857.14 less tax consequences** as agreed by the parties. *See* AX1.

Respondent is entitled to a credit of $**28,000.45** under Section 8(j) of the Act. *See* AX1.

ORDER

Accident & Causal Connection

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that he sustained a compensable injury on February 28, 2012 as claimed and a continued causal connection between his condition of ill-being and accident at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $581.33/week for 13 & 5/7th weeks, commencing December 20, 2012 through January 14, 2013 and April 24, 2014 through July 2, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from February 28, 2012 through December 14, 2016, and shall pay the remainder of the award, if any, in weekly payments.

As agreed by the parties, Respondent is entitled to a credit for payment of these short-term disability benefits as agreed by the parties less any tax benefits.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits 10-19 for medical bills that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner permanent partial disability benefits of $523.20/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole (left shoulder), as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

February 9, 2017
Date

FEB - 9 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION *ADDENDUM*

Craig Ullrich
Employee/Petitioner

v.

CST Storage
Employer/Respondent

Case # **12** WC **37617**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include whether Petitioner sustained a compensable accident on February 28, 2012, whether there is a causal connection between Petitioner's condition of ill-being and accident, Respondent's liability for payment of Petitioner's medical bills, Petitioner's entitlement to temporary total disability benefits commencing on December 20, 2012 through January 14, 2013 and April 24, 2014 through July 2, 2014, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Craig Ullrich (Petitioner) testified that he began working for CST Storage (Respondent) on October 4, 1993. He explained that Respondent makes water tanks and blue tanks. Petitioner testified that he was employed as a Material Handler in which he drove a forklift on the "glass line." Petitioner testified that he had never injured his left arm before or after February 28, 2012. Petitioner testified that he is left-hand dominant.

February 28, 2012

On February 28, 2012, Petitioner testified that he was shoveling white, liquid glass into a hopper because there was a broken conveyor belt. He and others had to shovel the glass out of a booth so that production could continue. Petitioner explained that the liquid glass was sprayed through spray guns located inside of a booth measuring approximately 3-4' by 8' and he had to shovel the glass up and over several steps into the hopper. Petitioner testified that he could not lift a full shovel of glass because it was so heavy. He could not remember exactly how long he was shoveling glass, but it lasted a couple of hours.

Petitioner testified that he had never done this type of work before and he felt aches and pains in his left shoulder. Petitioner did not report the aches and pains on February 28, 2012, but continued to experience these symptoms after his shift ended and he went home.

Notice & Accident Report

The following day, Petitioner testified that he told his first shift supervisor, Brian Kyrk (Mr. Kyrk), that he thought he hurt his shoulder the night before when shoveling out the booth. Petitioner testified that Mr. Kyrk told him to report it to the second shift supervisor.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Deposition Exhibits are further denominated "(Dep. Ex. _)."

Shortly after speaking with Mr. Kyrk before his shift started, Petitioner testified that he then spoke with Ron Brotz (Mr. Brotz). Petitioner testified that Mr. Brotz got a little upset. He explained that Mr. Brotz pulled him into the office and said that he should have reported it the same night. Petitioner testified that he understood that Mr. Brotz was going to fill out an accident report, and he (Petitioner) was not supposed to so. However, Petitioner testified that Mr. Brotz did not fill out the accident report for another six months. He testified that he kept asking Mr. Brotz every other day about filling out the accident report because he wanted to get his shoulder "looked at."

Respondent submitted into evidence Mr. Brotz's "Illinois Form 45: Employer's First Report of Injury" dated November 8, 2012. RX2. The form indicated that Petitioner had a "[s]ore shoulder while shoveling" and that the injury was a "Shoulder Strain[.]" *Id.*

On cross examination, Petitioner testified that Mr. Brotz filled out the form on November 8, 2012. He admitted that he told Mr. Brotz that he did not really want to shovel the glass, but shoveled the glass regardless. Petitioner denied telling Mr. Brotz that his "shoulder was fine" and admitted that he did not like how Mr. Brotz ran his shift, but testified that he told Mr. Brotz about the accident at the first opportunity. He explained to Mr. Brotz that he did not report the accident on February 28, 2012, because the time of their conversation was the first time he had seen Mr. Brotz since the accident.

Petitioner testified that his pain worsened from the time of the accident until he saw Dr. Choi after being authorized to do so by Ms. Robinson in human resources.

Medical Treatment

Petitioner testified that he had to go through HR to get medical treatment approved and HR required a work accident report before approval. Petitioner testified that Kay Robinson was the HR person. Petitioner testified that Ms. Robinson set up an appointment for him with Dr. Choi. His first visit with Dr. Choi was the first time that he got permission to seek medical treatment. Petitioner testified that Ms. Robinson arranged his appointment with Dr. Choi. Petitioner testified that he told Ms. Robinson about his injuries including left shoulder symptoms and left hand symptoms including losing strength in the hand. Petitioner could not recall when he talked to Ms. Robinson in this time period. On cross examination, Petitioner testified that the report should have been filled out at this point. He explained that he asked HR if he could see a copy of the report, but was told they could not find it.

Petitioner testified that he was able to work his regular job between the date of the accident and seeing Dr. Choi for the first time. He testified that he was safely able to operate a forklift despite his condition.

On October 16, 2012, Petitioner saw Tony Choi, M.D. (Dr. Choi). On cross examination, Petitioner testified that his left shoulder blade problem was more prominent than the hand. However, Petitioner testified that Dr. Choi focused on his left hand. Dr. Choi's medical records reflect a "Patient History Sheet" in which Petitioner noted that the reason for his visit was his "shoulders[,]" the date of onset was "03/12[,]" the type of accident involved "[s]hoveling white glass[,]" the injury was work-related, and he did notify his employer. PX1.

Dr. Choi noted the following initial history:

> Craig is a former patient of mine who I saw back in 2009 for a partial biceps rupture that underwent

> operative intervention. I followed him along for this and then in 2010 he came back with some cervical spine issues. These resolved on their own with conservative care. He did have an MRI and EMG. The EMG was negative, but the MRI did show that he had multilevel degenerative changes. I advised going to see the spine surgeons, but I do not think he ever went and saw them.
>
> He is here for pain in his shoulder blade and down his arm. He states that he was shoveling glass, which was back in March, and then all of a sudden he started having pain around his shoulder blade region. It really would not shoot into the shoulder. Occasionally, it would go down his arm, but not into his fingers. Over the last month, however, he has noticed a lot of weakness and difficulties in bringing his wrist into extension. He has noticed more and more difficulties extending his fourth and fifth fingers.

PX1. Petitioner underwent x-rays of the shoulder and neck which showed degenerative changes at C6-C7 as well as other areas of his spine. *Id.* Dr. Choi also reviewed Petitioner's MRI from 2010 of the cervical spine which showed a large disc extrusion at C8 impinging on the C8 nerve root, a moderate disc bulge at C6-C7 causing central canal stenosis, severe right sided and moderate left sided neural foraminal stenosis with impingement of the C7 nerve root, and bilateral neural foraminal stenosis at C6. *Id.* Dr. Choi diagnosed Petitioner with left upper arm and shoulder pain, but noted his examinations for cuff irritation and SLAP irritation were negative. *Id.* He indicated that Petitioner's condition could be neurological given the wasting in the left hand and difficulties moving the left hand. *Id.* Dr. Choi ordered an MRI and EMG to determine if he had peripheral nerve entrapment or cervical radiculopathy noting "pain shoulder blade/neck" in the order form. *Id.*

On October 25, 2012, Petitioner underwent the recommended cervical MRI. PX1. The interpreting radiologist noted the following: (1) C5-6 moderate left paracentral disc extrusion with 3 mm inferior migration, left ventral impression upon the cord with mild central canal stenosis, mild to moderate bilateral foraminal stenosis, disc extrusion was not present on the previous MRI August 13, 2010 and potential source of left-sided nerve root impingement; (2) C6-7 moderate bilateral foraminal disc protrusions with severe bilateral foraminal stenosis with impingement upon the bilateral exiting the C7 nerve roots unchanged since the prior MRI under: (3) C7-T1 moderate bilateral foraminal disc extrusions with moderate bilateral foraminal stenosis without definite nerve root impingement unchanged; and (4) C4-5 small central disc protrusion with a ventral impression upon the cord and mild central canal stenosis which is slightly larger when compared to the previous MRI. PX1.

The following day, on October 26, 2012, Petitioner underwent the recommended EMG/NCV, which showed a predominantly axonal lesion of the left posterior interosseous nerve with a superimposed C7, C8, and T1 radiculopathy on the left. PX1.

Petitioner returned to Dr. Choi on October 30, 2012. PX1. Dr. Choi noted that he reviewed Petitioner's cervical MRI and EMG/NCV, and that he spoke with the physician who administered the EMG/NCV, Dr. Malalis, who picked "up a cervical radiculopathy on the left side involving the C7-8 nerve roots, and then she also picks up a posterior interosseous nerve entrapment syndrome." *Id.* Dr. Choi diagnosed Petitioner with left upper extremity weakness noting his belief that there was nerve root involvement at C7 level, possibly a posterior interosseous nerve entrapment. *Id.* He referred Petitioner to Dr. Hwang for an evaluation and he ordered a left forearm MRI to ensure there were no masses pressing on the nerve. *Id.* Petitioner underwent the recommended left forearm MRI on November 1, 2012 then saw Dr. Hwang. *Id.*

On November 9, 2012, Raymond Hwang, M.D. (Dr. Hwang) noted the following history from Petitioner in pertinent part:

> The patient is a 47-year-old male, who presents with approximately seven months' worth of symptoms involving the left upper extremity. He reports that, in March of 2012, he was shoveling glass his left shoulder. He localizes his pain to the medial aspect of the left scapula, where there is sharp and achy pain. He also reports that, approximately three months ago, he developed atraumatic-onset numbness and tingling involving, primarily, the ulnar aspect of the left hand and ulnar 2-1/2 digits. He also experiences, to a lesser extent, numbness and tingling involving the ulnar aspect of his forearm. He denied upper arm numbness and tingling. He feels better with rest. He feels worse when he is working. ... She reports significant weakness in his left hand. In particular, he is unable to extend his digits actively. As such, he is having significant difficulty using his left hand. He reports that he noticed this approximately 3 months ago. He is primarily right-hand dominant.... He denies neck pain. ....

PX1. Dr. Hwang noted Petitioner's prior surgical history including a carpal tunnel release and biceps tear repair. *Id.* After an examination, Dr. Hwang assessed Petitioner to have seven months worth of posterior shoulder pain, three months worth of profound weakness involving the left and, diffuse cervical spondylosis, cervical stenosis at C4-C5, foraminal stenosis from C5-T1, radiculopathy and posterior interosseous nerve entrapment syndrome from C7-T1 by EMG, and suspected Parsonage Turner syndrome by MRI. *Id.* Dr. Hwang noted that there was a suspicion for cervical pathology in Petitioner's overall symptomatology, but it was complex and did not adequately explain Petitioner symptoms in total. *Id.* Dr. Hwang ordered a brachial plexus MRI and noted that a multilevel decompression and fusion of the cervical spine might be appropriate, but that Petitioner was averse to surgery at that time. *Id.*

On November 14, 2012, Petitioner returned to Dr. Hwang who recommended a posterior interosseous nerve release with Dr. Choi and further follow up with him (Dr. Hwang) thereafter. PX1. On November 26, 2012, Dr. Choi noted that Petitioner's brachial plexus MRI did not show evidence of Parsonage Turner syndrome. *Id.* he ordered physical therapy and recommended the posterior interosseous nerve release. *Id.*

On December 20, 2012, Petitioner underwent the recommended left posterior interosseous nerve entrapment release surgery with Dr. Choi. PX1-PX2. Petitioner returned to Dr. Choi post-operatively on January 3, 2013 voicing frustration with the lack of improvement and continued pseudo-claw of the left fourth and fifth fingers. *Id.* Dr. Choi noted that Petitioner wished to return to work, but he felt it was unsafe at that point without restrictions indicating that Petitioner might need several months to obtain nerve recovery. *Id.* Dr. Choi ordered physical therapy and released Petitioner to right-handed work only. *Id.* Petitioner testified that he returned to work after January 14, 2013, but his condition did not improve.

On January 21, 2013, Petitioner reported increasing bilateral scapular pain the time of his surgery. PX1. Dr. Choi ordered cervical and scapular thoracic physical therapy and referred Petitioner back to Dr. Hwang for follow. *Id.* Petitioner underwent the recommended physical therapy at Rochelle community hospital. PX3. Petitioner testified that after physical therapy his left hand was not better and that he continued to have pains in his left shoulder while receiving treatment for the left hand.

Petitioner continued to report scapular symptoms to Dr. Choi on February 18, 2013. PX1. Dr. Choi indicated his belief that there was something more proximal going on with Petitioner from a neurologic standpoint and he referred Petitioner to Dr. Hwang as well as Dr. Ta for a neurologic evaluation for possible Parsonage Turner syndrome and a repeat EMG/NCV. *Id.* Petitioner underwent the recommended repeat EMG/NCV with Dr. Ta on March 19, 2013. PX4. Dr. Ta noted compressive neuropathy of the ulnar nerve at the elbow (i.e., cubital tunnel syndrome), no clinical or electrical evidence of cervical radiculopathy, no evidence of posterior interosseous nerve entrapment, and lower brachial plexopathy. *Id.* Dr. Ta also indicated that "most of these cases are idiopathic in nature." *Id.*

Petitioner returned to Dr. Choi on April 5, 2013 reporting that nothing had really changed. PX1. Dr. Choi found Petitioner's ulnar nerve entrapment to be a bit concerning and that the irritation might be more upstream, but an ulnar nerve release might not improve all of Petitioner's symptoms. *Id.* He referred Petitioner to Dr. Ta for follow up regarding any available treatment for the lower brachial plexopathy. *Id.* Petitioner last saw Dr. Choi on June 3, 2013 with no improvement in the ability to move his fingers. *Id.* Dr. Choi diagnosed Petitioner with left arm lower brachial plexus happy and indicated that he did not have a good etiology for Petitioner's lower brachial plexus happy, but indicated that he had a large cervical disc osteophyte complex in the neck that he had for two or three years with no changes and, while he had no neck pain, the spine surgeon did not believe Petitioner would get much benefit from a cervical decompression. *Id.* Dr. Choi indicated that Petitioner might see the physicians at the Mayo Clinic but noted that without a stretch injury or laceration he was unsure how many options there works for Petitioner. *Id.*

Petitioner testified that Dr. Choi said that there was nothing for him to do other than go to St. Paul, Minnesota or St. Louis, Missouri for other options. Petitioner testified that he continued to have problems, so he found Dr. Chudik at Hinsdale Orthopaedics as referred by his sister. He also testified that he was unable to work during the temporary total disability period, but he did get short-term disability benefits during this period of time. On cross examination, Petitioner testified that he did not remember whether he needed to fill out paperwork indicating whether the injury was related or unrelated to work.

On October 18, 2013, Petitioner saw Steven Chudik, M.D. (Dr. Chudik) at Hinsdale Orthopaedics for the first time. PX5. Dr. Chudik noted the following history:

> CRAIG A ULLRICH is a 48 year old male who presents today with a chief complaint of left shoulder pain. It began approximately on 02/01/2012. The problem resulted [from an] injury at work.The problem resulted from shoveling wet glass. Currently it is a 6 on a pain scale of 10. The patient did not previously sustain any significant injury to this part of the body. The patient never had surgery on this part of the body. The patient has seen another orthopaedist, a physical therapist for this problem. The patient has had the following tests and/or treatments performed for this problem: Xray. The timing of the pain/problem is constant. Pain occurs when moving, working, reaching, lifting, carrying. The pain/symptoms radiating to the lateral arm, hand. The patient states that movement, work, reaching, lifting, carrying aggravates or increases the pain and/or symptoms. He had a posterior osseous nerve release on December 20, 2012. He is still unable to fully extend 4th and 5th digits.

Id. After a physical examination, Dr. Chudik diagnosed Petitioner with left shoulder pain noting weakness in the extensor carpi ulnaris and lack of motion in fourth and fifth phalanx. *Id.* He referred Petitioner to Dr. Fajardo to evaluate the left hand weakness noting possible nerve palsy. *Id.*

Petitioner returned to Dr. Chudik on November 4, 2013 who reviewed Petitioner's recent left shoulder MRI. PX5. Dr. Chudik diagnosed Petitioner with a traumatic rotator cuff tear noting his review of the MRI showing a non-retracted posterior tear in the infraspinitis and supraspinatus. *Id.* He recommended a left shoulder arthroscopy with rotator cuff repair. *Id.*

Petitioner also saw Marc Fajardo, M.D. (Dr. Fajardo) on November 4, 2013. PX5. Dr. Fajardo noted that Petitioner was a "48-year-old male, left-hand dominant, works as a utility operator status post work related injury in February 2012, where he was shoveling glass. Since that time, he has been complaining of extreme weakness over the dorsal ulnar aspect of his hand." *Id.* Dr. Fajardo ordered a repeat EMG/NCV of the left arm and neck, requested Dr. Choi's records. *Id.*

Petitioner underwent the recommended repeat EMG and returned to Dr. Fajardo on January 17, 2014. PX5. Dr. Fajardo noted that the EMG showed no brachial plexus happy and he diagnosed Petitioner with resolving brachial plexus happy/posterior cord and resolving radial tunnel syndrome. *Id.* He indicated that Petitioner was significantly improving since his last visit and he was cleared from his standpoint for a rotator cuff surgery as recommended by Dr. Chudik. *Id.* Petitioner was instructed to return as needed. *Id.*

On April 17, 2014, Petitioner returned to Dr. Chudik who reiterated his recommendation for a left shoulder arthroscopy with rotator cuff repair. PX5.

Petitioner underwent the recommended surgery on April 24, 2014 at Elmhurst Memorial Hospital. PX6. Dr. Chudik diagnosed Petitioner with left shoulder pain, left shoulder subcoracoid impingement, left partial rotator cuff labral tear, left shoulder impingement, left rotator cuff tear of the subscapularis, and left biceps instability and partial rupture proximally. *Id.* He performed a left shoulder arthroscopy, extensive glenohumeral debridement, subacromial decompression, subcoracoid decompression, subscapularis repair and open biceps tenodesis. *Id.*

Petitioner saw Dr. Chudik postoperatively on May 5, 2014 at which time he kept Petitioner off of work and ordered postoperative physical therapy. PX5. Petitioner underwent the recommended physical therapy. PX7.

Petitioner's Independent Medical Evaluation

On July 10, 2014 Petitioner saw Robert Eilers, M.D. (Dr. Eilers) at Petitioner's attorney's request. PX8 (Dep. Ex. 2). Dr. Eilers noted the following history from Petitioner in pertinent part:

> He indicated when he was at work in the factory on 02/28/2012, he had to shovel what is liquid glass which is very heavy. The conveyor belt between two sites broke down. The glass would have to be shoveled off. It could be 50-70 pounds a shovel. He would shovel it into a hopper and then move the hopper and unload it. The hopper is about 4-5 feet above the ground, maybe 5 x 6 feet wide when filled, and he estimated it would be at least 3000 pounds. He indicated he would then take the hopper and shovel out all the glass on the other side, basically having moved possibly 6000 pounds material. He demonstrated shoveling. He uses his left arm to hold the shovel forward. He uses that for lifting and then would have to place that in the hopper. He indicated after completing that task, he ended up having pain in his shoulders due to the conveyor being broken and having to physically move all of that material. He indicated he was having difficulty straightening out his small finger and ring finger on the left, which he had never experienced before. He indicated that just after he had moved all the material, he was sore. At about 1:30 a.m., he saw his boss. He went home thinking he was just sore. The next morning he was still sore in the shoulder. She told his first and second shift boss. He continued with the shoulder pain. He thought it would get better but then the left fourth and fifth digits would not straighten. Human Resources did receive the report of his injury and wanted the hand evaluated.

Id. Dr. Eilers reviewed various treating medical records, after which he issued a report rendering opinions regarding the relatedness, if any, of Petitioner's physical condition with the alleged incident at work. *Id.*

Specifically, Dr. Eilers diagnosed Petitioner explaining that he sustained a traumatic tear injury to the left rotator cuff with left biceps tenodesis and a left rotator cuff with injury to the subscapularis, treated with arthroscopic surgery as necessitated by his injury occurring on February 28, 2012, and improved by the surgery with Dr. Chudik, accounting for his shoulder deficits from his work-related injury which is consistent with the shoveling

and activity he carried out on February 28, 2012. PX8 (Dep. Ex. 2). Dr. Eilers also opined that Petitioner's "left hand weakness is probably related to his activity on 02/28/2012." *Id.* He explained that the lifting activity at work contributed to the ulnar nerve involvement and probably contributed to a proximal plexus involvement, but indicated that he could not absolutely rule out contribution from the proximal disk herniation and foraminal stenosis, which would cause compression on nerve roots in the neck. *Id.*

Continued Medical Treatment

Petitioner continued to see Dr. Chudik postoperatively from June 16, 2014 through September 29, 2014. PX5. During this period of time, Petitioner continued to undergo physical therapy at work with restrictions. PX5, PX7. On September 29, 2014, Dr. Chudik released Petitioner back to full duty work, indicated that he should continue with home exercise program, and noted Petitioner's report that his shoulder felt good, but a bit achy at times. *Id.*

Petitioner testified that he was placed off of work for this second period of time after which he returned to work. He testified that he has been able to do his job earning the same amount of money or more. Petitioner also testified that his left shoulder felt better after the surgery with Dr. Chudik and that his left hand condition was "straightened out." Petitioner testified that he had no further finger contractions after the left shoulder surgery.

Section 12 Examination – Dr. Verma

On July 27, 2015, Petitioner submitted to a medical evaluation at Respondent's request with Dr. Nikhil Verma (Dr. Verma). RX1 (Dep. Ex. 2). Dr. Verma examined Petitioner and reviewed his treating medical records after which he issued a report rendering opinions regarding the relatedness, if any, of Petitioner's physical condition with the alleged incident at work. *Id.* He opined that Petitioner's left shoulder condition was unrelated to an injury at work on February 20, 2012 "based on the lack of reporting of any shoulder condition or shoulder pain associated with this injury. In addition, Dr. Choi's initial evaluation clearly demonstrates normal function of the shoulder with no evidence of rotator cuff pathology." *Id.* Dr. Verma indicated that Petitioner's treatment had been appropriate, but it was unrelated to an injury at work in February of 2012. *Id.* He also opined that Petitioner was at maximum medical improvement with regard to the left shoulder. *Id.*

Deposition Testimony – Dr. Verma

On December 2, 2015, Respondent called Dr. Verma as a witness and he gave testimony at an evidence deposition. RX1. Dr. Verma testified that he is a board certified orthopedic surgeon. RX1 at 5-7; RX1 (Dep. Ex. 1).

Dr. Verma diagnosed Petitioner as status post left shoulder arthroscopy. RX1 at 10. He opined that Petitioner's left shoulder condition was neither caused nor aggravated by the accident described to him on February 28, 2012. *Id.*, at 10, 12. Dr. Verma explained that he did not see any report of a condition that was consistent with an acute or traumatic rotator cuff problem related to the alleged injury in February of 2012, and that Dr. Choi's initial examination of Petitioner was not consistent with an acute or ongoing rotator cuff problem, but rather a neck condition. *Id.*, at 10-11.

On cross examination, Dr. Verma acknowledged that he had no records showing that Petitioner had any left shoulder condition, medical treatment, or symptoms before February 28, 2012 or any left shoulder injury thereafter. RX1 at 14-15. However, he testified that Petitioner's MRI showed chronic, intrasubstance changes,

rather than an acute tear, which were consistent with chronic and degenerative processes. *Id.* Dr. Verma also testified that the only repetitive use associated with rotator cuff pathology in the literature involved overhead activities. RX1 at 17. Dr. Verma testified that he evaluated Petitioner for a left shoulder condition and the relatedness of that condition, if any, to a specific injury, not a repetitive use injury. *Id.*, at 18-19.

Dr. Verma also testified on cross examination about Dr. Choi's initial diagnosis and examination of Petitioner. RX1 at 21-23. He acknowledged that Dr. Choi diagnosed Petitioner with left upper arm and shoulder pain, but noted that Dr. Choi's examination findings were negative for rotator cuff and SLAP pathology and "[Petitioner's] symptoms neurologically driven and an MRI and EMG were recommended. So again, just because [Petitioner] had pain in the left shoulder doesn't mean it's coming from a rotator cuff." *Id.*, at 22. Dr. Verma opined that Petitioner's treatment with Dr. Choi from October 16, 2012 through June 3, 2013 showed no indication of a left shoulder rotator cuff tear. *Id.*, at 23. He maintained that there was no evidence that Petitioner had any rotator cuff pathology at the time he was first examined by Dr. Choi based on the physical examination findings at that time. *Id.*, at 26-27. Dr. Verma acknowledged that Petitioner would complain of left shoulder pain when he presented for diagnostic testing, but testified that "it was posterior based pain in the shoulder blade which is much more consistent with the neck diagnosis." *Id.*, at 30. He also acknowledged that Petitioner underwent a repair to the anterior rotator cuff or subscapularis, but noted that there was no tear in the posterior rotator cuff or supra-infraspinatus. *Id.*, at 32.

Dr. Verma further disagreed with the opinions of Dr. Chudik that Petitioner's left shoulder condition was causally related to shoveling at work on February 28, 2012 as well as his diagnosis of left shoulder traumatic upper border subscapularis rotator cuff tear and proximal biceps instability and partial rupture. RX1 at 26. He

Deposition Testimony – Dr. Chudik

On July 11, 2016, Petitioner called Dr. Chudik as a witness and he gave testimony at an evidence deposition. PX9. Dr. Chudik testified that he is an orthopedic surgeon specializing in shoulder and sports medicine. PX9 at 4-7; PX9 (Dep. Ex. 1).

Dr. Chudik testified that he reviewed Petitioner's November 4, 2013 MRI and saw a little bit of swelling that may have secured, and "kind of a non-retracted kind of tear in the supraspinatus and maybe it goes into the infraspinatus but more posterior to the supraspinatus. Maybe onto the anterior, but it can be misleading in some patients. It may be posterior." PX9 at 17-18, 45-46. He maintained that there was pathology that looked like a tear of the rotator cuff, but ultimately the operative findings were more complete than the MRI. *Id.*, at 18-20, 46-47. In an extensive response, Dr. Chudik ultimately maintained that Petitioner's mechanism of injury was consistent with the pathology seen at the time of the shoulder surgery including a rotator cuff tear involving the subscapularis and supraspinatus that allowed the biceps to be unstable which caused the majority of Petitioner symptoms. *Id.*, at 20-24.

On cross-examination, Dr. Chudik testified that the differences in terms of Petitioner's date of accident were likely errors, but he understood that Petitioner was shoveling glass on a day in February of 2012. PX9 at 29-34. Dr. Chudik also testified that Petitioner's more significant problem at the time he first saw Dr. Choi involved the cervical spine and some neurologic symptoms. *Id.*, at 35-37. He further explained that Petitioner's pre-existing condition from November of 2009 was related to the distal biceps at the elbow, which had nothing to do with the shoulder, although it is the same muscle at the opposite and reaching the shoulder. PX9 at 42-44. Dr. Chudik testified that Petitioner's distal biceps condition at the elbow and proximal biceps condition at the shoulder were treated very differently and had no relationship to one another. PX9 at 44. He also testified that

he found a supraspinatus tear intraoperatively that was partially obscured in the MRI. *Id.*, at 48-49. Dr. Chudik maintained that Petitioner's tear was consistent with the mechanism of injury reported to him and traumatic in nature. PX9 at 50-51.

Deposition Testimony – Dr. Eilers

On October 17, 2016, Petitioner called Dr. Eilers as a witness and he gave testimony at an evidence deposition. PX8. Dr. Eilers testified that he specializes in "physical medicine rehabilitation, namely the diagnosis and treatment of individuals with strokes, spinal cord, head injury, musculoskeletal and neuromuscular disabilities either acquired through injuries, or there are those which are developmental, amputations and various other issues, and we do electrodiagnostic studies." PX8 at 5-7; PX8 (Dep. Ex. 1). Dr. Eilers is also licensed as an attorney in Illinois. PX8 at 33.

As a result of his work activities on February 28, 2012, Dr. Eilers testified that "[Petitioner] sustained a traumatic tear of his left rotator cuff, the biceps tendon and rotator cuff injury as described in the involvement of the subscapularis. And he also sustained the neurologic deficits which were probably part and parcel of that have [sic] rotator cuff injury and his lifting which appears to have caused him more proximal brachial plexus involvement which predisposes you to distal nerve dysfunction when you injure the nerves more proximally." PX8 at 15. He maintained that Petitioner's surgeries with Dr. Choi and Dr. Chudik were necessitated by the injuries at work. *Id.*, at 15-16. On cross examination, Dr. Eilers testified that Petitioner's lack of medical treatment for eight months after his alleged injury was not a concern because Petitioner did not have a complete tear in the shoulder. PX8 at 23-24, 33-34.

Additional Information

Petitioner testified that he has not had other medical treatment. Petitioner testified that he is still able to perform his job as a fork lift operator. He testified that he no longer has any issues with his left shoulder or left hand. Petitioner testified that if he was asked to shovel liquid glass he would not have trouble doing so.

Petitioner also testified that he paid some of the medical bills $256.59. Petitioner returned to work full duty effective July 2, 2014.

Rick Pertell

Rick Pertell (Mr. Pertell) testified that he is a Glass Line Supervisor, and has been so employed since December of 2015. Mr. Pertell testified that Petitioner works for him and he is a good employee. He testified that he was not aware that Petitioner had a workers' compensation claim. He explained that supervisors have to fill out forms including first aid forms and "near miss" forms where an incident occurred that had the potential to be an accident, but where no one was injured. Mr. Pertell testified that he has seen the form completed by Mr. Brotz November 8, 2012.

ISSUES AND CONCLUSIONS

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

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries 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…." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). Additionally, Petitioner must establish the "'arising out of' component [which] refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

In this case, Petitioner testified that he was instructed to shovel heavy, liquid glass from a small booth up and over several steps into a hopper. He could not remember exactly how long he was shoveling glass, but it lasted a couple of hours. Petitioner testified that he had never done this type of work before and he felt aches and pains in his left shoulder. Petitioner's testimony regarding the mechanism of injury is uncontroverted.

While notice of the alleged accident is not in dispute, the circumstances regarding Petitioner's report of the alleged injury is a primary source of contention between the parties, particularly whether Petitioner is credible. Petitioner testified that he did not report the aches and pains on February 28, 2012, but continued to experience these symptoms after his shift ended and he went home. He testified that he then reported the injury and his symptoms to his supervisor, Mr. Brotz, when he first saw Mr. Brotz thereafter. Petitioner admitted on cross examination that he did not agree with Mr. Brotz on how he ran his shift and acknowledged a somewhat coarse conversation during which he reported his accident. Petitioner specifically denied telling Mr. Brotz that his shoulder was "fine." Petitioner explained that he did not seek medical treatment for many months because he had not been authorized to do so by Respondent. He explained that in order to get treatment for a work-related injury, his supervisor needed to complete an accident report after which the human resources department would become involved. Petitioner testified that he asked Mr. Brotz repeatedly, every other day, about the accident report.

Petitioner's testimony about the initial conversation with Mr. Brotz in which he reported the accident, and his repeated requests to have an accident report completed, is uncontroverted. Mr. Pertell, Petitioner's current supervisor, testified that Mr. Brotz completed the accident report in November, but provided no testimony to rebut Petitioner's assertion that he reported the accident to Mr. Brotz as described. Mr. Pertell also provided no testimony explaining why Petitioner's request for completion of an accident report went unanswered or establishing that Petitioner did not, in fact, make such requests of Mr. Brotz. While Petitioner's assertion that he asked Mr. Brotz about the accident report every other day seems exaggerated, he credibly testified that he

asked for completion of such a report so that he could receive medical treatment. Indeed, Petitioner's admissions on cross examination render his testimony credible overall and neither Mr. Brotz nor Ms. Robinson testified at the hearing. Petitioner's testimony regarding the mechanism of injury, his conversations with any supervisor or human resources person, and his ongoing condition between the date of accident and medical treatment is uncontroverted. Moreover, Petitioner's reported mechanism of injury and symptomatology thereafter is corroborated by the treating medical records of various physicians and Petitioner's report to Respondent's Section 12 examiner, Dr. Verma.

In addition, Petitioner testified that his pain worsened from the time of the accident until he saw Dr. Choi after being authorized to do so by Ms. Robinson in human resources. When he first received medical treatment after it was authorized by Respondent, Petitioner presented to Dr. Choi for "pain in his shoulder blade and down his arm. He states that he was shoveling glass, which was back in March, and then all of a sudden he started having pain around his shoulder blade region. It really would not shoot into the shoulder. Occasionally, it would go down his arm, but not into his fingers. Over the last month, however, he has noticed a lot of weakness and difficulties in bringing his wrist into extension. He has noticed more and more difficulties extending his fourth and fifth fingers." Petitioner had a prior history of cervical treatment with Dr. Choi who focused on the cervical spine as a generator for Petitioner's shoulder, arm and hand pain and symptoms. Petitioner underwent evaluation by other physicians as referred by Dr. Choi and Dr. Chudik, but ultimately received no real relief of the left shoulder, scapula, arm or hand symptoms that he testified were ongoing after his accident at work until his rotator cuff repair by Dr. Chudik.

The Arbitrator notes that Petitioner's own independent medical examiner, Dr. Eilers, testified that Petitioner's lifting activity at work contributed to the ulnar nerve involvement and probably contributed to a proximal plexus involvement, but that Petitioner's treating physicians, Dr. Chudik, Dr. Fajardo, Dr. Choi and Dr. Hwang were unable to determine the cause of the lower left arm symptoms. Notwithstanding, Petitioner's medical treatment beginning on October 16, 2012 focused on excluding pain generators from the cervical spine and neurological sources and Petitioner's left arm symptoms were ultimately relieved after his arthroscopic left shoulder surgery including a rotator cuff repair. However, there is no evidence that Petitioner had any prior left shoulder condition of ill-being. He had no medical treatment to the left shoulder prior to February 28, 2012. Moreover, there is no evidence to establish that Petitioner suffered an intervening accident. Petitioner was able to perform the duties of his job as a forklift driver between the date of accident and his first medical treatment with Dr. Choi, albeit with pain, as it did not involve the type of activities that caused the onset of his condition (i.e., shoveling heavy liquid glass up and over several steps into a hopper). Petitioner's reported mechanism of injury and symptomatology thereafter are consistent as reflected in the treating physicians' records of Dr. Choi, Dr. Chudik, Dr. Hwang and Dr. Fajardo as well as Petitioner's reports to Respondent's Section 12 examiner, Dr. Verma, and his own independent medical examiner, Dr. Eilers.

In light of the record as a whole, the Arbitrator finds Petitioner's testimony to be credible and also finds the opinions of Petitioner's treating physician, Dr. Chudik, to be persuasive. Based on all of the foregoing, the Arbitrator finds that Petitioner has established that he sustained a compensable injury at work on February 28, 2012 as claimed.

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

The medical records reflect that Petitioner received treatment for his left arm and shoulder symptoms after his request to have an accident report completed was acknowledged. Petitioner continued to receive treatment from

Dr. Choi and Dr. Hwang for his symptoms, but did not ultimately receive relief of his pain and symptoms until after consulting with Dr. Chudik and Dr. Fajardo and undergoing a left shoulder arthroscopy and rotator cuff repair surgery. As explained above, the Arbitrator finds that Petitioner sustained a compensable accident at work involving the left shoulder and that the opinions of Petitioner's treating physician, Dr. Chudik, are persuasive. There no evidence that Petitioner had any prior left shoulder condition of ill-being or any other accident beyond the one sustained at work while shoveling liquid glass. Thus, the Arbitrator finds that Petitioner has established a continued causal connection between his condition of ill-being and accident at work.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after his accident at work. As explained above, the Arbitrator finds that Petitioner sustained a compensable accident at work involving the left shoulder as claimed relying on Petitioner's credible testimony, the plausible sequence of events after Petitioner shoveled liquid glass at work, and the opinions of Dr. Chudik that Petitioner sustained a rotator cuff tear causing his pain and symptoms, including the clawing symptoms in the left hand. Thus, the Arbitrator finds that the treatment rendered to Petitioner is reflective of reasonable and necessary medical treatment to alleviate him of the effects of the injury he sustained to the left shoulder causing symptoms radiating into the left arm and hand. The Arbitrator awards payment of the medical bills submitted into evidence in PX10-PX19 subject to Sections 8(a) and 8.2 of the Act.

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

Petitioner's testimony and the medical records reflect that Petitioner underwent medical treatment and was incapacitated as a result of the effects of his injury at work such that he was placed off of work. This evidence is uncontroverted. Based on the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from December 20, 2012 through January 14, 2013 and April 24, 2014 through July 2, 2014. As agreed by the parties, Respondent is entitled to a credit for payment of these short-term disability benefits as agreed by the parties less any tax benefits.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of the injury, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that

establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time Material Handler at the time of his accident and he continues to work for Respondent. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident. This fact is supported by Petitioner's date of birth as reflected in the medical records. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there was no evidence of any diminishment in Petitioner's future earnings capacity as a result of his accident. Petitioner testified that after he returned to work full duty he earned the same amount of income or more. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained an injury to the left shoulder requiring an arthroscopic surgery to address left shoulder pain, subcoracoid impingement, a partial rotator cuff labral tear, shoulder impingement, a rotator cuff tear of the subscapularis, biceps instability and a partial rupture proximally. Petitioner also testified that he is still able to perform his job as a fork lift operator and no longer has any issues with his left shoulder or left hand. Thus, the Arbitrator assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 10% loss of use of the person as a whole (left shoulder) pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

[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

James Fait,
Petitioner,

vs. NO: 11 WC 11314

University Systems of
GA/SER-CAT,
Respondent,

19IWCC0143

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses, nature and extent, penalties and fees, "two md rule Resp. 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 21, 2017 is hereby affirmed and adopted.

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

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

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

DATED: MAR 1 - 2019

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CJD/rlc
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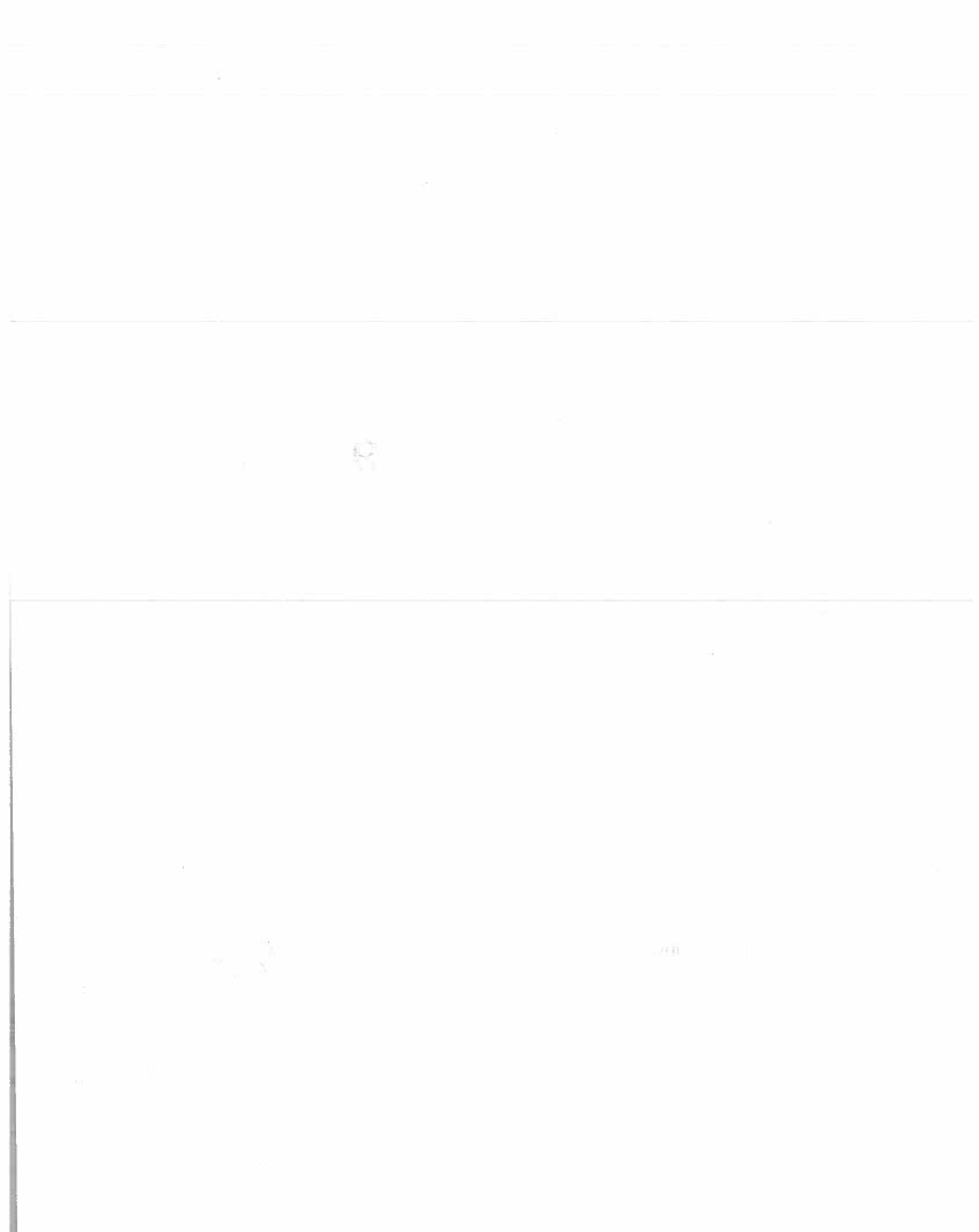
Charles J. DeVriendt

Joshua D. Luskin

Deborah Simpson



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FAIT, JAMES
Employee/Petitioner

Case# **11WC011314**

UNIVERSITY SYSTEMS OF GA/SER-CAT
Employer/Respondent

19IWCC0143

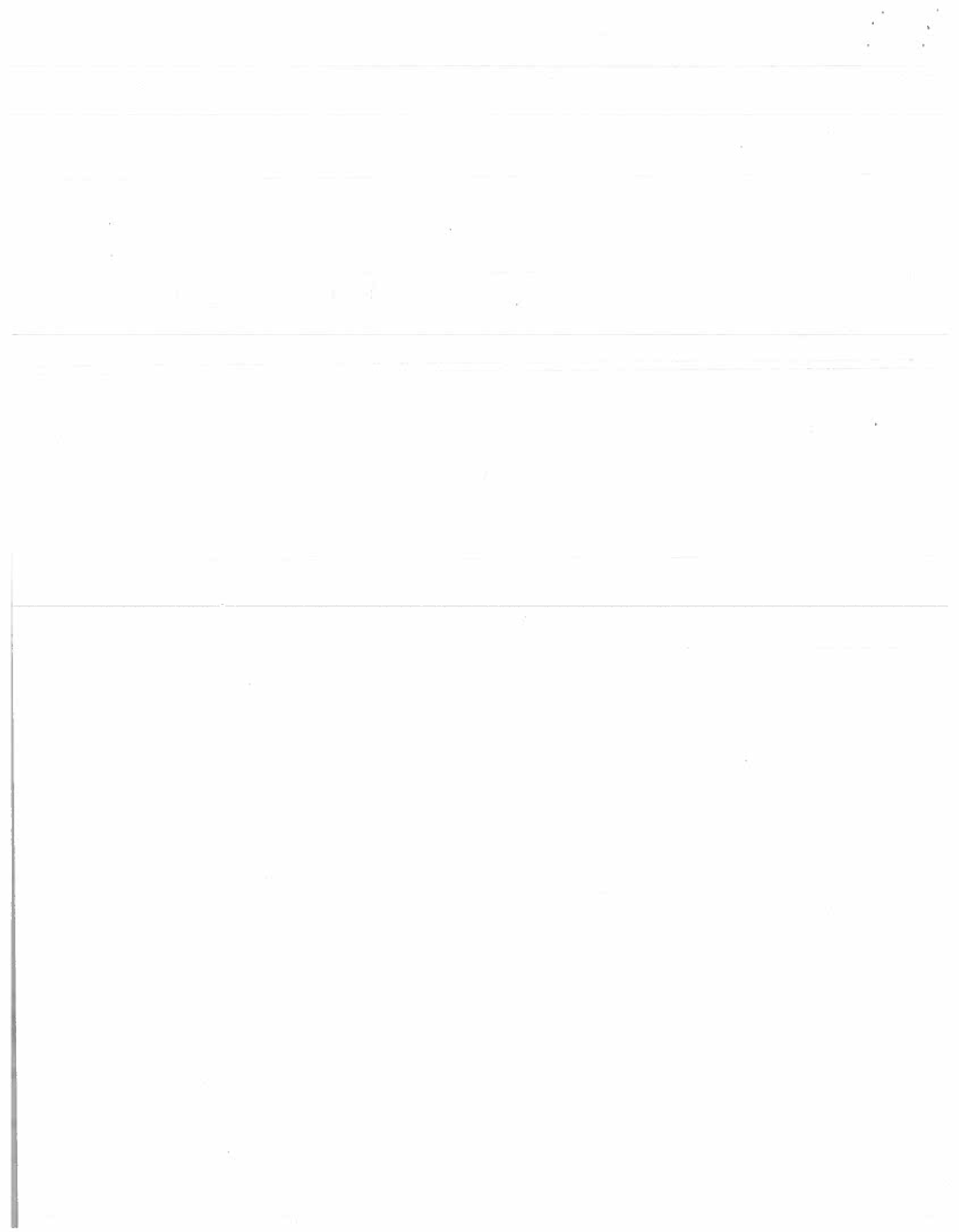
On 3/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1920 BRISKMAN BRISKMAN & GREENBERG
SUSAN E FRANSEN
175 N CHICAGO
JOLIET, IL 60432

1120 BRADY CONNOLLY & MASUDA PC
VALERIE PEILER
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

James Fait
Employee/Petitioner

Case # 11 WC 011314

v.

University Systems of GA/SER-CAT
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jeffrey Huebsch, Arbitrator of the Commission, in the city of Chicago, on 12/8/16 and 1/11/17. 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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ____

FINDINGS

On 8/13/10, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $130,000.00; the average weekly wage was $2,500.00.

On the date of accident, Petitioner was 52 years of age, *married* with 0 dependent children.

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

Respondent *has* 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, as no benefits are awarded.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act, as no medical benefits are awarded.

ORDER

Respondent shall pay Petitioner **permanent partial disability benefits of $669.64/week for 4.86 weeks,** because the injuries sustained caused the **3% loss of the right foot,** as provided in Section 8(e) of the Act.

Petitioner's claim for Penalties and Attorney's Fees is denied.

Respondent shall pay Petitioner all compensation benefits that have accrued from 8/13/2010 to 1/11/2017 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

March 21, 2017
Date

ICArbDec p. 2

MAR 2 1 2017

FINDINGS OF FACT

Petitioner testified that he worked at Argonne Laboratory as a beam line scientist. Respondent, University Systems of GA/SER-CAT was his employer. Petitioner's job duties included computer programming and light maintenance on scientific instrumentation, as well as building scientific instruments from scratch. Petitioner testified he was working on the date of accident with his supervisor, John Chrzas. On the date of accident, 8/13/10, Petitioner was 6 feet 6 inches tall and weighed 485 pounds.

Petitioner acknowledged that he had experienced problems with his low back for 32 years prior to the date of accident. He did not recall having any prior problems with his right ankle. Petitioner said that he had suffered from "lumbago," which he described as pain in the back radiating into the buttocks into the legs with cramping in the buttocks. He indicated the pain came and went, and that it was "very annoying more than anything else." Petitioner conceded he had undergone a series of injections by Dr. Orbregozo in the year prior to the date of accident. The last injection, according to Petitioner, was done in February of 2010. The injections provided months of relief. Petitioner also acknowledged treating with his family doctor, Dr. Alvi, and a physiatrist, Dr. Hung, for complaints pertaining to his back.

In fact, Petitioner was seen by Dr. Hung on the morning of the accident, August 13, 2010. Petitioner described the pain he experienced on that morning as a "mild backache, just enough to be nagging." Petitioner went to work after being examined by Dr. Hung. He testified that he experienced "no difficulties" in performing his job until the accident occurred in the early afternoon, around 1 p.m.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on August 13, 2010. Petitioner testified that, as he worked amidst a nest of cables, his left foot was hooked into a loop of cable, causing him to fall into the side of the enclosure that Petitioner was working in. He wrenched his back and he also stepped down hard with his right foot while trying to catch himself. Petitioner completed an accident report following the incident. (PX 19) Petitioner

testified he returned to his office and was then later taken home by co-workers. He described his back pain after the incident as so intense he had trouble breathing. Petitioner's right foot was also very painful. Petitioner tried to manage the pain with his "normal medications." These medications included Percocet and Oxycodone. Petitioner's wife took Petitioner to Provena St. Joseph Hospital at approximately 7 p.m. that day. Petitioner's foot was placed in a brace. X-rays of the low back and right foot were negative for acute pathology. The right ankle x-ray showed a questionable fracture. (PX 8) Petitioner remained in the hospital overnight and was off work for several days thereafter.

The medical records entered into evidence reveal years of ongoing treatment for Petitioner's low back and low extremities before the accident date. The same will be summarized below.

As early as July of 2008, Petitioner was being assessed for peripheral neuropathy vs. lumbar radiculopathy. (RX 4) Dr. Karlsson at M&M Orthopedics ordered x-rays of the lumbar spine following an injury Petitioner sustained moving furniture. Petitioner underwent physical therapy. Dr. Karlsson also prescribed an MRI study, which was performed on September 8, 2008. (RX 4) The MRI showed degenerative disc changes, several bulging discs, osteoarthritis and mild to moderate bilateral neural foraminal stenosis. (RX 4) Dr. Karlsson requested that Joliet Headache & Neuro Center perform an EMG to assist in defining the problem. The EMG/NCV was performed on September 4, 2008, and showed severe predominantly axonal sensory motor peripheral neuropathy, possibly superimposed on a lumbar radiculopathy. Petitioner also was seen at this time by Dr. Rezania at University of Chicago Hospital for low back pain with radiating pain into the right lateral thigh and numbness. (RX 5)

Dr. Pelinkovic, also of M & M Orthopedics, examined Petitioner in January of 2009, and reviewed the MRI study. The doctor noted Petitioner's "long history" of back pain. Petitioner complained of pain in the low back that radiated to the right anterior thigh and into the lower extremities. At that time, Petitioner indicated he could stand for only 10 minutes without noting discomfort. Dr. Pelinkovic recommended that Petitioner undergo conservative care. (RX 4)

Records of Dr. Alvi, petitioner's family doctor, indicate Petitioner was first seen on July 18, 2009. At that time, Petitioner was taking Neurontin and gave a history of sensory neuropathy. He presented for treatment of fatigue and sore throat. Petitioner gave a history of multiple arthroscopic surgeries. He was diagnosed as suffering from osteoarthrosis at multiple sites along with morbid obesity. On August 13, 2009, Petitioner reported developing a cramp in his back while undergoing physical therapy at ATI for his knee complaints. Petitioner gave a history of chronic low back pain for which he had received steroid injections as well as a disc decompression IDET six months previously. The IDET procedure was performed by Dr. Wilson. Petitioner confirmed that he underwent an IDET procedure at University of Chicago Hospital in 2009. On August 28, 2009, Petitioner returned to Dr. Alvi. Dr. Alvi charted that the MRI performed while Petitioner was in the hospital showed no changes compared to a prior MRI done in January of 2009. Diagnoses included pedal edema, low back pain, hypertension, sensory neuropathy, and morbid obesity. (RX 7)

On September 1, 2009, Petitioner treated with Dr. Zabiega for the peripheral neuropathy and "significant lumbar disc disease" with associated low back pain. Petitioner gave a history that he had been admitted to the hospital and undergone lumbar epidural injections. The doctor noted that Petitioner had undergone an MRI of the lumbar spine in June of 2009. (RX 9)

Petitioner was again seen by Dr. Alvi on September 25, 2009, having undergone additional epidural steroid injections. Petitioner reported improvement in his back pain and neuropathy. Petitioner advised Dr. Alvi that he was being seen by a pain specialist, Dr. Orbregozo, for his low back. (PX 6)

Petitioner was also seen by Dr. Rezania at University of Chicago Hospital on September 25, 2009. Petitioner reported a recent trauma to his spine that had caused a "regression" of his symptoms. Petitioner was being treated in a pain management program and had undergone one epidural steroid injection. Petitioner weighed 400 pounds. The doctor noted the presence of a right sided lumbar radiculopathy. (RX 5)

On December 22, 2009, Petitioner was seen by Dr. Orbegozo for low back pain radiating down the right leg to the knee and the left leg to the mid-thigh. Petitioner had terminated his use of Flexeril one week prior on

the advice of his psychiatrist. Petitioner's psychiatrist recommended increasing Oxycontin to 15mg. On exam, Petitioner had normal gait and station. There was no decreased range of motion or instability. The diagnosis remained lumbar disc disease. (RX 6)

Petitioner returned to Dr. Alvi on January 4, 2010, for weight gain and shortness of breath. Medications included Abilify, Celebrex, Effexor, Lasix, Lisinopril, Lyrica, Neurontin, Potassium Chloride, Primidone, Protonix, Provigial, Requip and Trazodone among others. Diagnoses included chronic low back pain. Progress notes from this day indicated Petitioner had been off work from July through September. (RX 7)

Petitioner returned to Dr. Orbegozo on January 21, 2010. Petitioner was taking Oxycontin with no pain relief. Petitioner complained of electric shocks down his legs. Medications included Oxycontin, Flexeril, Gabitril and Percocet. Petitioner was seen again by Dr. Orbegozo on February 17, 2010, requesting Lidoderm patches. Pain radiated from the mid back over to the right and down the leg with numbness to the calf all the way to the foot. Dr. Orbegozo performed a lumbar facet block via the dorsal median branch nerve on that date. On March 16, 2010, Petitioner advised Dr. Orbegozo that he had eliminated the Percocet because he had been diagnosed as having suffered a TIA. (RX 6) On March 30, 2010, Petitioner advised Dr. Alvi that he had reinjured his low back moving furniture at his mother's nursing home. He was contacting Dr. Hung for physical therapy. (RX 7)

Dr. Orbegozo next examined Petitioner on April 8, 2010. Petitioner continued to complain of low back pain. Petitioner returned to Dr. Alvi on May 8, 2010, complaining of weight gain and fatigue. He was not sleeping well due to his low back pain. He was still anticipating seeing Dr. Hung to start some "aggressive back physical therapy." Petitioner had been prescribed Oxycodone per Dr. Orbegozo at the pain clinic. Among the diagnoses by Dr. Alvi was worsening back pain. (RX 6 & 7)

On May 11, 2010, Dr. Hung examined Petitioner for worsening low back pain. The pain was predominantly localized in the right buttock area with episodic radiating pain down the lower extremities. Beatty maneuver caused increased buttock pain. Petitioner reported occasionally using a cane, although he

ambulated in the office without assistance at the time of the exam. Dr. Hung prescribed outpatient therapy. (RX 8)

On June 2, 2010, Petitioner was again seen by Dr. Orbegozo as well as Dr. Hung. On June 22, 2010, Dr. Hung examined Petitioner for low back pain and left ankle pain. The doctor prescribed continued therapy. Dr. Hung indicated in July of 2010 that Petitioner had significant impairment and that therapy had not been "fruitful." (RX 8)

On August 6, 2010, Petitioner advised Dr. Orbegozo that his mother had passed away in June and traveling at that time had increased to his low back pain. (RX 6) Neither Oxycontin nor Percocet were relieving the symptoms. On August 13, 2010, Petitioner was seen by Dr. Ming Hung for "significant low back pain issues." (RX 8) The doctor noted Petitioner had undergone outpatient therapy from July 20, 2010 through the date of this exam with no relief. The doctor noted tightness along the lumbar paraspinal muscles on examination along with decreases in heel contact and heel strength. The doctor diagnosed Charcot and low back pain. The doctor recommended that Petitioner continue the current course of out-patient therapy while also addressing the underlying back issues. Dr. Hung recommended additional imaging including lumbosacral x-rays on flexion and extension along with an MRI of the back. (RX 8)

Petitioner also had a preexisting Charcot-Marie-Tooth neuropathy condition, yielding lower extremity muscle atrophy and decreased sensation, along with bilateral foot pain.

On the evening of August 13, 2010, Petitioner was seen at Provena St. Joseph Medical Center emergency room for treatment regarding his low back and right leg as a result of a fall at work. His weight was estimated at 435.6 pounds. The history taken was one of chronic back problems and the patient had "wrenched" his back. This incident caused increased pain with increased numbness to the right lower leg and foot. Petitioner said that he was attending a pain clinic at the time of the occurrence. The "HPI" indicated pain in the lower back that began "approximately a few hours prior to arrival" allegedly occurring while at work. Petitioner described the incident as tripping at work. Petitioner acknowledged a history of chronic back pain with multiple

herniated discs. Petitioner was currently being followed in the pain clinic and was on medication. Petitioner said that the numbness in the right leg down to the foot occurred "since the fall." He also stated that the numbness in the right leg had increased following the incident. Petitioner was already scheduled to have an MRI on Monday, August 17, 2010, per Dr. Orbegozo. (PX 8)

Petitioner did undergo another MRI study in August of 2010. The MRI study noted small bony spur formations along the lower thoracic and lumbar intervertebral spaces with slight narrowing at the L5-S1 intervertebral space. Petitioner was also seen by Dr. Orbegozo on August 17, 2010. Petitioner gave a history of tripping over a cord at work at approximately 3:00, at which time he wrenched his back and came down hard on his ankles. Petitioner noted past medical history that included undergoing physical therapy by Dr. Hung for his right ankle with no improvement. Petitioner brought his x-rays of the ankle to the visit with Dr. Orbegozo. Petitioner was using a walker and had a boot on. The diagnosis was lumbar disc disease and ankle pain. Petitioner returned to Dr. Orbegozo on September 17, 2010, reporting improvement in ankle pain but worsening of the back symptoms. Dr. Orbegozo noted Petitioner had undergone a lumbar facet block in February of 2010. Petitioner advised it had not helped much and the doctor therefore held off on any further injections. (RX 6)

Petitioner also returned to Dr. Karlsson at M&M Orthopedics for the injury to his right ankle. Dr. Karlsson diagnosed Petitioner as suffering from a severe ankle sprain. X-rays did not show definitive evidence of a fracture. Petitioner was referred by Dr. Karlsson to Dr. Pelinkovic for evaluation of his low back. Petitioner was evaluated by Dr. Pelinkovic on September 13, 2010. Dr. Pelinkovic noted that at "this point in time, there is no distinct surgical procedure I would recommend. (RX 4)

Petitioner returned to Dr. Orbegozo on November 12, 2010. He had been seen by Dr. Hersonskey, a neurosurgeon, in October of 2010. Dr. Hersonskey was not recommending surgery, but suggested the patient undergo facet joint injections followed by RFTC. At this time, Petitioner was preparing to undergo bariatric surgery. Petitioner also noted he was developing deformed toes from his Charcot neuropathy. Diagnosis now included lumbosacral spondylosis with facet syndrome. The first lumbar facet block was administered on

November 24, 2010. Petitioner reported good pain relief in January of 2011. Accordingly, RFTC was recommended for the future, but deferred pending the bariatric surgery. By January 24, 2011, Petitioner had undergone his bariatric bypass. He indicated his back pain was "not flaring bad and not an added problem." Petitioner continued on multiple pain medications. (PX 5)

On March 4, 2011, Petitioner returned with complaints of low back pain occasionally radiating down the right leg. Dr. Orbegozo recommended Petitioner proceed with the RFTC. This procedure was performed on March 16, 2011. On March 30, 2011, Petitioner reported that the procedure reduced his pain by 33%. Accordingly, a repeat procedure was performed on the left on March 30, 2011. On April 26, 2011, Petitioner underwent an injection to the right piriformis muscle by Dr. Orbegozo. (PX 5)

On June 8, 2011, Dr. Orbegozo noted Petitioner had 80% relief from the piriformis injection. Petitioner was reporting shooting pain intermittently when he extended or stepped with long strides. Petitioner reported the pain with back extension, a new symptom. The doctor altered Petitioner's medications. Petitioner underwent a Functional Capacity Evaluation that showed him able to function at the medium to heavy physical demand level. In July of 2011, Petitioner reported that the shooting pain down the legs was constant with back extension. The doctor recommended a TRUFUSE procedure. (PX 5)

Petitioner was also treating with Dr. Karlsson at M & M Orthopedics for his low back complaints. On June 20, 2011, Dr. Karlsson discharged him from care, to return as necessary, but noted Petitioner was not at MMI due to ongoing pain clinic treatment. The doctor did not recommend surgery at that time. (PX 10)

Petitioner underwent a course of work hardening at ATI Physical Therapy. As of June 26, 2011, petitioner was able to function at the medium to heavy level. He was discharged from work conditioning on that date with goals achieved. (PX 15)

On August 25, 2011, Petitioner was seen by Dr. Orbegozo following an appointment with Dr. Hersonskey. Petitioner was now having bladder problems. Petitioner was declining to undergo the TRUFUSE procedure. The doctor was recommending injections with possible surgery. Petitioner underwent a new series

of diagnostic tests in September of 2011, including an MRI study done on September 16, 2011. This MRI study showed spinal stenosis at the L4-5 and L5-S1 levels. (PX 5)

Petitioner was seen by Dr. Orbegozo on October 20, 2011 reporting bilateral low back pain in a band like distribution. Petitioner's weight was improving. The doctor noted the pain was worsened with activity and extension. (PX 5)

On November 1, 2011, Petitioner was seen at Provena's Neuroscience Institute by Dr. Hersonskey. Dr. Hersonskey indicated Petitioner continued to suffer from excruciating back pain particularly on extension. Petitioner also reported occasional right sided leg pain. Petitioner had past improvement with facet injections to the L4-5 level, which Dr. Hersonskey considered to be the worst level in the lumbar spine. The doctor also noted some symptoms at the L5-S1 level, which he attributed to facet-related and not discogenic pain. Dr. Hersonskey recommended additional facet injections and transforaminal injections to confirm his suspicion as to the source of Petitioner's pain. The doctor noted petitioner was neurologically unchanged. (PX 13)

On November 15, 2011, Dr. Orbegozo administered the selective nerve root block at the right L4-5. On January 9, 2012, Petitioner noted a new onset of pain resulting from a "pop" in his back that caused pain in his groin and right thigh to the right leg. Dr. Hersonskey indicated this might be the result of pain at the L5-S1 level in addition to the prior pain at the L4-5 level. He continued to recommend surgery to the L4-5 level based on Petitioner's prior response to facet injections at that level. An MRI performed on January 16, 2012, showed degenerative changes from the L3-4 level through L5-S1. Dr. Hersonskey reviewed the MRI and recommended a fusion surgery to stabilize the arthritic L4-5 facets. (PX 13)

On April 30, 2012, Dr. Hersonskey performed a laminectomy and discectomy surgery, pursuant to approval by Utilization Review, from the L4 through S1 levels. The diagnosis was axial back pain, neurogenic claudication and lumbar radiculopathy. Petitioner was examined post-operatively on May 15, 2012. Petitioner indicated the nerve pain was gone. At that time, Petitioner was 6 feet 6 inches tall and weighed 310 pounds. The doctor recommended Petitioner continue to wear his brace and begin therapy for core strengthening and

stretching. Petitioner was to return in 6 months. On approximately June 13, 2012, Petitioner was discharged from his therapy program to pursue a home exercise program. (PX 13)

Petitioner continued to complain of pain in the low back, for which he sought treatment with Dr. Orbegozo and Dr. Hersonskey. On September 4, 2012, Dr. Hersonskey reviewed an MRI and noted the worsening of the facet joint at L4-5 bilaterally. The doctor prescribed a back brace and additional injections. On October 9, 2012, Dr. Hersonskey reviewed imaging studies and diagnosed facet arthropathy. He again recommended a fusion surgery. Dr. Hersonskey did perform a lumbar fusion surgery for spondylolisthesis and spinal stenosis on November 8, 2012. (PX 13)

Petitioner returned to Dr. Hersonskey post-operatively on December 4, 2012. Petitioner denied any leg pain following surgery but did note some continued back pain. He was therefore fearful of rotating, twisting and turning. Petitioner was released to sedentary duty only with no bending or twisting in order to allow the fusion to heal. Petitioner at that time denied a prior history of back pain. As of February 26, 2013, Petitioner's complaints were essentially unchanged and limited to his low back. The doctor noted bony fusion was beginning and prescribed a bone stimulator. Imaging studies done in June of 2013 showed good location of the lumbar screws and cage without any movement with some bone formation. Petitioner was allowed to wean himself from his brace gradually over the next four months. The doctor released Petitioner from care to return as needed. (PX 13)

Petitioner did return on November 18, 2013 reporting minimal back pain and no leg pain at all. Nonetheless, Petitioner was taking "considerable" pain medication. Petitioner was consulting with Dr. Orbegozo to manage the medications. Dr. Hersonskey requested petitioner return in six months to assess the status of the fusion. Work restrictions were modified to allow for lifting of up to 20 pounds but with continued avoidance of bending and twisting. (PX 13)

Petitioner was last seen by Dr. Hersonskey on May 22, 2014, following a new set of diagnostic studies. Petitioner's pain medications were being managed and he complained of "only minimal" pain radiating to the

anterior aspect of the right thigh. The doctor reviewed the X-rays and found they showed good location of the screws and cage. Petitioner was discharged from care. (PX 13)

The Parties submitted the evidence depositions of Drs. Tamir Hersonskey (Petitioner), Stanford Tack (Respondent) and Gunnar Andersson (Respondent) into evidence as PX 16, RX 2 and RX 3, respectively.

Petitioner presented the testimony of Dr. Tamir Hersonskey, a board certified neurosurgeon. He acknowledged that Petitioner was very overweight and testified that Petitioner's obesity could accelerate the rate of deterioration in the lower lumbar vertebrae and facet joints. Dr. Hersonskey testified that the MRI study he ordered showed a small subligamentous central disc herniation at L4-5 and facet arthropathy which resulted in a moderate degree of central foraminal stenosis. Small disc herniations were also shown at the L3-4 and L5-S1 levels. These findings were "more chronic in nature." On January 9, 2012, Petitioner was re-examined by Dr. Hersonskey and reported a pop occurring in his back recently which resulted in pain from his anus to his scrotum. Straight leg raise was now positive as well as the reverse Lasegue's test. Dr. Hersonskey did not recall seeing an annular tear in the L5-S1 disc prior to this date. On January 12, 2012, the doctor recommended a lumbar fusion for the L4-5 level. Dr. Hersonskey did not review any prior MRI studies or records regarding treatment that Petitioner had received prior to the first time that he saw Petitioner on October 26, 2010. Dr. Hersonskey acknowledged that it would be difficult to determine a change in Petitioner's condition when he did not have pre-accident imaging to review. Nonetheless, Dr. Hersonskey opined that the accident of August 13, 2010 "could have aggravated his pre-existing medical condition." (PX 16)

At Respondent's request, Petitioner was examined by Dr. Sanford Tack, a board certified orthopedic surgeon, on April 17, 2015. Following his review of records and examination of Petitioner, Dr. Tack diagnosed Petitioner as suffering from degenerative spinal stenosis of the lumbar spine. He also noted the presence of the unrelated Charcot-Marie-Tooth Disease. In his evaluation of Petitioner, Dr. Tack reviewed an MRI report from 2008 as well as actual MRI images from January of 2009. The doctor read those reports as showing moderate stenosis with degenerative changes at the L4-5 level, an area where subsequent treatments were focused. Dr.

Tack noted that all of the diagnostic studies showed "significant degenerative disc disease including spinal stenosis as early as 2008." He stated that the imaging suggested a progression over time of the degeneration that was unrelated to the August 2010 incident. Dr. Tack also noted that Petitioner received "very significant treatment pre-injury" from the same doctors who treated Petitioner subsequent to his August 2010 accident. Dr. Tack testified that "he found no evidence in the records that there was any significant exacerbation or aggravation of the pre-existing condition" of Petitioner's lumbar spine due to the injury. Instead, the "records were merely consistent with an ongoing symptomatic condition." Dr. Tack opined that Petitioner suffered from significant spinal stenosis at the L4-5 level. This was the level fused by Dr. Hersonskey. Dr. Tack further opined that the surgery performed on Petitioner was due to the degenerative nature of the disc disease and not for any conditions that were the direct result of the incident of August of 2010. (RX 2)

Dr. Gunnar Andersson examined Petitioner on January 26, 2012 at the request of Respondent. Dr. Andersson is a board certified orthopedic surgeon, specializing in neck and back disorders, who has now retired. His 47 page CV is impressive. (RX 3) Dr. Andersson opined that Petitioner did not aggravate or accelerate the pre-existing condition of his low back/lumbar spine as a result of this injury, relying on the substantial evidence of treatment to the low back up to an including the date of the accident. Dr. Andersson testified that the condition of Petitioner's low back was not caused, aggravated or accelerated by the work accident. Dr. Andersson believed that the type of accident that Petitioner described is highly unlikely to cause any permanent aggravation or acceleration of a spinal condition. Dr. Andersson noted Petitioner was diagnosed with mild to moderate spinal stenosis and degeneration of the facet joints as early as 2008. He concurred in that diagnosis. On exam, Dr. Andersson noted Petitioner had a negative straight leg raise and no tenderness of the lower back. Range of motion was limited. Dr. Andersson reviewed four MRI studies, ranging from 2009 to 2012. The 2012 MRI showed advanced stenosis that had worsened just since a prior exam in 2011. Dr. Andersson noted this progression was consistent with the "underlying degenerative condition." He found no evidence of an

acute injury to the lumbar spine on the diagnostic tests. In concluding, Dr. Andersson took into account both Petitioner's diagnostic tests and Petitioner's history of complaints.

Dr. Andersson agreed Petitioner was a surgical candidate, but the need for such surgery was not caused or necessitated by the work accident. The surgery discussed by Dr. Andersson was a laminectomy and fusion of the L4-5 level. (RX 3)

Dr. Karlsson authored a narrative report at Petitioner's request, supporting causation. Basically, Petitioner presented on August 27, 2010, complaining of right ankle pain and significant worsening of low back pain after a mishap at work. Dr. Pelinkovic did not find surgical indications. The MRI of the foot did not show a fracture. There could have been a worsening of Petitioner's low back symptoms. The ankle was noted to be fine on May 2, 2011. Petitioner was seen for an acute exacerbation of back pain on December 29, 2011, after leaning back at work. (PX 10)

Petitioner claimed entitlement to 18-6/7 weeks of TTD related to treatment for his foot, back and the bariatric procedure. Petitioner did receive full salary for all of his lost time, but he did use sick and vacation time to receive these benefits.

Petitioner testified that his back pain is better after the treatment and 2 surgeries that he had after the accident. He has been able to return to his regular job, although he does need assistance with some tasks. He has a permanent lifting restriction of 35 pounds. He bought an articulated bed to aid in sleeping. He no longer cross-country skis, as he is afraid that he may fall. He does continue to treat with a pain doctor.

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 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) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003) 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 the issue of Causal Connection, the Arbitrator finds as follows:

Petitioner failed to prove that there is a causal connection between the injury of August 13, 2010 and Petitioner's current condition of ill-being regarding his low back. The Arbitrator relies upon the medical records and the persuasive opinions of Dr. Tack and Dr. Andersson in reaching this conclusion. Dr. Tack and Dr. Andersson reviewed the prior medical records and the prior MRI study form 2009 (as well as the 2010 and forward MRI's) in forming their opinions that the injury of August 13, 2010 did not aggravate, accelerate or exacerbate Petitioner's lumbar spine condition.

Dr. Hersonskey's tepid causation opinion ("could have aggravated ") is not persuasive in this case, as he did not review the prior medical records and did not review the prior MRI studies. Further, it was Dr. Hersonskey's testimony that he relied upon Petitioner relating that he never had back pain before the injury and then had back pain thereafter in formulating his endorsement of causation by aggravation. The record clearly shows that Petitioner had extensive and ongoing treatment for his low back (indeed, seeing his physiatrist, Dr. Hung the morning of the accident), so Dr. Hersonskey's opinion is not only not tepid and non-persuasive, but is fatally flawed, as it is based upon an invalid premise.

Dr. Karlsson's causation opinion likewise is not persuasive. The Arbitrator finds the opinions of Drs. Tack and Andersson (spinal surgeons who are well-credentialed) to be more persuasive and to best comport with the evidence adduced.

The medical records do support a finding that Petitioner's condition of ill-being regarding his right ankle (status post right ankle strain with treatment as shown by Dr. Karlsson) is causally related to the injury.

With respect to the issue of Medical Bills, the Arbitrator finds:

Based upon the Arbitrator's findings on the issue of causation, above, Petitioner's claim for medical expenses is denied. To the extent that any claimed bills are related to emergency room treatment or treatment regarding Petitioner's right ankle, they should be paid by Respondent. The Parties should be able to ascertain any unpaid causally related bills on Review, although it does appear to the Arbitrator that the causally related bills have been paid by Respondent.

With respect to the issue of Temporary Total Disability, the Arbitrator finds:

Based upon the Arbitrator's findings as to causation, the Arbitrator finds respondent not liable for temporary total disability benefits. Petitioner lost only 4 days from work as a result of his ankle sprain and was paid full salary for that period. Petitioner's absence from work beyond the four days was not causally related to the work injury of August 13, 2010.

With respect to the issue of Permanent Partial Disability, the Arbitrator finds:

Based upon the Arbitrator's findings as to causation, no Permanent Partial Disability is awarded regarding Petitioner's low back condition.

The medical records demonstrate Petitioner suffered a severe sprain to his right ankle as a result of the accident of August 13, 2010. No fracture was shown on the MRI. Accordingly, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered permanent partial disability to the extent of 3% loss of use of the right foot.

With respect to the issue of Penalties, the Arbitrator finds:

Respondent presented the credible testimony of Dr. Tack and Dr. Andersson demonstrating the absence of a causal connection between the work accident and the condition of Petitioner's low back. Respondent's denial of liability based on those opinions was not vexatious, unreasonable, in bad faith or made for purposes of delaying benefits. Accordingly, the Arbitrator finds Respondent is not liable for penalties under §§ 19(k) and (l) of the Act and is not liable for attorney's fees under §16 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSHUA LARSON,

Petitioner,

vs. NO: 15 WC 27682

RHODES AUTO SSS, INC., **19IWCC0140**

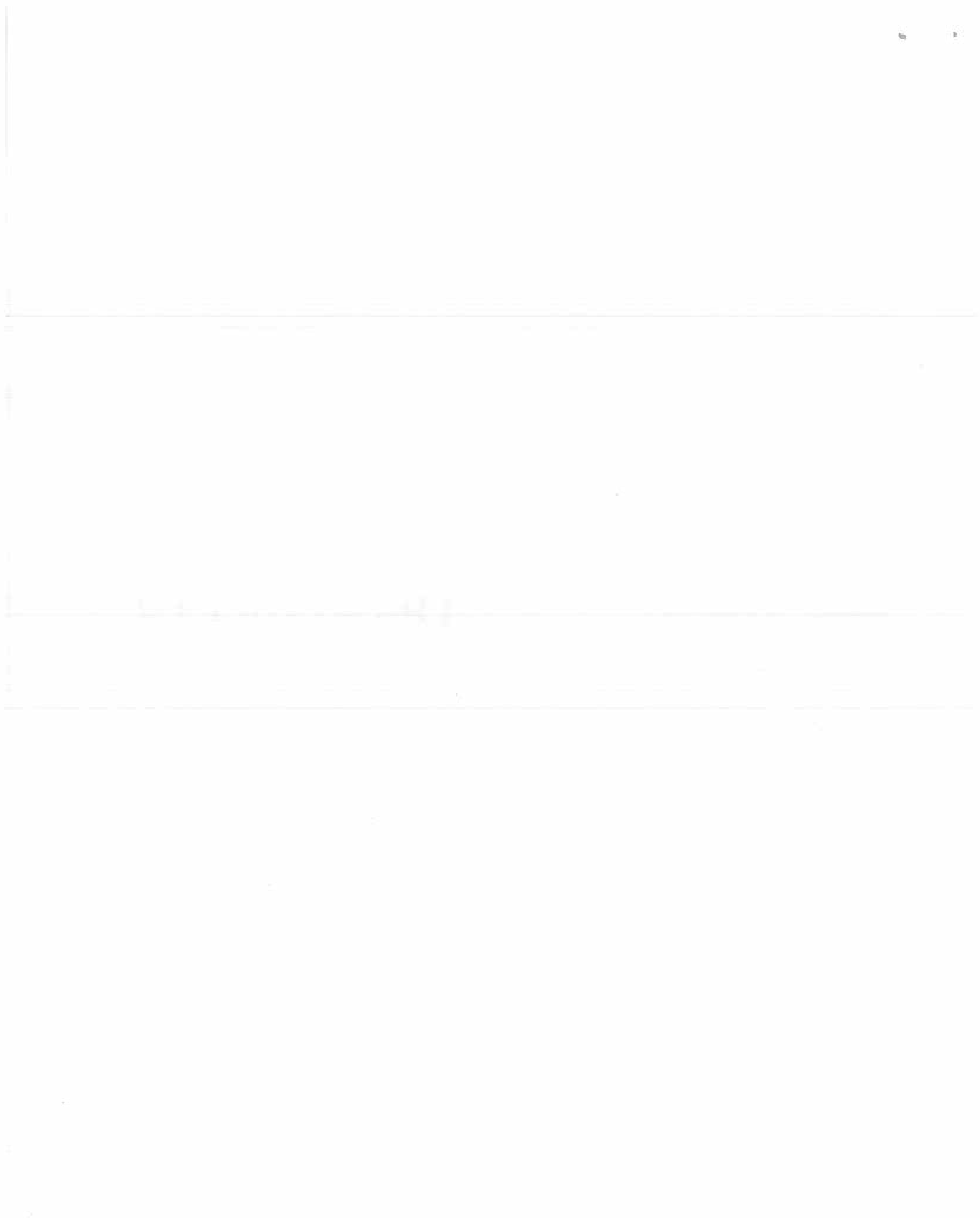
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), and prospective medical treatment, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 Arbitrator found that the Petitioner earned $25,142.80 in the year preceding the injury resulting in an average weekly wage (AWW) of $484.89 and a corresponding TTD rate of $330.00. However, pursuant to the Request for Hearing, and the subsequent stipulation of the parties, the parties stipulated that the Petitioner earned $29,890.75 in the year preceding the injury resulting in an AWW of $574.82 and a corresponding TTD rate of $383.21.

Accordingly, the Commission modifies the Decision of the Arbitrator to reflect that the Petitioner earned $29,890.75 in the year preceding the injury. The Commission further modifies



the Decision to reflect an AWW of $574.82 resulting in a TTD rate of $383.21. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $383.21 per week for a period of 17 weeks, July 10, 2015 through November 4, 2015, 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 all reasonable and necessary medical bills for services rendered to Petitioner through November 4, 2015 as reflected in Petitioner's exhibits that remain unpaid, if any, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills beyond November 4, 2015 is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for prospective medical care pursuant to Section 8(a) of the Act is denied.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

19IWCC0140

15 WC 27682
Page 3

DATED: MAR 1 - 2019

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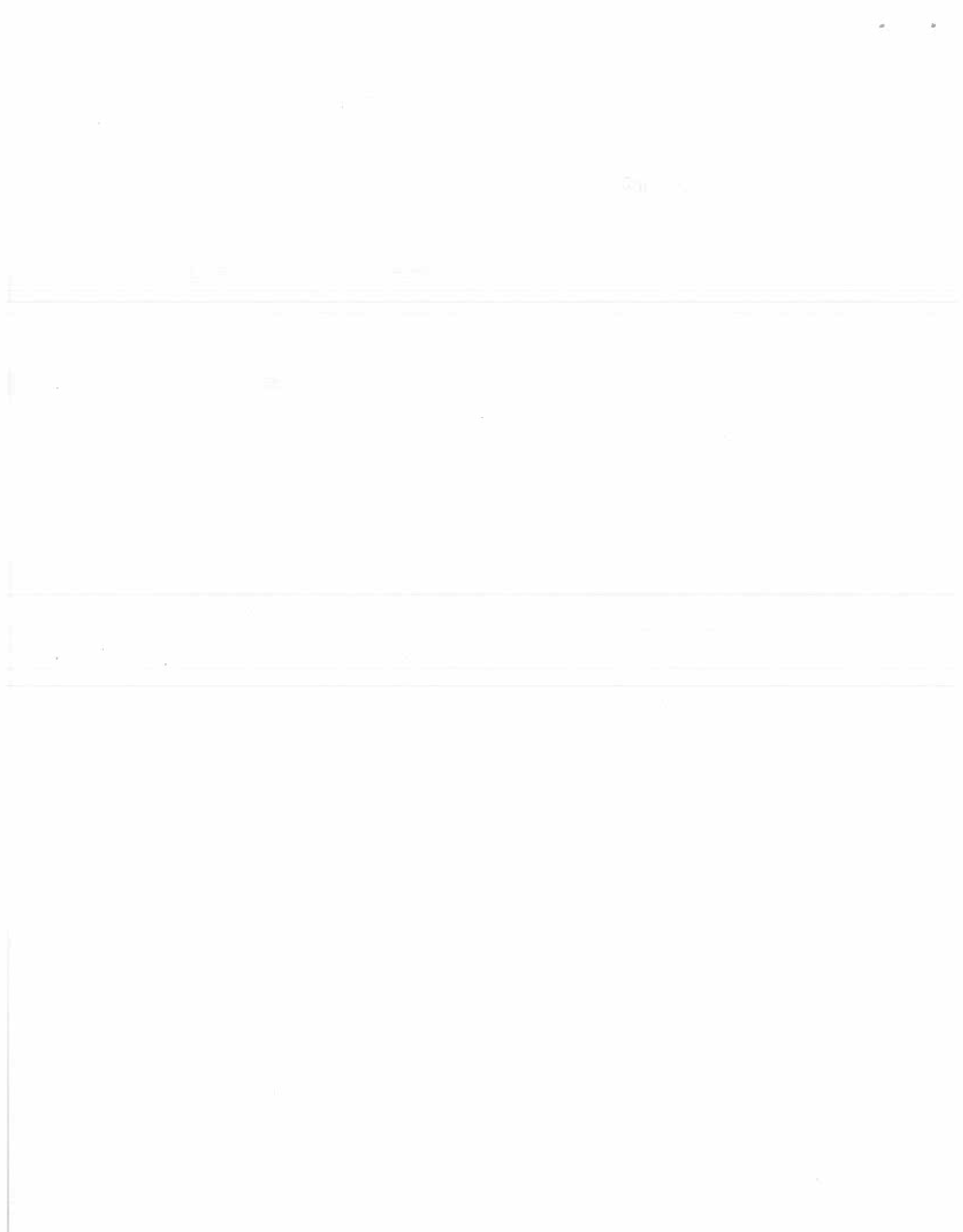
Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn



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

LARSON, JOSHUA
Employee/Petitioner

Case# **15WC027682**

RHODES AUTO SSS INC
Employer/Respondent

19IWCC0140

On 5/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0507 RUSIN & MACIOROWSKI LTD
SHALEIGH JANSEN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Joshua Larson
Employee/Petitioner

Case # 15 WC 27682

v.

Consolidated cases: N/A

Rhodes Auto SSS, 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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **April 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. [ ] 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, July 9, 2015, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 as explained *infra*.

In the year preceding the injury, Petitioner earned $25,142.80; the average weekly wage was $484.89.

On the date of accident, Petitioner was 36 years of age, *single* with 5 dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to his accident at work as claimed in reliance on the opinions of Respondent's Section 12 examiners, Dr. Li and Dr. Mather who opined that Petitioner sustained a lumbar strain.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 17 weeks, commencing July 10, 2015 through November 4, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from July 9, 2015 through April 10, 2018, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical bills for services rendered to Petitioner through November 4, 2015 as reflected in Petitioner's Exhibits that remain unpaid, if any, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills beyond November 4, 2015 is denied.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, Petitioner's claim for prospective medical care pursuant to Section 8(a) of the Act is denied.

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

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

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

Signature of Arbitrator

May 14, 2018
Date

ICArbDec19(b) p.2

MAY 15 2018

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

Joshua Larson
Employee/Petitioner

v.

Rhodes Auto SSS, Inc.
Employer/Respondent

Case # **15** WC **27682**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from July 10, 2015 through April 10, 2018, and whether he is entitled to prospective medical care in the form of an L5-S1 right sided laminectomy, discectomy and foraminatomy as ordered by Dr. Templin. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues.

Background

Joshua Larson (Petitioner) testified that he was last employed by Rhodes Auto SSS, Inc. (Respondent) in the position of Delivery Driver/Loader Driver/Warehouse Assistant. He testified that he worked for Respondent for approximately 8½ years through August 16, 2015. Petitioner explained that he had to lift over 50 pounds in his work for Respondent.

On July 9, 2015, Petitioner testified that he was crushing cars and before he could do this he had to empty the cars. Petitioner testified that he fell off the second to last step of the loader approximately four feet from the ground and felt a "really bad" jarring in his low back. He explained that he felt a lot of pain in his low back and a little bit of a sharp pain in his right leg.

Medical Treatment

The medical records reflect that Petitioner initially presented to St. Mary's Hospital for treatment on the date of the accident. PX5. The following history was noted:

> Patient came with a history that about one hour ago at work he was coming down the ladder and slipped and fell about 2 steps from the ground approximately 2 feet height and landed on his feet on the concrete. He complains of pain in the right lower back. His pain is in the right lower back and at times radiating to the right buttock and the right posterolateral thigh. He denies tingling numbness weakness in his arms and legs. He denies abdominal pain nausea vomiting. he denies fever or chills. He denies history of previous back problems.

Id. On physical examination, the emergency room physician noted straight leg raising on the right to 70 degrees and on the left to 80 degrees as well as mild tenderness noted on the right lower lumbar paraspinal and right sacral area. *Id.* Petitioner was diagnosed with a low back strain and released to return to work with a 5-pound

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

lifting restriction. *Id.*

Petitioner next presented at St. Mary's Immediate Care on July 13, 2015. PX6. The records indicate that Petitioner requested light duty restrictions. *Id.* Petitioner was provided with a 10-pound lifting restriction. *Id.*

On August 14, 2015, Petitioner returned to St. Mary's Immediate Care and reported he was not working and had been laid off at that time. *Id.* Petitioner continued to complain of low back pain and was again diagnosed with a low back strain. *Id.* Petitioner was given a 20-pound lifting restriction at that time. *Id.* Petitioner last presented to St. Mary's Immediate Care on August 28, 2015. *Id.* He reported that he was working light duty at that time according to the medical treatment notes. *Id.* Petitioner continued to complain of low back pain and was referred to a spine specialist. *Id.* The medical treatment notes refer Petitioner to Dr. Mir Ali. *Id.* However, Petitioner testified that Dr. Garg referred him to Dr. Malek, but "workers' comp" referred him to Dr. Van instead. He explained that Dr. Malek's office in Streator, Illinois was closed. Petitioner did not undergo an evaluation with Dr. Ali and sought treatment with Dr. Van.

On October 7, 2015, Petitioner presented for an initial evaluation at OSF Medical Group with Dr. Allen Van, an orthopedic spine surgeon. PX2; RX3. It was noted Petitioner's symptoms began on July 9, 2015 after Petitioner fell off a loader and jarred his low back. *Id.* Petitioner complained of low back and right leg pain as well as numbness and tingling at that time. *Id.* It was noted that Petitioner had undergone physical therapy and x-rays as well as medication management including flexeril and naproxen without relief. *Id.* Petitioner reported that lifting and prolonged sitting aggravated his low back pain, but he continued to have low back pain albeit with 50% improvement compared to the date of the injury. *Id.* Upon physical examination, Petitioner had full pain free range of motion and strength in the bilateral lower extremities. *Id.* Dr. Van diagnosed Petitioner with a sprain of the lumbar spine and prescribed Meloxicam. *Id.* He also recommended stretching exercises and stated he could seek employment as available. *Id.*

Petitioner returned to Dr. Van on November 4, 2015. PX2; RX3. Petitioner reported he had little pain and was taking over the counter medication for his pain. *Id.* Petitioner had finished the Meloxicam and was performing the light stretching exercises recommended by Dr. Van. *Id.* His physical examination was unchanged. *Id.* There was a negative straight leg raise test. *Id.* There was no tension sign and Petitioner had full pain free range of motion. *Id.* Dr. Van again diagnosed Petitioner with a lumbar strain and noted Petitioner was progressing well. *Id.* Petitioner was released to full duty work at that time. *Id.*

On January 7, 2016, Petitioner then began treatment at Orland Park Orthopedics with Dr. Blair Rhode. PX8. He reported that he sustained a low back injury at work on July 9, 2015 when "he was getting out of loader while crushing cars and slipped of[f] the ladder landing forcefully, straight legged on the ground. He felt instant pain into the back with radiation down both legs. He reported the injury and was sent to the ER. He was seen by the company physician who placed him on light duty and started PT. He states he saw minimal improvement and was ultimately set up for an MRI of the lumbar spine however it was cancelled last minute without explanation and he was told he could return to duty despite his continued back pain with radiation into the legs. He continues to have radicular complaints which he states have been consistent. He denies prior back issues." *Id.* On physical examination, Dr. Rhode noted tenderness to palpation to the lumbar and bilateral paraspinous muscles and a positive straight leg raise test on the right. *Id.* Petitioner was diagnosed with low back pain and lumbar radiculopathy. *Id.* Dr. Rhode recommended an MRI and placed Petitioner off work. *Id.*

Petitioner underwent the recommended MRI on January 14, 2016. PX3. The interpreting radiologist noted short pedicles with overall narrowing of the lumbar spine canal, contributing to spinal canal stenosis. *Id.* There

was a disc protrusion at L5-S1 which the radiologist believed was compressing the S1 nerve root. *Id*. There were intervertebral disc and facet joint degenerative changes and no acute compression deformities. *Id*. There were circumferential disc bulges without protrusion or extrusion at L3-4 and L4-5. *Id*. There were also mild bilateral hypertrophic changes and facet joint degeneration resulting in mild bilateral neuroforaminal stenosis at the L3-4 and L4-5 levels. *Id*.

Petitioner returned to Dr. Rhode on January 21, 2016. PX8. Petitioner reported he was terminated by his employer and was off work at that time. *Id*. Dr. Rhode reviewed the MRI report which showed a right paracentral disc herniation at L5-S1. *Id*. Dr. Rhode recommended an epidural steroid injection. *Id*.

First Section 12 Examination & Deposition Testimony – Dr. Li

On February 29, 2016, Petitioner presented for a medical evaluation with Dr. Li at Respondent's request. RX5. Dr. Li diagnosed Petitioner with a lumbar stain superimposed on underlying congenital spinal stenosis. *Id*. Dr. Li believed Petitioner exhibited symptom magnification behavior during the examination. *Id*. He noted specifically the stocking-like distribution of the numbness on the right side. *Id*. Dr. Li noted that if the medical treatment notes from Dr. Van were accurate, there was no need for additional medical treatment. *Id*. Dr. Li believed Petitioner was at MMI and his lumbar strain had resolved by the November 4, 2015 release from Dr. Van. *Id*.

Respondent called Dr. Li at a witness at an evidence deposition taken on August 22, 2016. RX5. Dr. Li agreed that during the initial visit at the ER on July 9, 2015 Petitioner complained of pain radiating down the right buttock and right posterior lateral thigh. *Id*., at 17-18. Dr. Li stated that he does not believe that those symptoms would be consistent and would be classified as a radicular complaint. *Id*. However, Dr. Li acknowledged that Petitioner's mechanism of injury is consistent for causing the type of symptoms he reported at the emergency room and when Dr. Li examined him. *Id*., at 19.

Continued Medical Treatment

Petitioner continued to see Dr. Rhode through September 29, 2016 with radicular symptoms down his right leg. PX8. Petitioner then underwent a course of physical therapy at Athletico and returned for treatment with Dr. Rhode approximately every two weeks. PX13, PX8.

On July 19, 2016, Petitioner received an epidural steroid injection. PX8. The August 4, 2016 treatment note reflects that Petitioner received minimal relief from the injection. *Id*. Petitioner was again placed off work and a third steroid injection was recommended. *Id*.

Petitioner was discharged from physical therapy on August 3, 2016. PX13. Petitioner attended 61 physical therapy sessions. *Id*. Petitioner had ten cancellations. *Id*. At the time of Petitioner's discharge from physical therapy he complained of mild low back pain and denied any radicular symptoms. *Id*. It was noted Petitioner's condition had not progressed, but it had not worsened. *Id*.

Petitioner received a second epidural steroid injection on August 23, 2016 and a third injection on September 29, 2016. PX8. Petitioner testified that he experienced little to no relief after receiving the injections. *Id*. Petitioner was then referred to an orthopedic surgeon, Dr. Templin. *Id*.

Surveillance Video

Respondent offered into evidence approximately 41 minutes of surveillance video taken of Petitioner over several days in November of 2016. RX13. Therein, Petitioner is observed carrying a baby, walking to and from a gas station to pump gas into his truck, walking to his truck with a baby from what appears to be a restaurant, walk cleaning out the back of a pickup truck and climbing out of the truck bed. *Id.* Petitioner is also observed climbing down from the truck bed onto the ground. *Id.* Petitioner is also observed bending at the waist. *Id.* Specifically, he bends at the waist and/or squats into the driver's side or passenger's side of the pickup truck to secure the baby inside, clean the contents of the inside of the pickup, or remove and place items such as a baby seat inside the pickup truck. *Id.*

Continued Medical Treatment

Petitioner presented to Hinsdale Orthopedics on November 29, 2016 for an initial evaluation with Dr. Templin. PX7. Petitioner complained of low back pain and right sided radiculopathy. *Id.* There was no tenderness to palpation, Dr. Templin noted there was a positive straight leg raise test. *Id.* Dr. Templin noted the MRI demonstrated a disc protrusion at L5-S1. *Id.* Dr. Templin recommended a L5-S1 laminectomy, discectomy, and foraminotomy. *Id.* He noted Petitioner may continue to have back pain after the surgery. *Id.* Petitioner was released to return to work with a 10-pound lifting restriction. *Id.*

Petitioner was subsequently referred by Dr. Rhode to Dr. Kukkar. PX12 at 17; PX8. Petitioner saw Dr. Kukkar's certified physician's assistant, Allison Blood, APN-C (Ms. Blood), on May 3, 2017. *Id.* After reviewing Petitioner's MRI taken on January 14, 2016, she determined that Petitioner's current symptoms would be the central to right paracentral disc protrusion at L5-S1 with compression of the right S1 nerve root. Due to the age of the MRI Allison Blood recommended that Petitioner undergo a new lumbar spine MRI. PX 8 Pg. 87-88.

Second Section 12 Examination & Addendum Report – Dr. Mather

On May 5, 2017, Petitioner presented for an independent medical evaluation with Dr. Steven Mather, an orthopedic surgeon at Respondent's request. RX6. At the time of the examination, Petitioner continued to complain of pain and stated that he could not even think about running or jumping. *Id.* He also reported he was unable to perform yard work and simply walking caused pain. *Id.* Dr. Mather reviewed Petitioner's prior medical treatment records from Dr. Van, Dr. Rhode, Dr. Li and St. Mary's Hospital. *Id.* Dr. Mather diagnosed Petitioner with a lumbar strain at most. *Id.* He opined this condition would have resolved after approximately 1-2 weeks. *Id.* Dr. Mather did not believe Petitioner required any additional treatment or diagnostic testing. *Id.* Dr. Mather opined Petitioner had reached MMI and could return to work without restrictions. *Id.*

Dr. Mather also noted that Petitioner had several positive Waddell findings and non-organic pain complaints. RX6. Dr. Mather also reviewed the surveillance footage obtained by Respondent and noted Petitioner was observed performing activities that he reported he could not even think of doing. *Id.*

Dr. Mather opined that Petitioner's medical treatment with Dr. Rhode was excessive and not reasonable or necessary. RX5. He also determined that the injections were performed at the wrong level by Dr. Rhode. *Id.*

Dr. Mather authored an addendum report on October 23, 2017 after reviewing Petitioner's May 3, 2017 MRI. RX7. Dr. Mather noted the MRI demonstrated disc degeneration at L5-S1 and a minimal disc bulge at the same

level which was non-compressive. *Id.* This study was also compared to the prior MRI dated January 14, 2016. *Id.* There were minimal changes demonstrated. *Id.* Dr. Mather opined Petitioner had no objective neurologic impairment and no objective orthopedic impairment. *Id.* Dr. Mather's original opinions were unchanged. *Id.*

Petitioner testified that he told Dr. Mather he could not perform household chores and that he has had the same type of pain since the accident. He also testified that he was unable to bend at the waist on some days.

Deposition Testimony – Dr. Rhode

Petitioner called Dr. Rhode at a witness at an evidence deposition taken on November 1, 2017. PX12. Dr. Rhode noted Petitioner's diagnosis of right L5-S1 radiculopathy secondary to a right paracentral disc herniation. *Id.*, at 19. He opined that based on Petitioner's lack of prior low back issues and an appropriate mechanism of injury, essentially a forceful axial load mechanism with subsequent symptomatology suggestive of radiculopathy, that Petitioner's right-sided radiculopathy was causally related to his accident. *Id.*, at 19-20. Dr. Rhode opined that Petitioner's MRIs were reflective of an acute disc herniation given his lack of prior low back symptoms. *Id.* He further opined that the mechanism of injury that Petitioner sustained is consistent with causing a disc herniation. *Id.*, at 21. Dr. Rhode testified that he is recommending that Petitioner undergo the treatment recommended by Dr. Templin in the form of an L5-S1 right sided laminectomy, discectomy and foraminatomy.

Additional Information

Petitioner testified that he has been off work or on light duty work restrictions per his physicians. Petitioner testified that Respondent had no light duty work for him and could not accommodate the restrictions from July 10, 2015 through the present time.

Petitioner testified that prior to the accident at work, Petitioner had previously been off work for four days back in 1997. He explained that he has not been off work thereafter until his accident at work.

Regarding his current condition, Petitioner explained that his low back condition felt like someone was stabbing him and that he continues to have radiating pain down his right leg. Petitioner testified that this pain has been the same since his date of accident. He explained that he cannot perform various activities of daily living such as mopping, vacuuming, cleaning up the yard, etc. Petitioner testified that he wishes to undergo the recommended surgery.

ISSUES AND CONCLUSIONS

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

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

The Arbitrator finds that Petitioner's current condition of ill-being in the spine is not causally related to the injury sustained at work on July 9, 2015. In so concluding, the Arbitrator relies on the opinions of Respondent's Section 12 examiners, Dr. Li and Dr. Mather.

Petitioner presented to the St. Mary's emergency room on July 9, 2015. He reported that he slipped and fell coming down a ladder landing about two feet down on his feet on the concrete. At the hearing, Petitioner testified that he fell approximately four feet and felt a "really bad" jarring in his low back. The emergency room records reflect that on physical examination Petitioner had straight leg raising on the right to 70 degrees and on the left to 80 degrees as well as mild tenderness noted on the right lower lumbar paraspinal and right sacral area. Petitioner was diagnosed with a lumbar strain.

Petitioner returned to St. Mary's Immediate Care on July 13, 2015 and, as of August 14, 2015, he reported continued low back pain that had improved 50% compared to the date of the injury. Upon physical examination, Petitioner had full pain free range of motion and strength in the bilateral lower extremities. No straight leg raise testing was noted. Dr. Van again diagnosed Petitioner with a lumbar sprain.

When Petitioner returned to Dr. Van on November 4, 2015, he reported little pain. On physical examination, Dr. Van noted a negative straight leg raise test. Petitioner had no tension sign and continued full, pain free range of motion. Dr. Van again diagnosed Petitioner with a lumbar strain and released him to full duty work.

Two months later, approximately six months after the accident at work, Petitioner first presented to Dr. Rhode. At that time, Petitioner reported a more serious mechanism of injury, "landing forcefully, straight legged on the ground." Dr. Rhode noted a positive straight leg raise test on the right and ordered an MRI. The interpreting radiologist noted congenital issues and a disc protrusion at L5-S1 which the radiologist believed was compressing the S1 nerve root. Dr. Rhode noted that the MRI report showed a right paracentral disc herniation at L5-S1 and he recommended an epidural steroid injection. Petitioner testified that he underwent the injection, but it provided no relief.

Petitioner then presented to Dr. Li at Respondent's request. Dr. Li noted symptom magnification behavior during the examination, placed Petitioner at MMI, and opined that Petitioner had a resolved lumbar strain.

Petitioner returned to Dr. Rhode for additional epidural steroid injections with no relief reported. Petitioner is then observed in surveillance video in November of 2016 carrying a baby, walking to and from a gas station to pump gas into his truck, walking to his truck with a baby, cleaning out the back of a pickup truck and climbing out of the truck bed. Petitioner is also observed climbing down from the truck bed onto the ground, bending at the waist and/or squatting into the driver's side or passenger's side of the pickup truck, etc.

Petitioner then presented to Dr. Templin for the first time on November 29, 2016, more than one year after his accident. Dr. Templin noted an MRI showing a disc protrusion at L5-S1 and a positive straight leg raise test. He recommended a L5-S1 laminectomy, discectomy, and foraminotomy.

After the surgical recommendation, Petitioner submitted to a second Section 12 examination with Dr. Mather at Respondent's request. Dr. Mather reviewed Petitioner's prior medical treatment records from Dr. Van, Dr. Rhode, Dr. Li and St. Mary's Hospital. Like Dr. Li, Dr. Mather noted positive Waddell findings and non-organic pain complaints. Dr. Mather also reviewed the surveillance video of Petitioner. He diagnosed Petitioner with a lumbar strain, at most. In an addendum report, Dr. Mather noted that Petitioner's MRI showed a minimal disc bulge at L5-S1 that was not compressive. He also noted that the injections performed by Dr. Rhode were done at the wrong level. Dr. Mather maintained that Petitioner sustained a lumbar strain, which had resolved.

In light of the totality of the record, the Arbitrator finds the opinions of Dr. Li and Dr. Mather to be persuasive as they plausibly reflect Petitioner's medical condition given objective diagnostic and clinical evidence of his symptomatology and are corroborated by the most contemporaneous medical records to the accident from St. Mary's and Dr. Van. Petitioner had minimal complaints for months following his injury and reported taking over-the-counter pain medications and performing home exercises. Indeed, within five weeks of the injury, Petitioner reported that he was 50% better than he was on the date of accident and his straight leg raise test was negative. Petitioner's physical examinations did not produce objective clinical evidence corroborating the debilitating radiculopathy he claims to endure beginning six months after the accident.

Moreover, Petitioner's credibility is called into question. After reviewing the surveillance footage, the Arbitrator notes that Petitioner was able to engage in the some of the very activities of daily living that he testified, and reported to Dr. Rhode, were not possible. The activities that Petitioner is observed performing over several days in November of 2016, approximately 16 months after his accident, undermine the reliability of Petitioner's subjectively reported complaints to Dr. Rhode, Dr. Templin, and at the hearing.

Given the totality of the medical evidence in this record, the Arbitrator does not find the opinions of Dr. Rhode to be persuasive and notes that Dr. Templin, the physician recommending surgery for Petitioner, did not testify. Thus, the Arbitrator finds the opinions of Dr. Li and Dr. Mather to be persuasive and adopts those opinions and findings about Petitioner's medical condition herein. Based on all of the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being in the spine is not causally related to his injury at work as opined by Respondent's Section 12 examiners Dr. Li and Dr. Mather.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to his accident at work to the extent claimed in reliance on the opinions of Respondent's Section 12 examiners, Dr. Li and Dr. Mather who opined that Petitioner sustained a lumbar strain that resolved by November 4, 2015. Thus, the Arbitrator finds that Respondent shall pay reasonable and necessary medical bills for services rendered to Petitioner through November 4, 2015 as reflected in Petitioner's Exhibits that remain unpaid, if any, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills beyond November 4, 2015 is denied.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to his accident at work as claimed in reliance on the opinions of Respondent's Section 12 examiners, Dr. Li and Dr. Mather who opined that Petitioner sustained a lumbar strain. Thus, the Arbitrator denies Petitioner's claim for prospective medical treatment.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary total disability benefits for the disputed period beginning July 10, 2015 through April 10, 2018.

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

Petitioner's current condition of ill-being is not causally related to his accident at work as claimed in reliance on the opinions of Respondent's Section 12 examiners, Dr. Li and Dr. Mather who opined that Petitioner sustained a lumbar strain. Petitioner was placed on light duty work restrictions and released back to full duty work by Dr. Van effective November 4, 2015. Thus, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from July 10, 2015 through November 4, 2015. Petitioner's claim for temporary total disability benefits thereafter is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Greg Sylvester,
Petitioner,

vs. NO: 16WC 16152

19IWCC0141

Gonnella Baking, Co.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2018, is hereby affirmed and adopted.

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

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

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

DATED: MAR 1 - 2019

L. Elizabeth Coppoletti

o022719
LEC/jrc
043

Charles J. DeVriendt

Joshua D. Luskin

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

SYLVESTER, GREG
Employee/Petitioner

Case# **16WC016152**

GONNELLA BAKING CO
Employer/Respondent

19IWCC0141

On 2/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.78% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC, LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

19IWCC0141

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)

GREG SYLVESTER
Employee/Petitioner
v.
GONNELLA BAKING CO.
Employer/Respondent

Case # **16** WC **16152**

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **MARCH 1, 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 $**66,361.53**; the average weekly wage was $**1,276.18**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **1** dependent child.

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

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

1) The Petitioner's claim for benefits under the Act is denied;

2) The Petitioner's request for payment of medical bills and prospective medical care under Section 8(a) is denied; and

3) The Petitioner's Petition for Penalties and Attorneys' Fees is denied.

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

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

Signature of Arbitrator

February 14, 2018
Date

ICArbDec19(b)

FEB 1 4 2018

GREG SYLVESTER v. GONNELLA BAKING CO.

16 WC 16152

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on December 6, 2016. The issues in dispute were accident, causal connection, medical bills, prospective medical care, and penalties and attorneys' fees. (*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 worked for the Respondent as a bread delivery driver. He had a prior date of accident of June 4, 2001 involving his left leg. He underwent surgery on his left leg and a settlement contract notes the Petitioner was paid 46-2/7 weeks of temporary total disability benefits and received a settlement of 26% loss of use of the left leg. (*Respondent's Exhibit* 1). The Petitioner, when examined on May 19, 2016 by Dr. Mark Levin pursuant to the Respondent's Section 12 request, advised Dr. Levin he has had no treatment on his left knee since 2002. (*Respondent's Exhibit* (hereinafter, *RX*) 7 at 12 and *Transcript* at 47). He also advised Dr. Levin that, prior to March 1, 2016, he did not have any symptoms and never walked with a stiff left leg or limp. (*RX* 7 at 13 and *Transcript* (hereinafter, *T.*) at 51, 52).

The Petitioner was seen by his family doctor, Dr. Mangurten, on November 3, 2008, and Dr. Mangurten reported ... "constant left knee pain. Worse when walking. Takes 2 Aleve in the a.m. which helps during the day." (*RX* 2). The Petitioner also provided Dr. Mangurten with a history on November 13, 2012, of ... "Having some issues with his left knee." (*RX* 3). The Petitioner testified Dr. Mangurten suggested referral to an orthopedic at that time for his knee, but he did not schedule or see an orthopedic thereafter. (*T.* at 21, 22, 50). He also admitted that prior to March 1, 2016, he would continue to take Aleve in the mornings. (*T.* at 35). Also, the Petitioner's supervisor, Larry Klasen, testified that, preceding March 1, 2016, he observed the Petitioner to walk with a limp on his left side and not a straight gait. (*T.* at 77).

The Petitioner admitted he was aware of the rule to report any accidental injury on the job immediately to his supervisor. (*T.* at 56). He worked his regular shifts through March 21, 2016, without a report of any incident or medical treatment. (*T.* at 30). On March 21, 2016, he reported to Mr. Klasen that he was injured on March 1, 2016, at 2 o'clock a.m. (*T.* at 58). There were no reported witnesses to the alleged occurrence. (*T.* at 50). On his incident report, the Petitioner stated that he was in the lot unplugging the truck engine heater in front of the truck and while unplugging it "Stepped on ice or snow twisted knee". (*RX* 4). Mr. Klasen testified that, prior to receipt of the Petitioner's incident report, he had no knowledge from any source of the Petitioner allegedly having been injured on the job. (*T.* at 79).

The Petitioner testified that, on March 1, 2016, he parked his truck close to the electrical cord extension. He admitted it was his determination as to how close he would park the vehicle. (*T.* at 59). Mr. Klasen indicated the extension cord was 12 to 20 feet long. The Petitioner testified that while unplugging the extension cord, he stepped on something and twisted his knee, causing him to hear a crunching noise. (*T.* at 23). He did not seek immediate medical care and, instead, went on a scheduled vacation fishing in Tennessee during the week of April 10, 2016. (*T.* at 33). The Petitioner instead first sought medical care from Concentra on April 18, 2016. He also completed an incident report on that date and stated the incident occurred when he "Stepped on curb or ice and twisted knee". (*RX* 5).

The Petitioner subsequently underwent an MRI on May 2, 2016 at Advantage MRI. (*RX* 7, Deposition Exhibit 3). Dr. Levin reviewed the actual MRI films and reported they showed prior meniscal surgery and no acute tear. (*RX* 7 at 16). The ACL was absent but not an acute tear. The MRI showed bone-on-bone contact and tri-compartmental arthritis with flexion deformities. It also showed a chronic chondral calcinosis with the chondral loose bodies in the synovium of the knee demonstrating a longstanding condition consistent with chronic arthritis and not consistent with an acute traumatic episode. (*RX* 7 at 16, 17). Furthermore, the MRI showed no evidence of bone bruising and no acute injury to the ACL. (*RX* 7 at 18). X-rays were taken at Concentra on May 3, 2016, as well as by Dr. Levin during his examination of May 19, 2016, and these showed marked osteoarthritis of the knee, degenerative osteophytes, with bone-on-bone involvement showing longstanding tri-compartmental arthritic findings. (*RX* 7 at 18, 19).

The Petitioner was referred by Concentra to Dr. Burra for further medical care. He saw Dr. Burra on May 3, 2016, and Dr. Burra reported the Petitioner sustained the incident of March 1, 2016 when he tripped over the electrical cord and fell. It was noted the Petitioner did not actually hit the ground but had a significant pivot shifting injury. (*RX* 6). The Petitioner further advised Dr. Burra he did not have any problems after his prior meniscal pathology that he

described as having occurred in 2000. (*RX* 6). Dr. Burra reviewed x-rays and noted them significant for bone-on-bone degenerative joint disease on the left side and fairly advanced degenerative changes on the right side. His impression was degenerative joint disease of the left knee. He advised the Petitioner this was the natural history of degenerative joint disease. Based upon the history of an event occurring and assuming Petitioner's history was accurate as to no preexistent symptomatology, Dr. Burra reported there may have been a traumatic exacerbation[1] from the fall and it would require a four-week period of work modification. He stated, however, beyond that the primary underlying basis of the Petitioner's condition was a preexisting arthritis that would need to be addressed with a total knee replacement. (*Id.*).

The Petitioner, during his Section 12 examination with Dr. Levin on May 19, 2016, provided a history of going to plug in, rather than unplug, the electrical heater to warm the engine of the van, and, as he walked around the van, he miss-stepped in a tight space. (RX 7 at 8). He did not advise Dr. Levin of the presence of any curb, snow, or ice, or of tripping on an electrical cord.

On June 8, 2016, at the request of his attorney, the Petitioner saw Dr. Chudik for further medical attention. (*T.* at 48). He provided Dr. Chudik with a history that, prior to March 1, 2016, he had some aches and pains and took Aleve, but could walk up and down stairs with no difficulty and now was walking stiff-legged. (*PX* 5 at 8). The history of incident the Petitioner gave to Dr. Chudik during that visit was of tripping over an electrical cable and twisting his left knee. (*PX* 3). Dr. Chudik treated Petitioner with an injection and restricted his work activities. However, the Respondent advised the Petitioner it would try to accommodate his light-duty restriction, but as no such work was available, he would need to work his regular duties. The Petitioner acknowledged he has been working in a regular capacity since mid-August of 2016, and not losing any time. (*AX* 1).

The Petitioner also prepared a video on October 5, 2016 to re-create the scene of his accident. (*PX* 7 and *T.* at 25, 26). He acknowledged he would determine how close he would pull the truck to the outlet. He is heard on the videotape stating that he tripped on something on the curb or a hole. He did not know what he did. (*PX* 7).

Elizabeth Marcucci, Corporate Safety Director for the Respondent, first learned of the Petitioner's alleged injury on April 17, 2016, when the Petitioner sought medical care. She

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[1] Exacerbation under the AMA guidelines merely is a temporary change of the condition and does not equate to an aggravation, which requires a permanent change of condition. (*AMA Guidelines*, Sixth Edition, at 25).

19IWCC0141

viewed surveillance video of the Respondent's premises that showed the entrance to the break room, the break room itself, and the dock loading area for the period from mid-February of 2016 through the first week of March of 2016. The surveillance video from the last week of February shows the Petitioner limping, dragging his left leg, and walking in a stiff- legged fashion. He is observed in a similar fashion on the dock. (*T.* p. 95-97). Ms. Marcucci testified an individual would need to enter the break room to get the keys for their vehicle.[2] The Petitioner is observed on March 1, at 1:43 a.m., arriving and noted to be walking with the same limp. He later is seen in the break room on March 1, at 2:29, after the alleged occurrence, with no change in his gait. (*RX* 7, Deposition Exhibit 6). Further, he is observed on the loading dock and, significantly, there also is no snow at the entrance of the break room on March 1, 2016.[3]

Dr. Chudik diagnosed the Petitioner as having severe tri-compartmental arthritis. (*PX* 5 at 11). He noted the Petitioner had the option of undergoing a total knee replacement and further testified the pre-existent condition was aggravated by the alleged incident. (*PX* 5 at 18). Dr. Chudik stated he had reviewed the Petitioner's medical records from his April 20, 2016 appointment at Concentra and his MRI report. He also relied upon the history the Petitioner reported to him. (*PX* 5 at 29). He acknowledged the tri-compartmental arthritis would have pre-dated March 1, 2016. (*PX* 5 at 30). He also relied upon the accuracy of Petitioner's statement that he was having no problems before March 1, 2016. (*Id.* at 35). Dr. Chudik acknowledged that an individual, such as the Petitioner, who is 6 feet 2 inches tall and weighs 300 pounds, would put stress on an arthritic knee. Dr. Chudik also admitted that, if the Petitioner was having difficulty walking and walking stiff-legged before March 1, 2016, it might make a difference as to his opinion on the Petitioner's condition.

Dr. Levin, whose practice consists of 25 percent to 30 percent treating knees along with performing two to four knee surgeries a week, performed a Section 12 examination of the Petitioner, including performing a physical examination of the Petitioner himself. (*RX* 7 at 5, 6). Dr. Levin also reviewed the Petitioner's incident report, MRI films, Concentra records, Dr. Burra's records, and video surveillance of the Petitioner. (RX 7 at 6, 7).

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[2] The Petitioner testified his supervisor, Mr. Klasen, was aware that he had a second set of keys to his truck in his car. However, Mr. Klasen denied any knowledge of same. (*T.* at 56, 81).

[3] The Petitioner offered into evidence weather records from Chicago's O'Hare Airport, approximately 15 miles from the Respondent's Schaumburg location. (*PX* 8). These records do not demonstrate any precipitation on March 1, 2016 until after 3:45 a.m., which would have been well after the Petitioner's incident. (*T.* at 54).

19IWCC0141

Dr. Levin testified he viewed the video of the Petitioner preceding his March 1, 2016, accident, beginning on February 13, 2016. (*RX* 7 at 13). Dr. Levin reported the video showed the Petitioner walking with a limp, secondary to a flexion contracture of the knee, that did not change after the March 1, 2016, incident. (*RX* 7 at 13-15). He stated flexion contracture as demonstrated by the Petitioner before his March 1, 2016, episode would be due to the arthritic condition of the knee, the condyle not being as round, and the bone rubbing on bone, and the soft tissue structures including the chondral calcinosis or the calcium deposits preventing one from totally straightening the knee up. (*Id.* at 21). Dr. Levin also testified the Petitioner was found to have his knee fixed with inability to straighten the knee out more than 25 degrees preceding March 1, 2016 with the abnormality not changing thereafter. (*Id.* at 21-22).

Dr. Levin stated the March 1, 2016, video showed the Petitioner entering the Respondent's break room at 1:43 a.m. with the same limp and gait pattern with flexion contracture of the knee that he demonstrated since mid-February of 2016. There was no change on March 1 at 2:29 a.m. on the dock, which would have been after the alleged occurrence. (*RX* 7 at 15). Dr. Levin also observed the Petitioner's gait did not change following the alleged accident based upon the video of March 4 and March 5. (*RX* 7 at 15-16). Dr. Levin testified the Petitioner had bone-on-bone tri-compartment arthritis and the Petitioner's weight would have an adverse impact on his arthritic condition. (*Id.* at 20). Based upon that pre-existing flexion contracture, and the radiographic findings, Dr. Levin agreed the Petitioner would be a candidate for a knee replacement due to compartmental bone-on-bone arthritis. (*Id.* at 21-23).

Dr. Levin diagnosed the Petitioner with end-stage tri-compartmental arthritis of the left knee with synovial chondral calcinosis, chronic in nature, with a flexion contracture in the knee of longstanding duration. (*RX* 7 at 25). Dr. Levin found no evidence of any objective acute pathology injury occurring on March 1, 2016, and he considered the Petitioner's statements of not limping or walking stiff-legged before March 1, 2016, to him and to Dr. Chudik to be a material misrepresentation of fact. (*RX* 7 at 26). Based upon his review of the diagnostic studies, records, and videos, Dr. Levin opined there was no evidence of any relationship between the Petitioner's current condition of ill-being in the left knee and need for surgery and the accident of March 1, 2016. (*Id.* at 26, 27). He also found no evidence the alleged incident aggravated or accelerated the Petitioner's condition, need for medical treatment, or need for surgery. (*Id.* at 28). Further, Dr. Levin commented the Petitioner's condition would not be due to his job duties on a repetitive basis as his knee arthritis is a condition of the synovial chondral calcinosis, which is not a post-traumatic repetitive episode nor associated with repetitive trauma. (*Id.* at 33).

19IWCC0141

Dr. Levin also testified the Petitioner's prior surgery for his June 4, 2001, accident would not have been a causative factor in his current condition, as that was due to a meniscal condition and this is chondral calcinosis, which is not caused by a meniscal tear. He noted tri-compartmental arthritis is not in one compartment, so there would be no relationship. (*RX* 7 at 34, 35). Dr. Levin further commented the Petitioner's January 4, 2016, appointment with his family doctor, an internist, was not relevant as the Petitioner was being seen for vision abnormalities, with no indication of a physical exam having been performed on his legs. (*RX* 7 at 48, 49). He concluded there is no clinical evidence or radiographic evidence of an acute episode that changed or aggravated Petitioner's condition. (*Id.* at 50, 51).

The Petitioner seeks authorization under Section 8(a) of the Act for prospective medical care in the form of a left knee replacement procedure. (*AX* 1 and *T.* at 44).

CONCLUSIONS OF LAW

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

Issues C and F: *Accident and Causal connection*

The Arbitrator does not find the Petitioner's testimony to be credible. He denied to Dr. Levin and Dr. Chudik any difficulties before March 1, 2016, denying any type of limp or walking in a stiff-legged fashion. He also denied to Dr. Levin any treatment beyond 2002. However, the Petitioner was seen in 2008, complaining of constant knee pain, and in November of 2012, indicating his knee was having issues. He was referred to an orthopedic specialist, but elected not to pursue that referral. The Petitioner also admitted he was taking Aleve in the morning before March 1, 2016. The Petitioner's statements to Dr. Levin and Dr. Chudik of not having a limp or walking stiff-legged prior to March 1, 2016, also are refuted by the testimony of his supervisor, Mr. Klasen, and the Respondent's surveillance video. (*T.* at 77 and *RX* 7, Deposition Exhibit 6).

Even though the Petitioner was aware of the rule to report all accidental injuries on the job immediately, he made no report of the incident on March 1, 2016. Furthermore, there were no witnesses to the alleged incident. Instead, he continued to work his regular shifts and first reported the incident on March 21, 2016. On the incident report, the Petitioner stated he stepped on ice or snow and twisted his knee. (*RX* 4). However, in the Petitioner's October 5, 2016, video, he stated he tripped on something on the curb, possibly a hole, and did not know what he did. (*PX* 7). The video of the curb reveals it to be a normal curb with no difference from any curb found on any street. Furthermore, when the Petitioner first sought medical care

19IWCC0141

at Concentra on April 18, 2016, he provided an accident history of stepping on the curb or ice. (*RX* 5). But, when he saw Dr. Burra on May 3, 2016, he advised Dr. Burra he tripped over the electrical cord and fell, but made no mention of ice, snow, or a curb. Finally, when he met with Dr. Levin on May 19, 2016, he reported he miss-stepped in a tight space while making no mention of ice, snow, curb, or a hole.

The Arbitrator notes that the Respondent's surveillance video shows the Petitioner walking with a limp and stiff-legged before March 1, 2016. (*RX* 6). The Petitioner was to obtain the keys for his delivery vehicle by entering the Respondent's break room. He is observed arriving at 1:43 a.m. and walking with a limp and stiff-legged. This impaired gait is present before his alleged incident and there is also no indication of snow on the ground at that time. Later, the Petitioner is seen in the break room at 2:29 a.m. with no change in his condition. Furthermore, the weather records admitted into evidence do not establish snowfall before or at the time of the Petitioner's alleged incident. (*PX* 8).

Due to the various versions of incident and lack of credibility based upon the Petitioner's demonstrated limp and walking stiff-legged prior to March 1, 2016, the Arbitrator finds the Petitioner failed to prove an accidental injury arising in and out of the course of his employment on March 1, 2016.

The Arbitrator also finds Chudik's testimony not to be credible. Dr. Chudik relied upon the accuracy of the Petitioner's history of the event and lack of prior symptomatology, but only reviewed the MRI study and the record from Concentra. He did not have the benefit of viewing the surveillance video. Instead, the Arbitrator finds Dr. Levin's testimony credible based upon his viewing of all records, studies, examinations, and the video evidence, all of which show no change in Petitioner's gait before March 1, 2016, and his gait thereafter. The Arbitrator adopts Dr. Levin's opinion that Petitioner had bone-on-bone tri-compartmental arthritis that was not caused nor aggravated by an alleged incident of March 1, 2016. Consequently, the Arbitrator also finds the Petitioner failed to prove any causal connection between his current condition of ill-being in the left knee, his need for medical treatment, and his need for a left knee replacement procedure, and his alleged accident of March 1, 2016.

As such, the Petitioner's claim for benefits under the Act is denied.

19IWCC0141

Issues J and K: *Medical bills and Prospective medical*

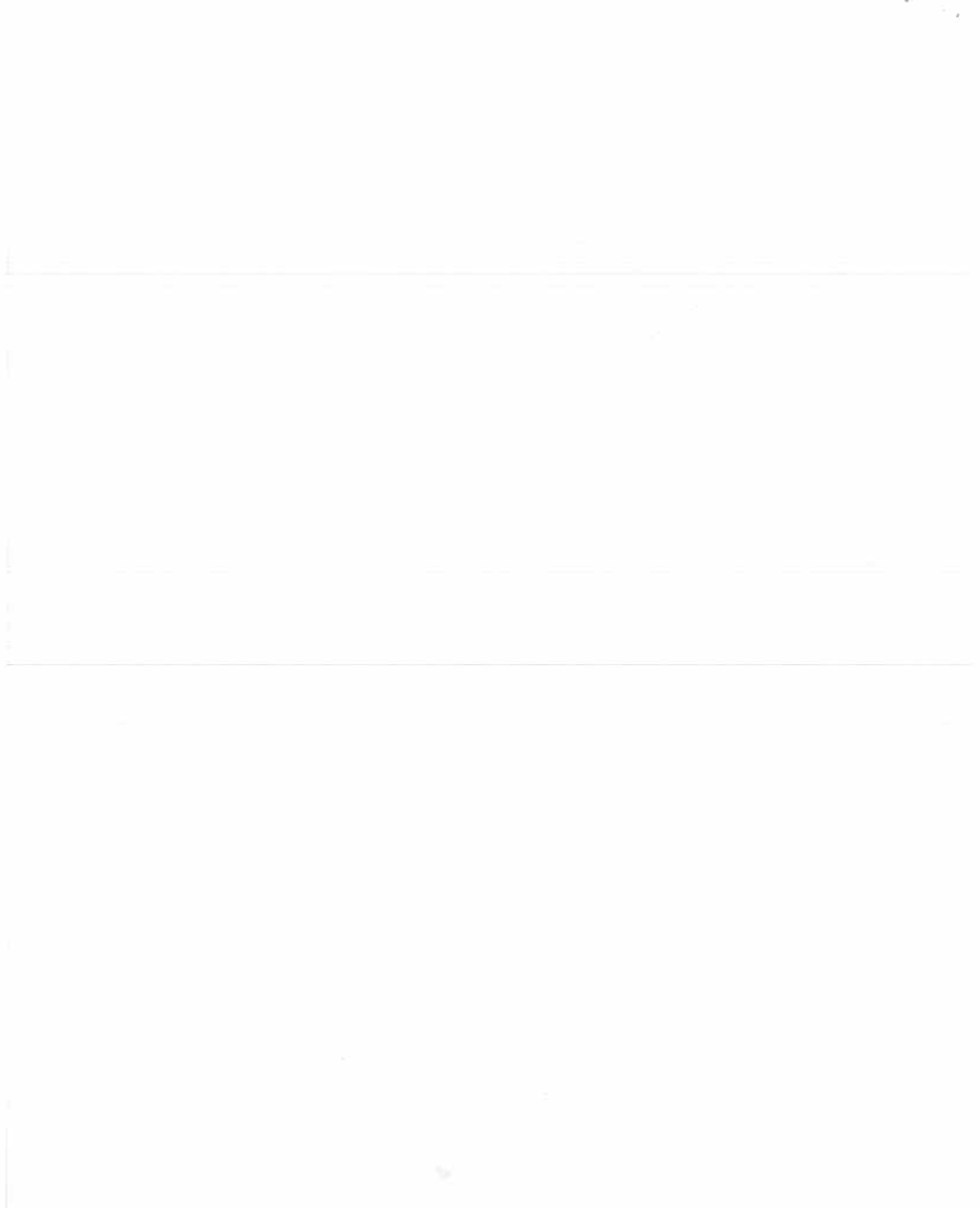
Based upon the findings regarding **Issues C and F** above, the issue of medical bills is moot and the Petitioner's request for prospective medical care under Section 8(a) is denied.

Issue M: *Penalties and attorneys' fees*

Based upon the findings regarding **Issues C and F** above, the Petitioner's Petition for Penalties and Attorneys' Fees is denied.

Signature of Arbitrator

February 14, 2018
Date



STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TOMI BURTLEY,

Petitioner,

vs. Nos: 10 WC 24513, 13 WC 6660, & 13 WC 6661

HARVEY POLICE DEPARTMENT,

Respondent

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties Pursuant to §19(k) and Fees Pursuant to §16 of the Act. A hearing was held before Commissioner Simpson on February 19, 2019 in Chicago, the parties were represented by counsel, and a record was taken.

On September 25, 2017, a settlement of the underlying claim was approved by the Commission. In the settlement, Petitioner was awarded $39,592.46 representing loss of the use of 27.5% of the left leg. The contract also provided that the settlement would be paid in 18 monthly installments. At hearing, Petitioner asserted the payment plan provision was inserted at Respondent's request. Petitioner also asserted that he received six payment, the last on March 8, 2018, and that at the time of hearing there were 10 payments in arrears. He alleges $21,995 in late payments and seeks $10,997.90 in §19(k) penalties and $4,399.16 in §16 attorney fees.

Respondent's lawyer noted that it was making payments pursuant to the contract until mid-March when Respondent's bank account funding settlements and awards was frozen by order of a federal judge. Later, the account was actually liquidated by federal court order to pay for a judgement in a federal law suit. Respondent argues those actions "affected several settlements and awards in the work comp area as well as general liability arena in other issues the City had to deal with." Respondent also wanted the Commission to "take judicial notice of the financial stress the City of Harvey has been experiencing." Respondent submitted an independent audit revealing a deficit of $55 million and evidence that the Illinois Comptroller withheld tax revenues to help fund a $7 million judgement. Respondent asked that Petitioner's petition be denied and that it be given additional time to fund the remainder of the settlement amount.

The Commission has consistently denied assessing penalties and fees based on delay of payments by governmental entities when the delay in payment is due to lack of funding, budgetary problems, or financial stress. In the claim now before the Commission, Respondent was actually legally precluded from fulfilling its obligation under the settlement by federal court order. In fact, because Respondent's account was frozen and later expended by federal court order, it was totally unable to access any funds to pay the settlement. Therefore, the Commission finds there was no bad faith on the part of Respondent and denies Petitioner's petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition for Penalties Pursuant to §19(k) and Fees Pursuant to §16 of the Act is denied.

DATED: MAR 4 - 2019

Deborah L. Simpson

David L. Gore

DLS/dw
R-2/19/19
46

Stephen J. Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOTTA HARRIS,

Petitioner,

vs. No: 13 WC 27148

STATE OF ILLINOIS-DEPARTMENT OF HUMAN SERVICES,

Respondent

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties Pursuant to §19(k) and §19(l), and Fees Pursuant to §16 of the Act. A hearing was held before Commissioner Simpson on November 8, 2018 in Collinsville, the parties were represented by counsel, and a record was taken.

Petitioner sustained a stipulated accident on June 13, 2013. Prior to arbitration, the parties filed a Request of Hearing form in which they stipulated that Petitioner was entitled to 39&2/7 weeks of temporary total disability ("TTD") benefits. The matter was arbitrated on only the issue of the nature and extent of Petitioner's permanent partial disability ("PPD"). The arbitration hearing transcript reveals that Respondent's lawyer agreed that Respondent owed the TTD amount and that it would be paid.

The Arbitrator issued her decision on December 29, 2017. The decision form specified that it was dealing with the issue of nature and extent only. The preamble to the decision indicted that "necessary medical services and temporary compensation benefits have been provided by Respondent." The Arbitrator then awarded Petitioner 4.3 weeks of PPD representing loss of the use of 2% of the right leg. The award did not specifically order Respondent to pay TTD and the decision awarded "0" credit for paid TTD or any other paid benefits. The records of the Commission indicate that neither party filed a Petition for Review or a petition to address a clerical error pursuant to §19(f) of the Act.

The Commission finds itself in a quandary. It is clear that Respondent, at least through its lawyer at the time of arbitration, acknowledged it owed Petitioner a specific amount of TTD. At the instant review hearing, Petitioner's lawyer repeatedly referred the instant petition as an "enforcement action." The Commission has no enforcement powers, it can only try to coerce compliance through the assessment of penalties for non-compliance. However, in this matter the Decision of the Arbitrator did not order Respondent to pay TTD. Therefore, the Commission cannot impose penalties because Respondent did not fail to comply with an order of the Commission. Petitioner's proper action would have been to file a petition to address a clerical error in the Arbitrator's decision pursuant to §19(f) or file a Petition for Review of the Decision of the Arbitrator to the Commission. Petitioner did neither.

The Illinois Workers' Compensation system is meant to be expeditious. While it is adversarial in nature, there is no discovery. The system works best when the parties are able to stipulate to certain issues prior to arbitration; that is the reason we utilize the Request for Hearing form, commonly referred to as a "stip sheet." The Commission expects parties to comply with its stipulations and that respondents would pay benefits for which they acknowledged liability. In the instant situation, the Commission highly recommends that Respondent abides by its prior stipulation and pay Petitioner the TTD benefits as it previously agreed. The Commission does not have authority to coerce an employer to pay benefits that were agreed to by the parties at the time of arbitration and were therefore not an issue for the Commission to resolve and subsequently not specifically ordered by the Commission. However, we note that if Respondent does not satisfy its previously acknowledged obligation, it will lose some credibility with the Commission and we will likely look more askance at its stipulations and subsequent actions in future matters.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition for Penalties Pursuant to §19(k), §19(l), and Fees Pursuant to §16 of the Act is denied.

DATED: MAR 4 - 2019

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
R-11/8/18
46

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TINA MORRIS, WIDOW OF THOMAS MORRIS, DECEASED,

Petitioner,

19IWCC0144

vs.

NO: 15 WC 35579

C & C GENERAL CONTRACTORS,

Respondent.

DECISION AND OPINION ON REVIEW

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

This matter was arbitrated as an uncontested death claim. Decedent died in a forklift accident on April 1, 2014. Respondent never disputed the claim and paid decedent's funeral expenses and began paying death benefits to his survivors prior to arbitration. In her decision, the Arbitrator did not include language specifying the credit due Respondent, to which the parties had stipulated. In addition, the Arbitrator did not include language indicating that the survivors may be entitled to benefits from the Rate Adjustment Fund. While the Commission notes that the inclusion of such language is probably not necessary legally because Respondent's obligation is prospective in nature and tied to specific dates, irrespective of what it has already paid and similarly, the survivors are entitled to cost-of-living adjustments from the Rate Adjustment Fund by operation of law, irrespective of the language in the Decision of the Arbitrator. Nevertheless, the Commission changes the Decision of the Arbitrator for purposes of clarification and completeness.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay death benefits as of April 1, 2014 at the minimum rate of $733.33 per week to Tina Morris, surviving spouse for her own benefit and for the benefit of Hailey Marie Morris, Michael Patrick Morris, and Lilian Paige Morris for 25 years or $500,000, whichever is greater, have been paid because the injury caused the death of employee, Thomas Tyrone Morris as provided in §7 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that if the surviving spouse dies before the maximum benefit level has been reached, and the children herein named still survive, the Respondent shall continue to pay benefits until the youngest child reaches 18 years of age; however, if such child is enrolled as a full-time student in an accredited educational institution, payments shall continue until the child reaches 25 years of age.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the survivors may become eligible for 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 interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit of $122,404.44 for death benefits Respondent had paid prior to arbitration.

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: MAR 4 - 2019

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-2/21/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

19IWCC0144

MORRIS, THOMAS EMPLOYEE/MORRIS TINA Case# 15WC035579
Employee/Petitioner

C AND C GENERAL CONTRACTORS
Employer/Respondent

On 6/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.07% 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:

0874 FREDERICK & HAGLE
PHILLIP W PEAK
129 W MAIN ST
URBANA, IL 61801

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Thomas/Morris, Employee/Tina Morris, Petitioner Case # 15 WC **35579**
Employee/Petitioner
v.
C and C General Contractors.
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 of **Kankakee** on **April 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 Decedent's employment by Respondent?

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

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

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

G. [ ] What were Decedent's earnings?

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

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

J. X Who was dependent on Decedent at the time of death?

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

L. [ ] What compensation for permanent disability, if any, is due?

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

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, **April 1, 2014** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Decedent's death ***is*** causally related to the accident.

In the year preceding the injury, Decedent earned $**57,200.00**; the average weekly wage was $**1,100.00**.

On the date of accident, Decedent was **35** years of age, ***married*** 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 $ for TTD, $ for TPD, $ for maintenance, and $**0** for other benefits, for a total credit of $**0.**

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

The Arbitrator finds that Decedent, **Thomas Tyrone Morris** died on **April 1, 2014**, leaving **four** survivor(s), as provided in Section 7(a) of the Act, including spouse, **Tina Morris,** and three dependent children: **Hailey Marie Morris,** born October 27, 1998; **Michael Patrick Morris,** born January 21, 2011 and **Lillian Paige Morris,** born September 3, 2005. No dependent has any mental or physical disabilities.

ORDER

Death Benefits

Respondent shall pay death benefits as of April 1, 2014 at the minimum rate of **$733.33** per week to **Tina Morris,** surviving spouse for her own benefit and for the benefit of **Hailey Marie Morris, Michael Patrick Morris,** and **Lillian Paige Morris** for **25 years, or $500,000,** whichever is greater, have been paid because the injury caused the death of employee, **Thomas Tyrone Morris,** as provided in Section 7 of the Act.

Respondent shall pay benefits until the youngest child reaches 18 years of age; however, if such child is enrolled as a fulltime student in an accredited education institution, payments shall continue until said child reaches 25 years of age.

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

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

06/06/2017
Date

JUN 7 - 2017

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

CAROL THOMAS,

Petitioner,

vs.

NO: 15 WC 21845

CENTERS FOR NEW HORIZONS,

19IWCC0145

Respondent.

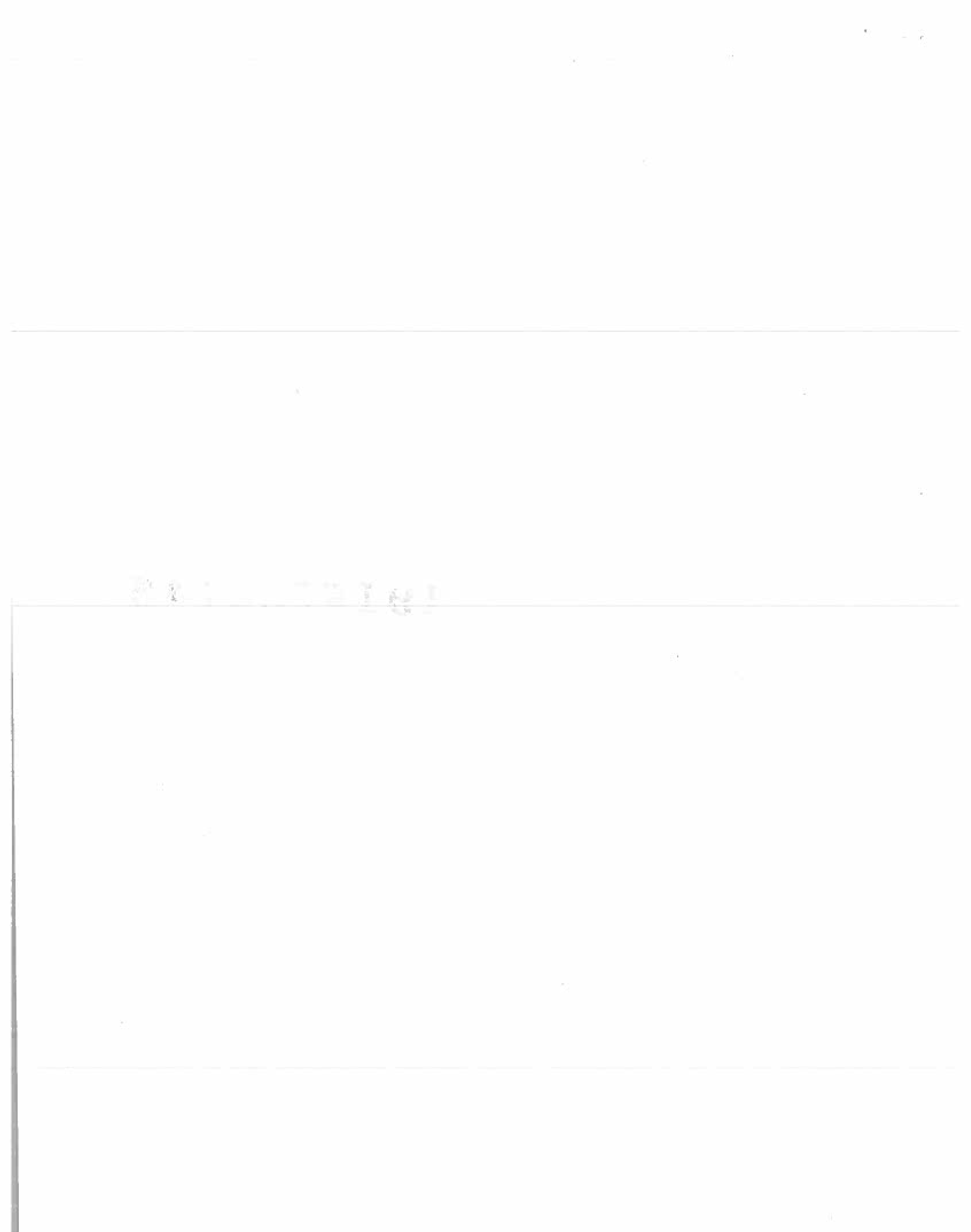
DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation and prospective medical, and being advised of the facts and law, corrects the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 makes a correction to the prospective medical award. The Arbitrator ordered Respondent to "authorize" the treatment recommended by Dr. Daniel Stormont; the Commission strikes that language and instead, consistent with Section 8(a), orders Respondent to provide and pay for the left knee replacement surgery.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 11, 2017, as modified above, is hereby affirmed and adopted.



IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for medical treatment as recommended by Dr. Stormont 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 without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: MAR 6 - 2019

LEC/mck

O: 2/27/19

43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

THOMAS, CAROL
Employee/Petitioner

Case# **15WC021845**

CENTERS FOR NEW HORIZONS
Employer/Respondent

19IWCC0145

On 10/11/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

3998 ROSARIO CIBELLA LTD
JACOB R SCHNEIDER
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

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)

Carol Thomas
Employee/Petitioner

v.

Centers for New Horizons
Employer/Respondent

Case # **15** WC **21845**

Consolidated cases: _____

19IWCC0145

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **September 26, 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. [x] Is Petitioner entitled to any prospective medical care?

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

19IWCC0145

FINDINGS

On the date of accident, **December 5, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$32,613.88**; the average weekly wage was **$627.19**.

On the date of accident, Petitioner was **60** years of age, *married* 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 **$973.98** for TTD.

ORDER

Respondent shall authorize the left knee replacement surgery prescribed by Dr. Daniel Stormont.

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

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

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

David A. Kane
Signature of Arbitrator

October 11, 2017
Date

ICArbDec19(b)

OCT 11 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION

CAROL THOMAS,	)	
Petitioner,	)	
v.	)	No. 15 WC 21845
CENTERS FOR NEW HORIZONS,	)	
Respondent.	)	

ATTACHMENT TO ARBITRATOR'S DECISION

I. Findings of Fact.

Petitioner began working for Respondent as a social worker in January, 2011. She testified that on December 5, 2013, she slipped on a wet floor and twisted her left knee. She subsequently sought medical treatment from her primary care physician, Dr. Daniel Hidaka, on January 13, 2014. (PX 1, p. 63) Dr. Hidaka diagnosed a sprained knee for which he prescribed physical therapy. (PX 1, p. 66)

Petitioner attended physical therapy for her left knee at Athletico for a total of 15 visits from February 13, 2014 through March 28, 2014. (PX 3, p. 33-83) She returned to Dr. Hidaka on April 22, 2014 complaining that her left knee was still painful and swollen. (PX 1, p. 59) Dr. Hidaka prescribed an MRI. (PX 1, p. 63)

On May 15, 2014, Petitioner underwent an MRI of her left knee. It revealed a partial tear of the medial meniscus and Grade II chondromalacia patella. (PX 1, p. 105) On May 20, 2014, Dr. Hidaka referred Petitioner to Dr. Mark Bowen of Northshore Orthopedics. (PX 2, p. 29)

Petitioner saw Dr. Bowen on May 22, 2014. He recommended surgery. On June 12, 2014, Petitioner underwent a left knee partial medial meniscectomy and tricompartmental synovectomy by Dr. Bowen. (PX 2, p. 58) Post-operative physical therapy was administered at Athletico beginning on June 26, 2014. (PX 3, p. 84) On September 10, 2014, Dr. Bowen noted that Petitioner was doing well despite some ongoing soreness and swelling in the knee. He encouraged her to continue with range of motion exercises but otherwise released her from care. (PX 2, p. 7)

Petitioner returned to Dr. Bowen on December 10, 2014 complaining of left knee pain after prolonged periods of standing or walking. Dr. Bowen felt that Petitioner was "struggling recovering from her injury and knee surgery" and he recommended a series of cortisone or viscosupplementation shots. (PX 2, p. 3-4) Petitioner testified that she decided to switch treating doctors in light of some offensive comments that Dr. Bowen had made to her. She contacted her primary care physician, Dr. Hidaka, and was referred to Dr. Daniel Manning of Northwestern Medicine.

Petitioner saw Dr. Manning on January 16, 2015. He administered a cortisone injection to her left knee. When Petitioner returned to Dr. Manning on July 24, 2015, she complained of medial-sided left knee pain. Dr. Manning recommended an MRI and indicated that a medial compartment arthroplasty might be considered. (PX 4, p. 1) Shortly thereafter, Petitioner moved from Chicago to Freeport, Illinois.

On October 28, 2015, Petitioner saw Dr. Daniel Stormont, an orthopedic surgeon in Darlington, Wisconsin. He recommended an MRI and felt that she would need a knee replacement surgery. (PX 5, Ex 2)

In July, 2016, Petitioner began working as a manager at Wal-Mart.

On August 30, 2016, Petitioner was examined at the request of Respondent pursuant to Section 12 of the Act by Dr. Troy Karlsson of DMG Orthopaedics. Dr. Karlsson felt that Petitioner sustained a partial tear of her left medial meniscus on account of her accident at work. He felt that her current complaints stemmed from degenerative arthritis which was neither caused nor aggravated by the work accident. (RX 1)

Petitioner underwent an MRI of her left knee on June 5, 2017. It demonstrated significant osteochondral abnormalities involving the medial compartment associated with osteophytes. The radiologist felt that this reflected advanced osteoarthritis and possibly coexistent osteonecrosis of the medial femoral condyle.

Petitioner returned to Dr. Stormont on June 22, 2017. After reviewing the recent MRI, he recommended knee replacement surgery. He felt that this was due to a progression of Petitioner's degenerative knee condition since her accident. (PX 6)

On August 7, 2017, Dr. Karlsson reviewed Petitioner's recent MRI at Respondent's request. He felt that it demonstrated tricompartmental osteoarthritis and osteophytes, worst on the medial side. He reiterated his opinion that this represented the natural progression of Petitioner's preexisting degenerative condition. He agreed that Petitioner would be a candidate for a knee replacement surgery, but he felt that this was unrelated to her work accident. (RX 2)

Petitioner testified that her left knee has not been symptom-free since the accident at work. She has had no accidents or injuries involving her left knee since the accident at work. She further testified that her left knee is painful and swollen. She desires to undergo the knee replacement surgery prescribed by Dr. Stormont.

ii. Conclusions of Law.

In support of the Arbitrator's decision relating to whether Petitioner's current condition of ill-being is causally connected to the accident ("F"), the Arbitrator concludes as follows:

This case involves a medical dispute. The parties agree that Petitioner injured her left knee at work in an accident which resulted in an arthroscopic medial meniscectomy. Respondent believes that this condition attained maximum medical improvement, presumably when Dr. Bowen released Petitioner from care on September 10, 2014; and that all treatment downstream from that point is no longer related to the work accident. In support of this position, Respondent has put forth the opinions of Dr. Troy Karlsson who has indicated that Petitioner's current condition--and her need for a left knee replacement surgery--are due solely to pre-existing degenerative arthritis which was neither caused nor aggravated by the work accident.

By contrast, Petitioner argues that although Dr. Bowen released her from care on September 10, 2014, she returned to his office exactly three months later with ongoing complaints of left knee pain. Petitioner argues that whatever pre-existing condition she may have had was quiescent prior to the work injury, and that she neither suffered from left knee problems nor required medical treatment for her left knee. Petitioner argues that her left knee complaints began on the day of her work accident, that they have persisted continuously since that time and that she has had no intervening accidents or injuries involving the left knee. In support of her position, Petitioner has put forth the opinions of Dr. Daniel Stormont who has indicated that Petitioner's current condition--and her need for a left knee

replacement surgery--are due, at least in part, to the aggravation of her previously asymptomatic degenerative arthritis by the work accident. (PX 5, p. 10, 12-13, 27)

On balance, the Arbitrator finds the opinions of Dr. Stormont to be more credible. The absence of left knee problems prior to Petitioner's work accident; and the persistence of those problems--clearly documented in the treating medical records--since Petitioner's work accident weigh heavily in favor of a finding of causation. Stated differently, in order for Dr. Karlsson's opinion to prevail, the Arbitrator would have to conclude that it was merely a coincidence that the left knee pain from which Petitioner has suffered since the day of her work accident began on that very day. In the absence of prior symptoms, in the absence of intervening trauma, the Arbitrator finds that to be highly unlikely.

Based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being relative to her left knee is causally connected to her accident at work on December 5, 2013.

In support of the Arbitrator's decision relative to whether Petitioner is entitled to prospective medical treatment ("K"), the Arbitrator concludes as follows:

Both Dr. Karlsson and Dr. Stormont feel that Petitioner requires a total knee replacement surgery. They have disagreed only on whether the need for that surgery is causally connected to Petitioner's accident at work. Having determined that such a causal connection exists, the Arbitrator further concludes that Petitioner is entitled to undergo the prescribed surgery and that Respondent shall provide the necessary authorizations for her to do so.

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

Marietta Jackson,
Petitioner,

vs. No: 14 WC 13438

19IWCC0146

Loretto Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review having been filed timely by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability and being advised of the facts and law, affirms 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 on August 29, 2017, 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.

19IWCC0146

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

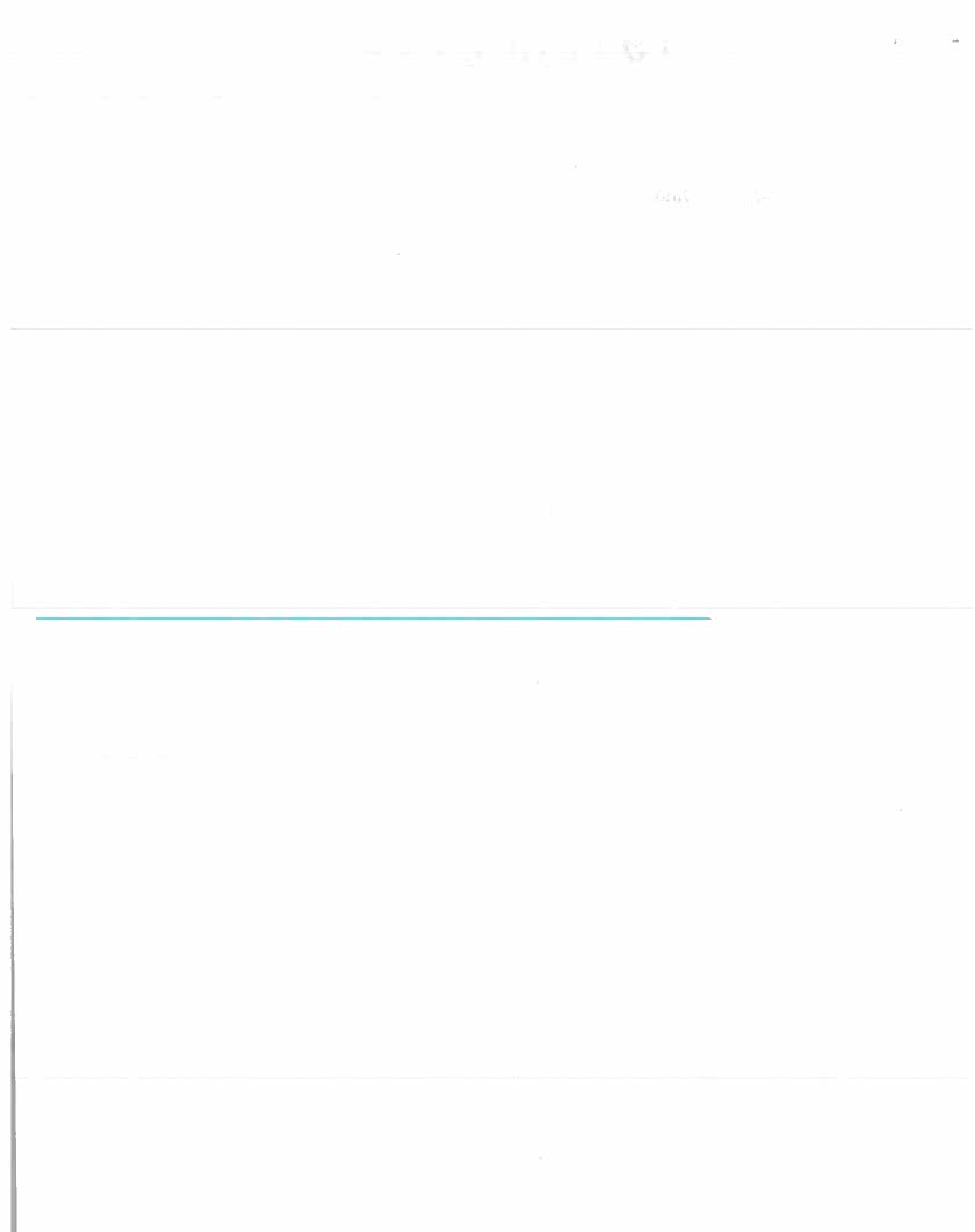
DATED: MAR 6 - 2019

Joshua D. Luskin

o-02/27/19
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACKSON, MARIETTA
Employee/Petitioner

Case# **14WC013438**

LORETTO HOSPITAL
Employer/Respondent

19IWCC0146

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2004 JEROME SCHACHTER & ASSOCIATES
RICHARD DOMASH
9933 N LAWLER SUITE 100
SKOKIE, IL 60077

1109 GAROFALO SCHREIBER & STORM
JAMES R CLUNE
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

Marietta Jackson **19IWCC0146** Case # 14 WC 13438
Employee/Petitioner

v. Consolidated cases: None

Loretto Hospital
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 17, 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] 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 – HFS Lien.

FINDINGS

On **2/25/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned: **$31,318.70** and the average weekly wage, pursuant to Section 10, was **$602.28.**

On the date of accident, Petitioner was **45** 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 $**1,835.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,835.52**.

Respondent is entitled to a credit under Section 8 of the Act for payment of medical services prior to trial.

ORDER

The petitioner has failed to prove by a preponderance of credible evidence that she sustained an accidental injury arising out of her employment. All other issues are rendered moot by the decision regarding this dispositive issue.

The respondent is entitled to credit for all TTD and medical bills heretofore paid.

The petitioner is not entitled to prospective medical care.

See the attached findings of fact and law for a further explanation of this order.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 — 08.29.17 Date

AUG 29 2017

Marietta Jackson v Loretto Hospital
14WC13438

Findings of Fact and Conclusions of Law

Findings of Fact:

The petitioner had been working for about two and one-half years for respondent at the time of the alleged accident. Tr. 8 Her job was that of a medical record technician. She assembled charts and obtained missing signatures of the responsible doctors. Tr. 8 Her day involves sitting and standing as part of her job. However, there is no heavy lifting involved. Tr. 9

On February 25th 2014 the petitioner stated she slipped coming in to work. The security guard caught her. Tr. 9 Upon revisiting her testimony, the petitioner stated she was walking up stairs and "I stumbled." The security guard caught her before she fell into the guard's desk. Tr. 10

After the guard caught her, the petitioner noticed throbbing pain on the outside of her right ankle. Tr. 11 She then proceeded to her department to perform her job. Upon advising her supervisor what had happened she was told to go to the emergency department of Loretto. Tr. 11 She received x-rays and an ACE bandage. She was told she could return to work, but upon standing it was clear she was having too much difficulty and she was told to take three days off. Tr. 12

On March 3, 2014 the petitioner saw Dr. Joshi (Tr. 13) who advised the petitioner to return to work. By March 7, 2014 the petitioner was experiencing pain in her right knee. Tr. 14

On March 31 the petitioner went for treatment to Rush Oak Park Hospital. Tr. 16 Thereafter, the petitioner received treatment from Dr. Vucicevic. Tr. 16, PX 3 at Tr. 32 Vucicevic recommended an MRI of the petitioner's knee. Tr. 16 The petitioner also had an MRI of her back. Tr. 17 Dr. Vucicevic then recommended to the petitioner that she take two weeks off work pending the results of the MRIs. The petitioner received prescriptions for medications, but did not have surgery to either her knee or her back. Tr. 18

On October 24, 2014 the petitioner returned to work as a data entry specialist for Advanced Resources at Elmhurst Hospital, and later for other employers as placed by a medical staffing network. Tr. 19 – 21 She continues to complain of pain to her right ankle, knee, and low back. Tr. 22 – 25

Legal Standard:

A decision by the Commission cannot be based upon speculation or conjecture. Deere and Company v Industrial Commission, 47 Ill.2d 144, 265 N.E. 2d 129

(1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. Three "D" Discount Store v Industrial Commission, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove, by a preponderance of credible evidence, all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. Martin vs. Industrial Commission, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. Smith v Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. U.S. Steel v Industrial Commission, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. Board of Trustees of the University of Illinois v. Industrial Commission, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also Hansel & Gretel Day Care Center v Industrial Commission, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991). "[A]lthough medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only, and not within the common knowledge or comprehension of laymen, expert testimony is necessary to show that a claimant's work activities caused the condition complained of." Interlake Steel v. Industrial Commission, 136 Ill. App. 3d 740 (1985). See also Ledbetter v State of Illinois, 13-IWCC-0131, regarding the relative knowledge of testifying experts.

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. Caterpillar Tractor vs. Industrial Commission, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. Neal vs. Industrial Commission, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See generally, Gallentine v. Industrial Commission, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also Seiber v Industrial Commission, 82 Ill.2d 87, 411 N.E.2d 249 (1980), and Caterpillar v

Industrial Commission, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. O'Dette v. Industrial Commission, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); Hosteny v Workers' Compensation Commission, 397 Ill.App. 3d 665, 674 (2009).

Conclusions of Law:

C.

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

The petitioner testified that she was "walking up the stairs, and I stumbled." The petitioner stated she was coming in to work at the time. She did not describe a defect associated with the staircase. The petitioner did not state that she was performing any particular or special task for the respondent that necessitated her carrying anything that contributed to her fall, caused her to be moving at a greater speed than normal, or that prevented her from catching herself when she fell adding to her injury.

In order for an accident to be compensable the accident must arise out of the employment in that the employment must be a causative factor. There are three risks to which an employee may be exposed: risks distinctly associated with the employment, personal risks, and neutral risks that have no particular employment or personal characteristics. Compensation for neutral risks is determined by whether the petitioner was exposed to a risk of injury to an extent greater than that to which the general public is exposed. Illinois Institute of Technology Research Institute v Industrial Commission, 314 Ill.App.3d 149, 731 N.E.2d 795, 247 Ill.Dec. 22 (1st Dist. 2000).

In the instant case, while the event occurred in the course of the petitioner's employment, it did not arise out of her employment. Climbing a staircase is a neutral risk and is not compensable if the petitioner did not face a risk to a greater degree than that faced by the general public. There was no testimony from the petitioner that the risk the petitioner faced was any greater than that faced by any member of the general public when climbing stairs.

In the event of falls on the company premises the petitioner has the burden of proving the cause of the fall and that the premises or the employment provided the unique causative factor. See First Cash Financial Services v Industrial Commission, 367 Ill.App.3d 102, 853 N.E.2d 799, 304 Ill.Dec. 722 (1st Dist. 2006). There is no such evidence in this case. Compensation is denied.

F.

Is Petitioner's current condition of ill-being causally related a work injury or illness on or about October 8, 2012?

This issue is rendered moot due to the decision regarding accident, above.

K.
What temporary benefits are in dispute?

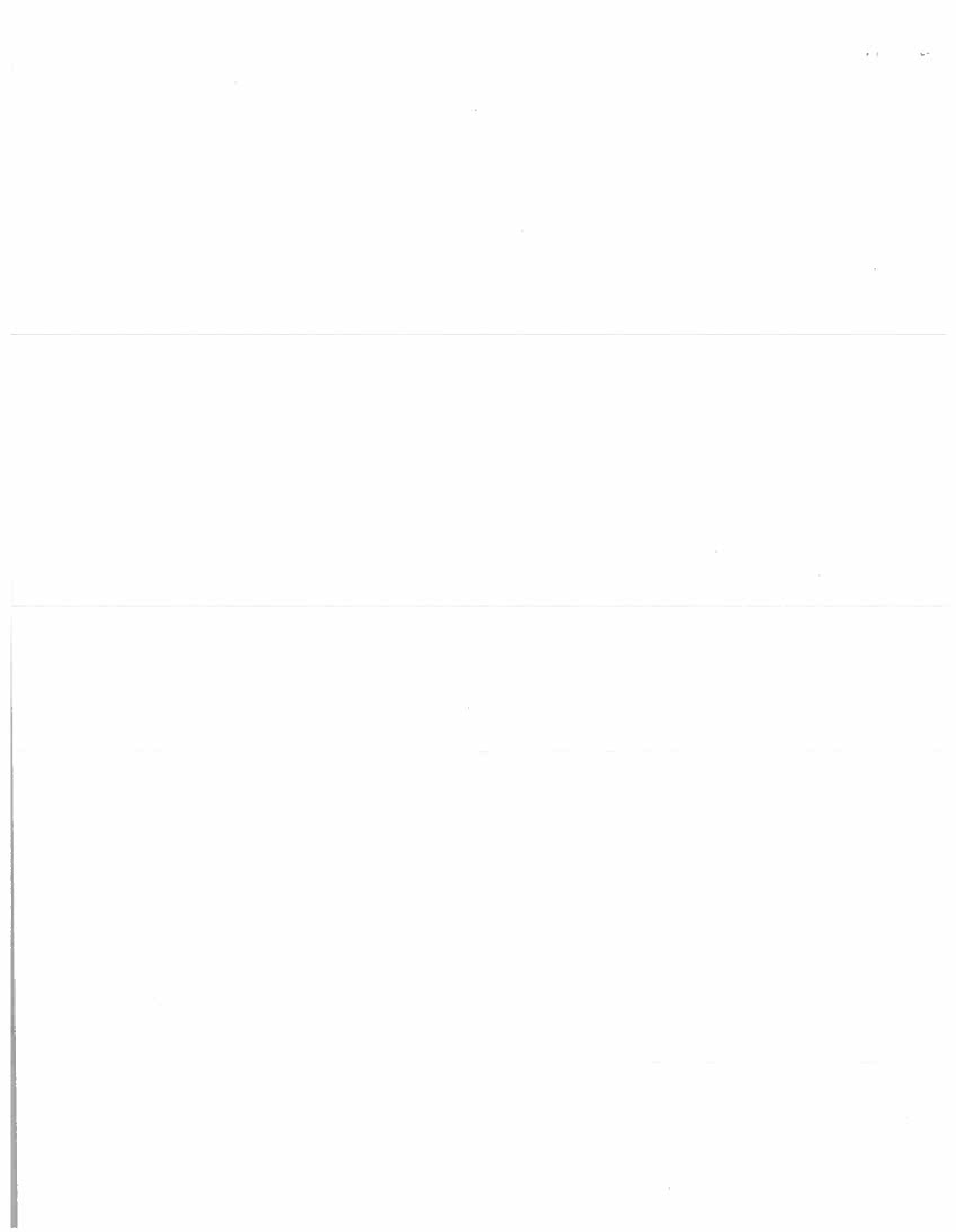
This issue is rendered moot due to the decision regarding accident, above.

L.
Nature and Extent.

This issue is rendered moot due to the decision regarding accident, above.

O.
HSF Lien

This issue is rendered moot due to the decision regarding accident, above.



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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James B. Hausler,
Petitioner,

vs. NO. 14 WC 08410

Cook Illinois Corporation,
Lakeside Transportation,
Respondent.

19IWCC0147

DECISION AND OPINION ON REVIEW

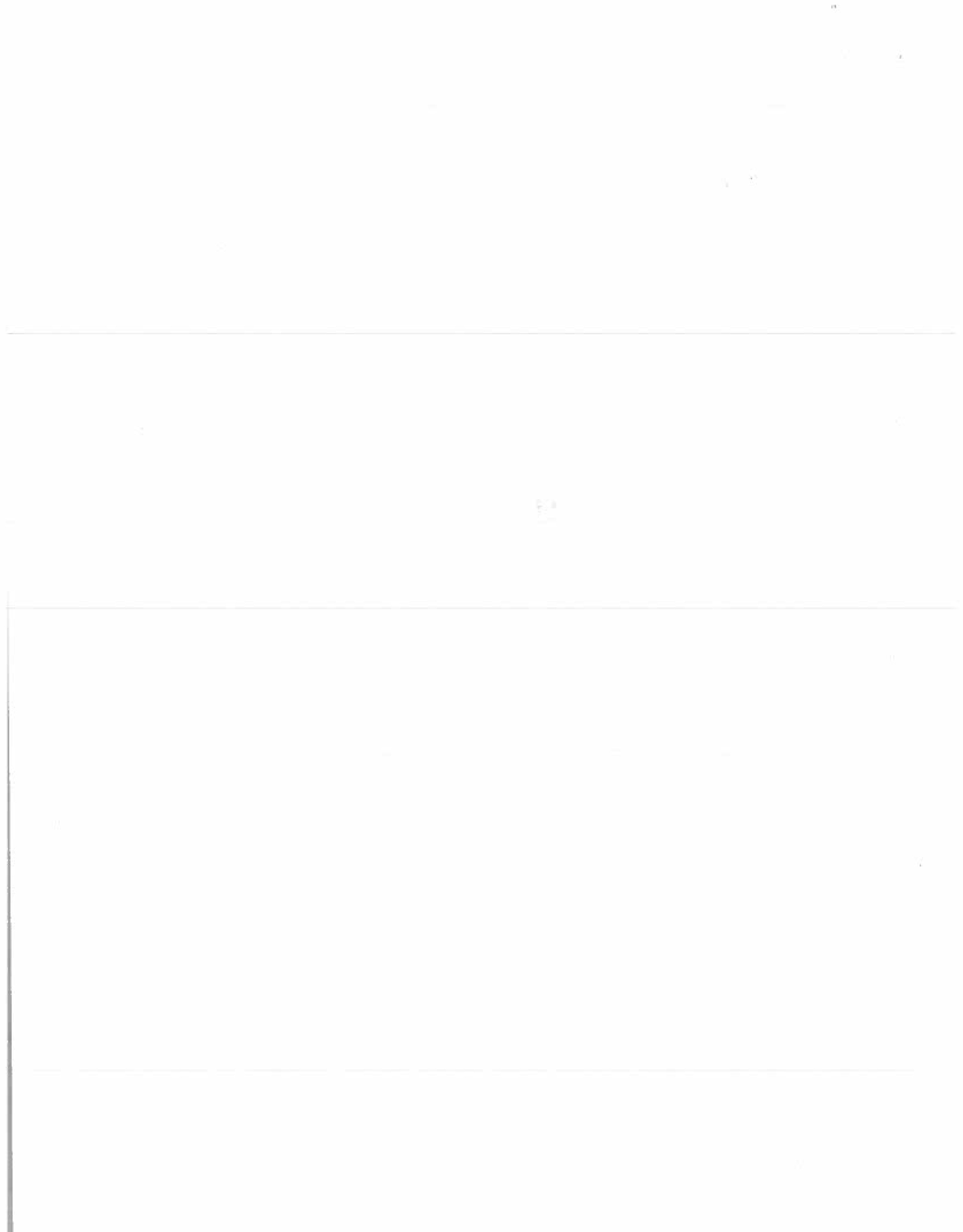
Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and prospective medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof . The Commission 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 on August 25, 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.

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



Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

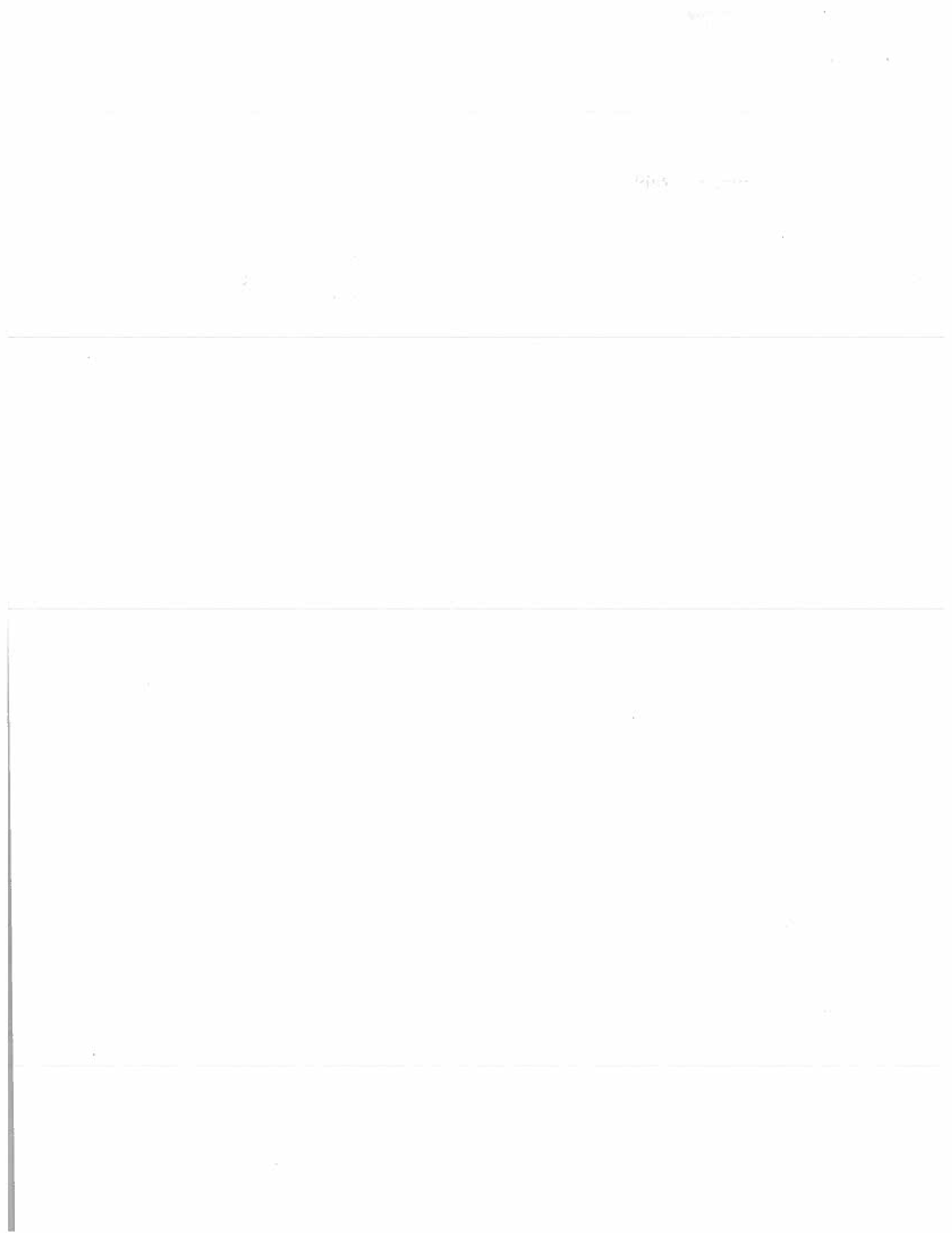
DATED: MAR 6 - 2019

Joshua D. Luskin

o-02/27/19
jdl/wj
68

Charles J. DeVriendt

L. Elizabeth Coppoletti



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

HAUSLER, JAMES N
Employee/Petitioner

Case# **14WC008410**

CCOK ILLINOIS CORPORATION-LAKESIDE TRANSPORTATION
Employer/Respondent

19IWCC0147

On 8/25/2017, 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:

1987 RUBIN & CLARK LAW OFFICES LTD
CATHERINE KRENZ DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0208 GALLANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

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
19(b)

James N. Hausler 19IWCC0147 Case # 14 WC 08410
Employee/Petitioner

v. Consolidated cases: N/A

Cook Illinois Corporation-Lakeside Transportation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **June 26, 2017** and in the city of **Chicago**, on **July 10, 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. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **January 21, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$27,088.88**; the average weekly wage was **$520.94**.

On the date of accident, Petitioner was **40** years of age, *single* with **1** dependent child.

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

Respondent shall be given a credit of **$238.05** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$238.05**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $347.29/week for 3/7 weeks, commencing January 22, 2014 through January 27, 2014, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$238.05** for TTD paid.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. De Leon, including a right lateral epicondyle release with denervation and right medical epicondyle release, any post operative treatment, physical therapy or other reasonable and necessary care.

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

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

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

Signature of Arbitrator

August 23, 2017
Date

ICArbDec19(b)

AUG 25 2017

19IWCC0147

Statement of Facts

Petitioner James Hausler testified that he is employed by the Respondent as a bus driver. On January 21, 2014, he had been so employed for 5 ½ years. He is right handed. His duties required him to pick up and drop off children from designated stop locations. He drives a school bus that is 39 feet long, weighs 15,000 pounds and carries 71 passengers. The driver's area has the steering wheel in front of him with pedals. To the right of the steering wheel, there is a parking brake used when he stops the bus to pick up or drop off children. The parking brake is electric. You pull it and hold it for a couple of seconds to apply the brake and push it to disengage. He normally pulls the brake with his front two fingers. A light will go on and there will be a beep when the parking brake becomes engaged. The dashboard panel is approximately at arm's length from his body when he is seated.

Petitioner testified that he climbed up and down stairs at the service door. He reached to check the bus before his route and to check the mirrors and the emergency hatch. Petitioner performed overhead work when he checked the hatch. The hatches are located on the roof top and require approximately fifteen pounds of force to lift or lower. Petitioner pushed and pulled hatches and windows.

Prior to January 21, 2014, Petitioner performed all of his job duties. He testified that he was in good health. He testified he never had any prior injuries or medical treatment of for his right elbow or neck. He did have a back strain in March, 2000.

On January 21, 2014, Petitioner was driving the school bus for Respondent in Wonder Lake, Illinois when he was involved in a motor vehicle accident. Petitioner had stopped the bus to drop children off and was rear ended by a moving vehicle while he was at a full stop. Petitioner had applied the service brake and the bus was in neutral. He applied the parking brake with his right arm extended. He heard the parking brake beep, indicating that it was engaged, but before he could pull his hand back, the bus was rear ended. Petitioner testified that at the time of the collision, his right arm was extended in front of him against the dash panel where the parking brake was. He testified that he was thrown forward pushing all his body weight onto his hand. Petitioner testified that he weighs 300 pounds. He also testified that he sustained a whiplash event.

Petitioner testified that he was taken to Centegra Hospital by ambulance. The records of Centegra Hospital were admitted as Petitioner's Exhibit 1. Petitioner provided a history of a MVC just prior to admission. The records note complains of pain in the lower back. The physical examination notes that he was in a cervical collar on a backboard. The examination noted pain on movement of the neck. He had muscle spasm of the back but no tenderness. The examination of the extremities revealed no findings with respect to any of the extremities with normal range of motion. X-rays taken of the lumbar spine noted degenerative changes. CT of the cervical spine noted degenerative changes and straightening of the lordosis which could be positional. Petitioner was diagnosed with lumbosacral and cervical sprains. He was discharged home with instructions to seek follow up in 2-3 days (PX 1).

Petitioner testified that the physician at Centegra treated his back and neck because he arrived in a collar and that was the first thing they looked at when he arrived. He testified that he complained of overall body pain focusing on the neck and back. He testified that he was told that the overall body pain may increase or subside over time. He testified they did not want to speculate too much because he was overall in pain everywhere. Petitioner testified that he started noticing the right elbow pain on the next day.

Petitioner sought further treatment with Dr. Shropshire at Northwestern Medical Physician's Group on January 29, 2014. He testified that he was referred there by Respondent and was seen as soon as they could get him in. The records from Northwestern Medical Physician's Group were admitted as Petitioner's Exhibit 2. X-rays of the right elbow revealed osseous hypertrophy and a small osteophyte in the radial head. X-rays of his left knee noted joint effusion and degenerative changes. Petitioner was diagnosed with a cervical/lumbar strain and knee/elbow strain. He released to full duty work and instructed to wear an ACE wrap on his knee. On February 5, 2014, he was referred to physical therapy for his neck, knee and elbow (PX 2). On March 5, 2014 Petitioner was referred for orthopedic evaluation. The diagnosis was right epicondylitis, cervical strain/disc syndrome, and acute lumbar strain/disc syndrome (PX 2, p 7).

Petitioner began physical therapy on February 25, 2014. On February 28, 2014, Petitioner reported complaints of neck pain, headaches, right medial elbow pain, left posterior/lateral knee pain and lower back pain. He informed the physical therapist that he was rear ended while driving a school bus, while at a stop, by a car going 30 mph. He felt whiplash type injury with neck. His right hand was on the brake and he felt his arm pushed forward (PX 3, p 6).

Petitioner was examined by Dr. Stanford Tack at Illinois Bone & Joint on March 11, 2014 (PX 4). Dr. Tack documented a history of a motor vehicle accident which occurred on January 21, 2014. Petitioner reported onset of low back pain and subsequent pain in the neck. He complained of headaches, neck and back pain and right medial elbow pain. Examination noted marked focal tenderness on palpation of the flexor pronator origin of the medial epicondyle. Dr. Tack diagnosed post-traumatic cervical strain, post-traumatic lumber strain and right medial epicondylitis. Dr. Tack performed a corticosteroid injection to the elbow (PX 4, p 1). Petitioner testified that the injection provided short term relief; however, the pain returned after three or four weeks. Petitioner continued physical therapy through March 24, 2014 (PX 3). On April 1, 2014, Dr. Tack noted improvement with therapy. He noted development of lateral elbow symptoms. Petitioner was transitioned to home exercise for his neck and back. He received an additional injection into the right elbow (PX 4, p 3).

Petitioner was examined by Dr. Steven Mash at Respondent's request on May 7, 2014 (RX 3, Ex 2). He diagnosed resolved cervical and lumbar sprain/strain, resolved sprain-left knee, and chronic lateral epicondylitis. He opined that the diagnosis does relate to the injury. He noted minimal residual difficulty about the right elbow which appears to have responded to conservative care. He did not believe further treatment was indicated.

On May 13, 2014, Dr. Tack noted that Petitioner has made substantial progress since the injury but remains mildly symptomatic. He recommended completing his course of physiotherapy. He scheduled follow up in a month for anticipated maximum medical improvement. On June 10, 2014, Dr. Tack notes recurrent symptoms of medial epicondylitis. He administered a third injection. Petitioner was advised to follow up as needed only (PX 4, p 4, 6). Petitioner testified that he received two to three weeks relief from the injection and then the pain returned. On August 11, 2014, Petitioner returned to Dr. Tack. Dr. Tack noted that the injection improved symptoms dramatically, but that the symptoms recurred. Dr. Tack recommended a course of therapy for the persistent symptoms (PX 4, p 7). Petitioner testified that he did not undergo the recommended therapy because it was not approved by workers' compensation.

Petitioner underwent a DOT physical on August 14, 2014 (RX 1). Petitioner reported a back injury or sprain. He noted that the problem still exists and he should be under treatment. He stated the condition does not interfere with the safe operation of a school bus. Petitioner indicated that he did not have "missing or impaired

hand, arm, foot, finger, toe" condition. He did indicate that he had an illness or injury in the past five (5) years. The report notes "1-23-14, back strain, physical therapy, Dr. Salzburg, Dr. Tack, NSAI." The examination did not find loss or impairment of the upper extremity or insufficient grasp and prehension in upper limb to maintain steering wheel grip. Petitioner was certified to drive but required monitoring due to elevated BMI (RX 1). Petitioner testified that the DOT physicals are performed annually. The physician checked the patient's height, weight, blood pressure, eyesight and general health condition and performed a drug test. Petitioner testified that he did not advise the DOT physician that he had any missing or impaired hand, arm, foot, leg, finger or toe because he did not have any missing body parts. He also testified that his upper extremity was not impaired for driving. Petitioner testified that he has undergone more DOT physicals since August 14, 2014. He answers the questions in the same manner. Petitioner testified that no examination was performed of his upper extremity during the physical.

Petitioner testified that from August 11, 2014 through June 28, 2015, he continued to experience pain in his right elbow. He did not sustain any new accidents or injuries involving his right elbow between August 11, 2014 and June 28, 2015. Respondent offered surveillance of Petitioner through testimony of Dave Smart, his investigation reports (RX 4, Rx 5) and video (RX 6, Rx 7). Petitioner was documented to play basketball in March 14, 2015 with limited video obtained. On March 21, 2015, he was observed hooking up his landscaping trailer used a riding lawn mower and doing some repairs on the mower including lifting up the back (RX 4, RX 6). On August 30, 2015 and September 5, 2015, Petitioner performed lawn service including loading and unloading the mower from the trailer, operating the riding mower and a push mower and a string trimmer (RX 5, RX 7). Petitioner testified that since the accident he has played basketball very little because it caused pain. He performs yard work at home. He testified that he was doing up to 40 hours per week and now can't even go close to 20 hours without really being in pain. He uses a riding mower, string trimmer and occasionally a chainsaw. He testified that he does yardwork for himself and for friends and neighbors. Since the accident he has done landscaping for 5 to 10 places.

Petitioner was examined Dr. Serafin De Leon at IBJI Gurnee on June 29, 2015 (PX 5). Dr. De Leon's history is that Petitioner was injured in an auto accident on January 23, 2014. Petitioner complained of pain with gripping, grasping which increases with work activities. Dr. De Leon's physical examination records tenderness to palpation of the right lateral epicondyle and to a lesser extend the right medial epicondyle. There is mild pain with resisted wrist flexion. There is full range of motion. Dr. De Leon diagnosed right lateral and medical epicondylitis. Given the Petitioner's symptoms for over a year, he recommended a right lateral epicondyle release with denervation and medial epicondyle release. He set forth the restrictions of no lifting more than twenty pounds with the right hand (PX 5).

Dr. Mash authored an updated report on October 19, 2015 following review of the DOT physical and the Video Ergonomic Analysis for a Lakeside Transportation Bus Driver (RX 2) and having physically examined the bus, sat in the driver's seat and activated the electronic braking mechanism (RX 3, Ex 3). He opined that the mechanism of injury as described by the Petitioner in activating the emergency brake did not cause or aggravate a condition about the Petitioner's elbow. He opined that Petitioner reached maximum medical improvement in June, 2014 and was not in need of further medical treatment from the incident (RX 3, Ex 3).

Dr. De Leon prepared a narrative report dated February 22, 2016 (PX 6). He diagnosed right lateral and medial epicondylitis and opined that the current condition of ill-being in the right elbow was causally aggravated as a result of the work-related accident of January 21, 2014. He recommended that Petitioner undergo a right lateral epicondyle release with denervation and right medical epicondyle release. He also set

forth restrictions of no lifting more than twenty pounds with the right hand. Dr. De Leon stated that he did not agree Dr. Mash that the accident was not causative factor. He stated that with the bus being rear ended, Petitioner's hands were likely on the wheel causing an isometric contraction of the forearm musculature which would lead to eccentric loading of the tendons, leading to the damage (PX 6). Dr. Mash authored a further report on June 17, 2016 disagreeing with Dr. De Leon and stating that Dr. Deleon's suggestion is not consistent with the facts offered. Dr. Mash reaffirmed his opinions as presented in his October 19, 2015 report (RX 3, Ex 4).

Dr. De Leon testified by evidence deposition taken November 9, 2016 (PX 7). He testified to his examination and diagnosis of right lateral and medial epicondylitis based upon his examination. Petitioner's subjective complaints were consistent with the objective findings. He opined that the condition was causally connected to the accident. He testified that being rear ended and bracing with the right arm could lead to the development of lateral and medial epicondylitis. He opined that Petitioner was in need of surgery and had not yet reached maximum medical improvement. Dr. De Leon testified that he has no record that states Petitioner's hands were on the steering wheel at the time of impact. He testified that Dr. Mash's report stating that Petitioner was reaching over the parking brake and pulling it backward when he suffered a sudden pulling sensation on the elbow is inconsistent with his assumption. He stated that Petitioner's hand did not have to be on the steering wheel to cause the condition. His hand just needed to brace him, whether on the steering wheel, brake lever or other surface. He did not find the reporting of lateral symptoms 10 weeks later inconsistent with his causation opinion. He noted Petitioner had received an injection to the medial side (PX 7).

Dr. Mash testified by evidence deposition taken February 2, 2017 (RX 3).He testified to his examination on May 7, 2014 including the history and review of records. He noted that the first onset of lateral elbow complaints was on April 10, 2014. He diagnosed resolved cervical and lumbar sprain/strain, resolved left knee sprain and chronic lateral epicondylitis. He found the three conditions causally connected to the accident. He did not find Petitioner engaged in symptom magnification. Dr. Mash testified to reviewing the ergonomic study and operating the bus. He testified that before doing so he had assumed that the brake lever was long with a handle that you need to squeeze and crank backward. The actual brake lever is a short lever that takes less force than activating the turn signal on a car. He opined that activating and deactivating the brake would not cause or aggravate lateral epicondylitis because the force is too mild. Dr. Mash disagreed with Dr. De Leon's opinions expressed in the February 22, 2016 report. The facts put forward are inconsistent with the history provided to Dr. Mash. He opined that even if the suppositions were correct, that the activity would not permanently aggravate chronic lateral epicondylitis. Dr. Mash testified that the ergonomic study did not address forces during an impact. Being rear ended with enough force to push someone forward over his arm would not cause epicondylitis. You would need a varus stress to the elbow to create an injury to the lateral supportive structures of the elbow. Bracing with enough force could result in a varus thrust. It's not going to happen bracing yourself if somebody hits you from behind. The mechanism describe by the physical therapist would not cause or permanently aggravate lateral epicondylitis (RX 3).

Petitioner testified that he has not undergone the surgery recommended by Dr. De Leon since it has not been approved by workers' compensation. He would like to undergo the surgery since he continues to experience pain in his right elbow and he wants to have his health back. He notices that he cannot do heavy lifting or repeated stress actions. He continues to perform his job duties for Respondent.

Conclusions of Law

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

The parties hereto have no current dispute as to causal connection of Petitioner's conditions of ill being in the neck, back and left knee. Said conditions are not currently under treatment or in dispute. The current dispute is with respect to the Petitioner's condition of ill being in the right elbow.

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. 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. Nothing in the statutory language requires proof of a direct causal connection." *Sperling v. Industrial Comm'n*, 129 Ill. 2d 416, 421, 544 N.E.2d 290, 292 (1989). A causal connection may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892 (1994). "In addition, a chain of events suggesting a causal connection may suffice to prove causation even if the etiology of the disease is unknown." *Id.* 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). Petitioner has established a causal connection between the accident on January 21, 2014 and his current condition of ill being in the right elbow under either analysis.

The Arbitrator observed the testimony of Petitioner and finds his testimony credible. Petitioner's unrebutted testimony was that he had no prior injury or treatment for his right elbow before the accident. While the initial emergency treatment records do not record complaints in the right elbow, the Petitioner advanced such complaints within days at his first visit with Dr. Shropshire. The Arbitrator finds Petitioner's testimony of the events at the emergency room and his explanation of the delayed onset of his right elbow complaints reasonable and credible. Following the initial treatment, Petitioner has had consistent, credible complaints in the right elbow with a diagnosis of epicondylitis and treatment consisting of therapy and multiple injections. All doctors including Dr. Mash found Petitioner's symptoms consistent with the diagnosis. The Arbitrator does not find the DOT physical performed August 14, 2014 inconsistent with the Petitioner's testimony of ongoing symptoms. The Arbitrator notes that Petitioner continued to perform his job duties even during the initial period of therapy and treatment, and that Petitioner raising questions to the state medical examiner of his ability to operate a bus might jeopardize his certification to continue to work. The Arbitrator also has viewed the video surveillance. While Petitioner is clearly not totally disabled, none of the activities recorded would contradict his testimony of ongoing complaints in the right elbow with heavy lifting or repeated stress actions. Therefore, based upon the chain of events, Petitioner has established causal connection.

Petitioner also offered the medical opinion of Dr. De Leon opining that the Petitioner's condition of right lateral and medial epicondylitis is causally connected to the accident on January 21, 2014. Dr. Mash testified for Respondent that the accident did not cause or aggravate the condition of ill being in the right elbow. It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert

testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

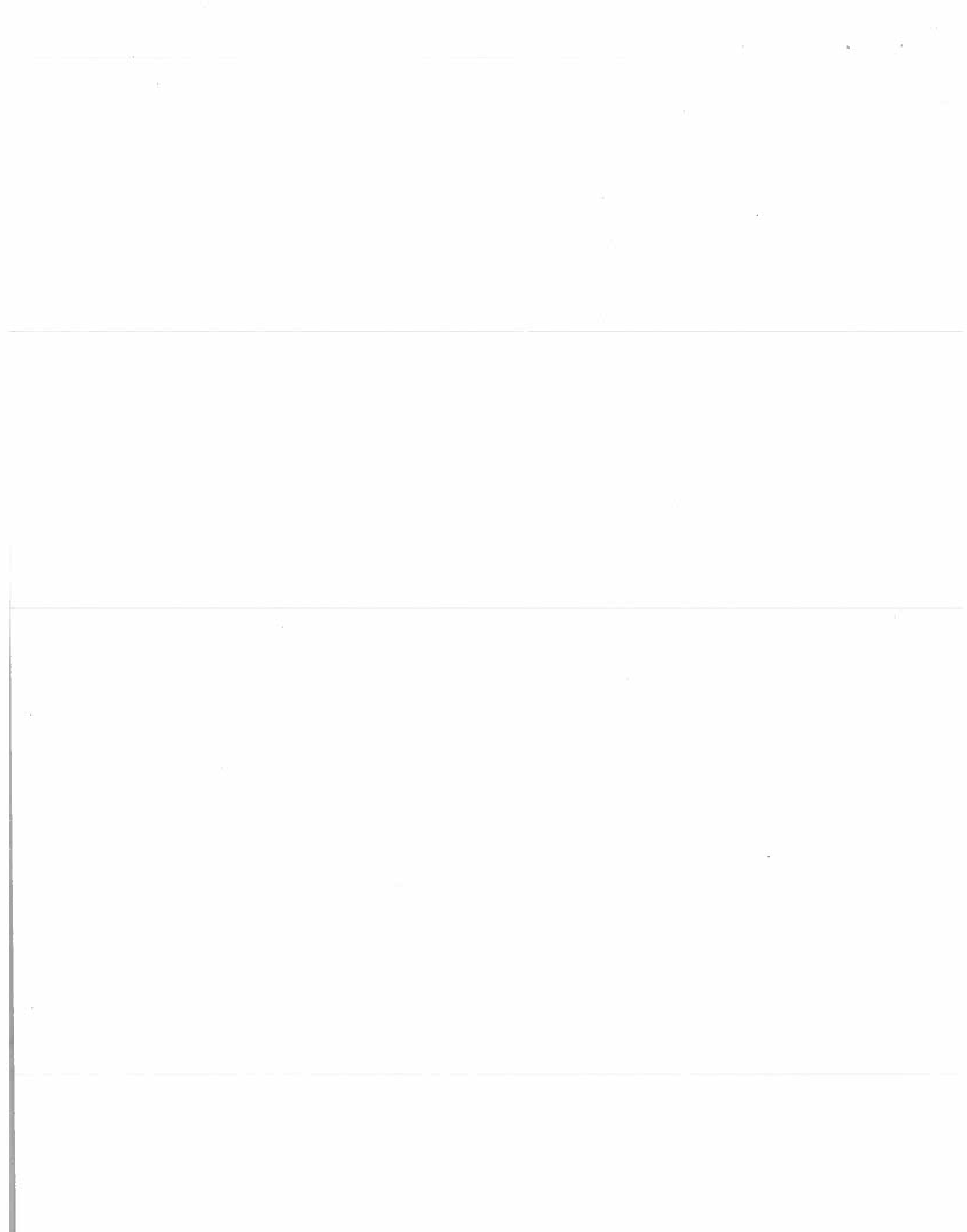
The Arbitrator has reviewed the reports and testimony of the medical experts and finds the opinions of Dr. De Leon more persuasive that those of Dr. Mash. Dr. De Leon's opinion that being rear ended and bracing with the right arm could lead to the development of lateral and medial epicondylitis is consistent with the incident. His initial report discussing the Petitioner's hands on the steering wheel is corrected in his deposition where he opines that his hand just needed to brace him, whether on the steering wheel, brake lever or other surface. His explanation of the delayed onset of lateral symptom is similarly persuasive and consistent with the medical treatment with a series of injections. Dr. Mash's more complete review of the job duties, ergonomic study and personal operation of the bus controls would be persuasive in a claim of repetitive trauma, but since none of these recreated the forces of a rear end impact at 30 mph, are of questionable value in the current case. Dr. Mash's initial report found causal connection of the diagnoses made including the epicondylitis. His explanation of his changed opinion based upon the small lever used to operate the brake in unpersuasive in light of the impact forces involved in the accident. While Dr. Mash opines that a rear end force would not cause the varus stress required to cause lateral epicondylitis, he concedes that it could happen with sufficient force.

Based upon the record as a whole, the Arbitrator finds that based upon a chain of events theory and the medical opinion of Dr. De Leon, that Petitioner has proved by a preponderance of the evidence that his current condition of ill being in the right elbow is causally connected to the accidental injuries sustained on January 21, 2014.

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

Under section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are necessary to diagnose, relieve, or cure the effects of his injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470, 949 N.E.2d 1158, 1165, 351 Ill. Dec. 63 (2011). Based upon the Arbitrator's finding with respect to Causal Connection, and the Arbitrator's finding that the medical opinions of Dr. De Leon are more persuasive that those of Dr. Mash, The Arbitrator finds Dr. De Leon's opinion that Petitioner would benefit from further treatment similarly persuasive.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. De Leon, including a right lateral epicondyle release with denervation and right medical epicondyle release, any post operative treatment, physical therapy or other reasonable and necessary care.



STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrew Spear,

Petitioner,

vs. NO: 13 WC 14298

Driver Solutions, Inc., **19IWCC0148**

Respondent.

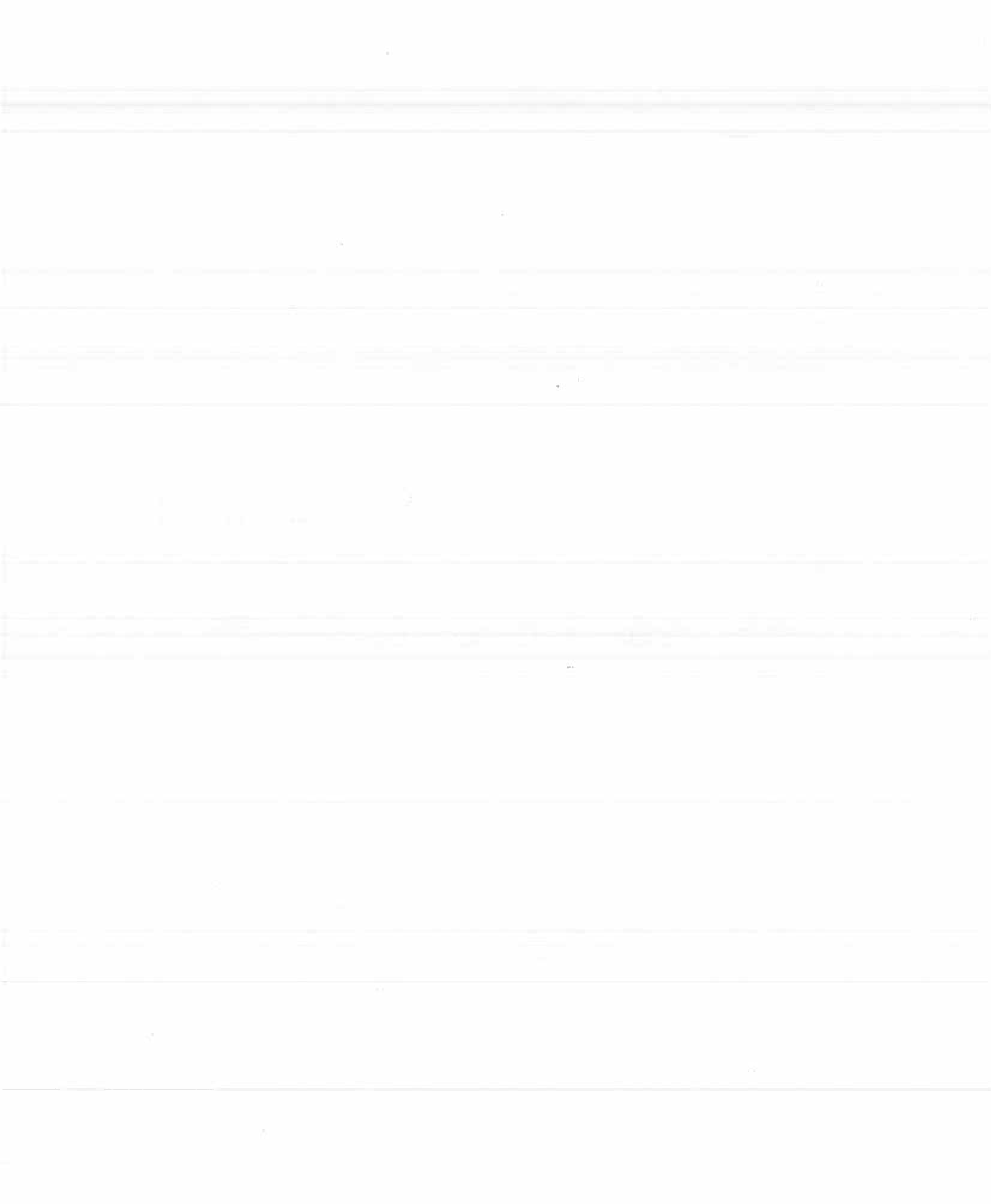
DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2017, is hereby affirmed and adopted.

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

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



Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 7 - 2019
TJT:yl
o 1/14/19
51

Michael J. Brennan

Kevin W. Lamborn

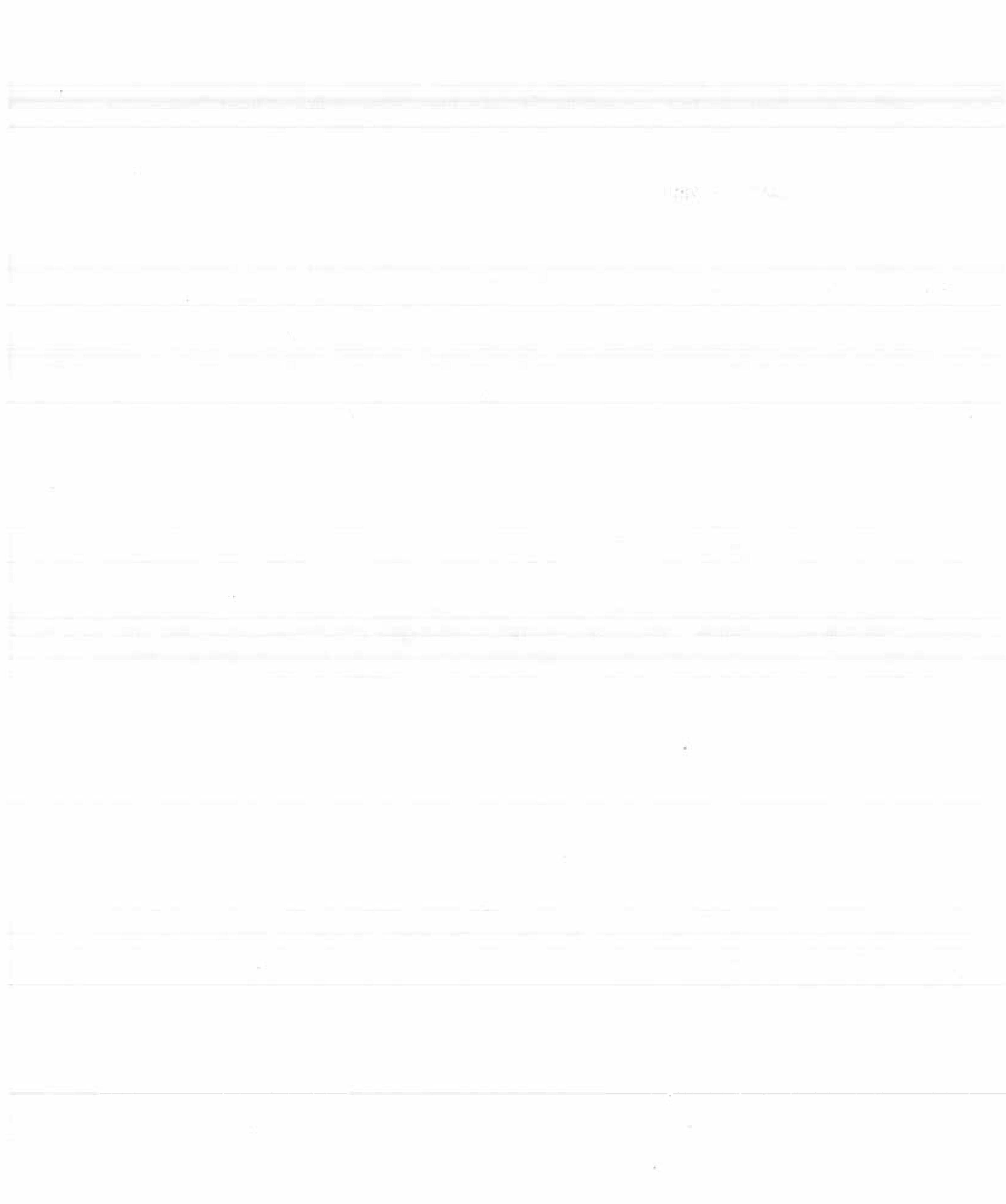
DISSENT

I dissent from the majority opinion and would find that Petitioner's current condition of ill-being is causally related to the undisputed accident on 4/16/13. More to the point, I disagree with the Arbitrator's parsing of the record in order to arrive at her desired endpoint, and believe that there is ample evidence to support Petitioner's claim relative to his lower back.

Along these lines, the Arbitrator attempted to discredit the opinion of treating orthopedic surgeon Dr. Lee by claiming he was essentially "... speculating and/or merely expressing his 'belief' as to what entries in the records from [4/16/13 through 6/10/13] meant... [and that] [h]e repeatedly stated one needed to ask the doctors who wrote the notes for those visits what they meant", as if physicians are not expected to interpret medical records every day or that his placing the ultimate responsibility for the accuracy of those notes on the physicians who authored them was somehow proof of his unreliability.

In fact, the evidence supports Dr. Lee's "belief" that Petitioner complained of low back pain during the period immediately following the incident, including a reference to "complain[t]s about his Back" in Concentra notes taken on the very day of the accident, 4/16/13. (PX2). Subsequent references to back complaints can be found in Concentra notes dated 4/17/13, 4/19/13, 4/26/13, 5/7/13, 5/10/13 and 5/15/13. (PX2). To claim that these references to "back" and "mid back" complaints somehow dealt exclusively with the thoracic spine is to ignore the totality of the evidence and the substance of the notes themselves, which repeatedly and separately describe complaints and/or diagnoses of *both* thoracic *and* back pain, the latter of which one could reasonably infer to mean the low back or lumbar region of the spine.

Furthermore, I found the opinion of Respondent's §12 examining physician, Dr. Wilkey, to be disingenuous and wholly unpersuasive, particularly in light of the fact that he had, on no less than two prior occasions, opined that the lumbar condition and need for surgery was causally related to the accident in question, only to have a change of heart 2-1/2 years later after receiving a letter from defense counsel asking him to reconsider -- this despite the fact that there is absolutely

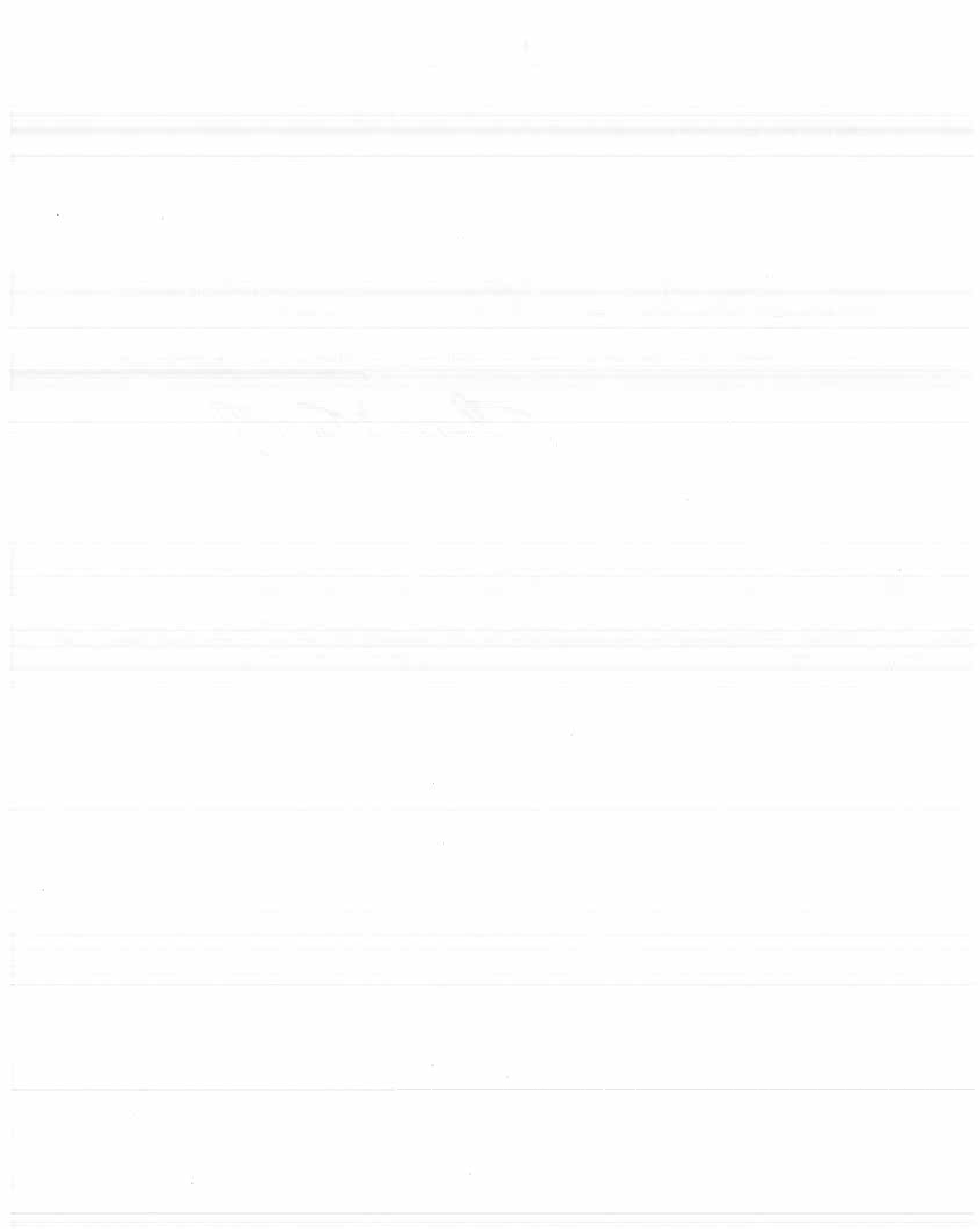


no reason to believe Dr. Wilkey did not possess the very same records at the time of his initial reports that he now finds so troubling.

Finally, the medical record shows that Petitioner previously underwent fusion surgery at L5-S1, or directly below the fusion surgery he would undergo at L4-5 following the current work accident ten years later. I would suggest that it does not take a medical degree to understand that an incident such as the one described by the Petitioner could have aggravated the level directly above a previous fusion. Indeed, even Dr. Wilkey conceded that he could not rule out that the accident might have at least been a causative factor in aggravating Petitioner's preexisting adjacent segmental deterioration. (RX1, p.26).

As a result, I would reverse the Arbitrator on the issue of Petitioner's current condition of ill-being with respect to the lower back, and would have awarded benefits accordingly.

Thomas J. Tyrrell



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPEAR, ANDREW
Employee/Petitioner

Case# **13WC014298**

DRIVER SOLUTIONS INC
Employer/Respondent

19IWCC0148

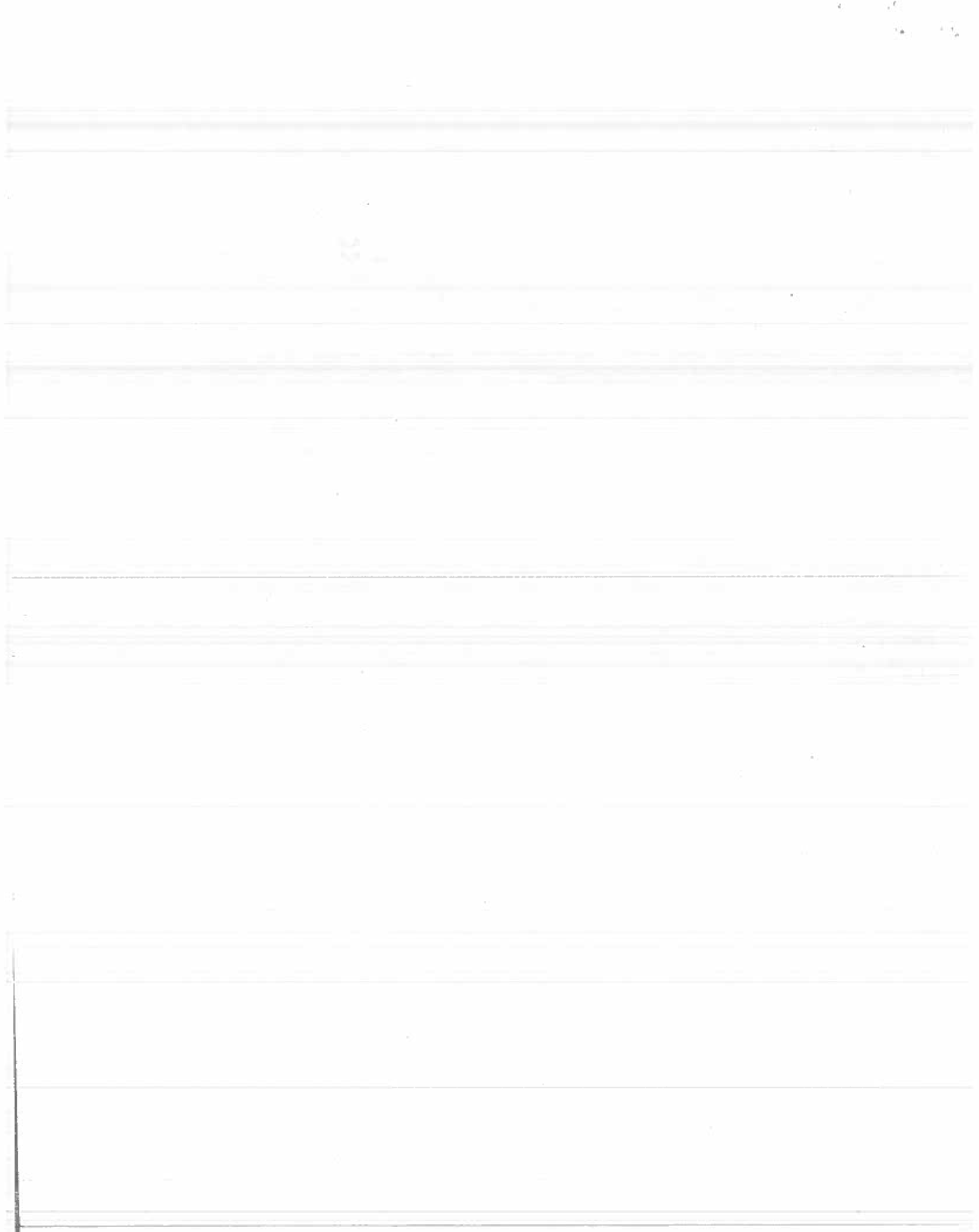
On 12/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

1001 SCHREMPF BLAINE KELLY & NAPP
MATTHEW W KELLY
307 HENRY ST SUITE 415
ALTON, IL 62002

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704



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

Andrew Spear
Employee/Petitioner

v.

Driver Solutions, Inc.
Employer/Respondent

Case # 13 WC 014298

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **October 5, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/16/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**4,308.57**; the average weekly wage was $**1,160.00**.

On the date of accident, Petitioner was **31** years of age, *married* with **1** dependent child.

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

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

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

Respondent is entitled to a credit of $0 for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay benefits of **$696.00/week** for **15** weeks because the injuries sustained caused the permanent partial disability of **3% loss of a person-as-a-whole** pursuant to Section 8(d)(2) of the Act.

Petitioner failed to prove that his condition of ill-being in his back after 6/10/2013 was causally connected to his accident. Because Petitioner's condition of ill-being after 6/10/2013 is not causally connected to the accident, medical benefits, maintenance benefits, and penalties and fees are denied.

Respondent shall pay Petitioner compensation that has accrued between 4/16/13 and 10/5/17 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

December 1, 2017
Date

DEC 6 - 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner's case proceeded to arbitration on October 5, 2017. At the time of the hearing the disputed issues were causal connection, medical bills, maintenance benefits, nature and extent, and penalties and attorney's fees. Petitioner was the sole witness testifying at the hearing. The primary dispute in the case is causal connection with Respondent disputing causation after June 10, 2013.

The Arbitrator finds:

Petitioner worked as a concrete laborer in 2002 and 2003. (PX 14, px. 2)

Petitioner came under the care of Dr. David Lange in June of 2003 as a result of symptoms he related to working on May 8, 2003 as a concrete worker. Petitioner stood up and twisted while lifting a "stack of wood" and noted abrupt right low back pain followed quickly by discomfort passing down to the posterior side of his leg towards his heel. This was followed by numbness in his right lateral foot. He had undergone therapy. An MRI taken on June 4, 2003 showed a large herniated disc at L5-S1. Petitioner eventually underwent a discectomy and fusion at L5-S1. Post-operatively, he appeared to do fine. He had some ongoing right hip discomfort that the doctor felt related to the site of the bone graft. As of January 8, 2004, Petitioner was acknowledging that he was getting better with time and rehab efforts. He was increasing work simulation in therapy/work hardening and the doctor felt he would probably be ready to return to his usual job in March. Dr. Lange noted that Petitioner reported being given the "cold shoulder" by his employer and would probably be looking for an alternative job, perhaps in the restaurant industry. By the next visit, he was noted to be doing quite well in work hardening and almost ready to be released. Dr. Lange noted that Petitioner was now desiring to stay in the construction trade but not in concrete work and he was hoping to come up with some type of vocational re-education for this. Dr. Lange found Petitioner to be at maximum medical improvement (MMI) on March 22, 2004 and released him to return to work as a construction worker. Petitioner reported already obtaining alternative employment as he didn't wish to continue in the construction field long-term. (RX 1, dep. ex. 3)

Petitioner worked in various restaurants thereafter performing services as a dishwasher and cook. He then attended vocational school in 2004 and 2005 studying heating, ventilation and air conditioning. He graduated in October of 2005 and then worked for about eight months installing air conditioning units in residential and commercial property. He was then laid off. After being laid off he drove a shuttle bus for a hotel and performed maintenance work at the hotel. (PX 14, px. 2)

Petitioner then returned to see Dr. Lange on June 12, 2006. Petitioner reported that he had been retrained for HVAC work and had been "faithful" in his workouts. He had recently descended a ladder when he felt his "whole right side tense up." It sounded to the doctor like he developed significant pain just above his previous incision site with spasms ascending up his back and to his neck. Petitioner denied any extremity symptoms but was currently experiencing back discomfort and a tingling sensation in his right lower extremity, through his right thigh and calf, down to his heel. X-rays showed a solid fusion. Dr. Lange wrote, "He was told that likely this is simply muscle spasm as far as the neck is concerned. The more likely diagnosis is herniation immediately above his previous surgery. ....He was placed on Flexeril today for muscle spasms." (RX 1, dep. ex. 3)

Dr. Lange re-examined Petitioner on June 29, 2006. Petitioner denied any improvement since the earlier visit. He had diffuse spasms up and down his back and difficulty deciding where the worst of his symptoms were. He indicated that, at times, it was in the mid-lumbar area, and at other times more cephalad. At times, his

neck would be fine and then, other times, it was tight. He appeared to be in no acute distress on examination but complained of diffuse low back pain during range of motion testing. An MRI had been taken. It showed the fusion was solid but there was evidence of early degenerative desiccation at L4-5 but no definite herniation. The right iliac donor site looked a little unusual with either signs of perforation or a possible fracture. Physical therapy was recommended with additional diagnostic studies felt to be appropriate depending upon therapy results. (RX 1, dep. ex. 3)

Petitioner returned to see Dr. Lange on August 1, 2006. A CT had been performed of the lumbosacral area, including the iliac wing. Petitioner had no fracture of the iliac wing but there was perforation throughout. He had a solid L5-S1 fusion with some narrowing of the right L5 nerve root canal due to overgrowth of bony healing. At the next level up, there was early ectopic calcification of the ligamentous flavum on the opposite side from his primary complaint. The canal was marginally narrowed without definite disc herniation. Dr. Lange noted Petitioner was reporting he was miserable and that physical therapy efforts had made him worse, not better. Petitioner had not had any income for the last eight weeks and was getting desperate. On examination he complained bitterly of thoracolumbar discomfort with any range of motion of the spine. Range of motion of the neck brought on significant pain posterolaterally on the right. Nevertheless, his neurologic exam was benign. Straight leg raising in the seated position brought on no leg symptoms. It did bring on a pulling at the thoracolumbar junction. Dr. Lange's diagnosis was "certainly unclear." Dr. Lange, noting that he had always found Petitioner credible, suspected an organic thoracic lesion and recommended further work-up by MRI. Dr. Lange also found Petitioner to be unemployable at the time. Therapy was being stopped because it wasn't helping. The doctor's office was going to contact the adjuster about moving forward. (RX 1, dep. ex. 3)

In 2007 Petitioner attended the New Way Driving Academy in St. Louis and earned his CDL. (PX 14, px. 2) Froom May of 2007 through October of 2010 Petitioner performed over the road truck driving for PI & I with a flat bed trailer and hauling steel. He next drove for Bolt Express but stopped after being involved in an accident in October of 2011. (PX 14, px. 2)

On January 26, 2012 Petitioner was seen by Dr. Lukasz Curylo regarding cervicalgia with radiation into his right shoulder blade and right upper extremity after being rear-ended by a 70,000 lb. truck. Prior to the appointment Petitioner had undergone a trial of medications and physical therapy without much success. He was also seen by a rehab specialist. Petitioner subsequently underwent surgery for a herniated C5 disc. While recovering, Petitioner did report bouts of mid-back pain and "knots on his back." He underwent an MRI of his thoracic spine which showed mild multilevel degenerative disc disease/disc protrusions with no evidence of herniation. Dr. Curylo recommended therapy for what he described as a thoracic sprain superimposed on degenerative changes. As of June 7, 2012 Petitioner was reporting very little success with therapy to his thoracic spine. When last seen by Dr. Curylo on July 19, 2012, Petitioner's thoracic spine wasn't mentioned. Petitioner was reporting being asymptomatic and taking no pain medication. He was released with no restrictions. (RX 1, dep. ex. 3)

Petitioner returned to truck driving for PI & I from August through December of 2012. He then worked for Pro Driver for two months. (PX 14, px. 2)

Petitioner began working for Respondent in February of 2013.

Petitioner was involved in an undisputed accident on April 16, 2013 while working for Respondent.

According to medical records, Petitioner was examined at Concentra, on April 16, 2013. Petitioner was seen by Dr. Galeano complaining of severe pain in the thoracic spine and left side of his chest. Two summaries of Petitioner's accident are found in the record. The initial one states "'Coming down ramp. Hurt middle back.'"

The additional history states that he was delivering cases of liquor and the dolly slipped on the wet ramp and he held onto the dolly and felt a jerk in his left back." Petitioner also noted tingling in his left leg. The pain had begun immediately a few hours earlier and was located on the left chest. Petitioner's symptoms were exacerbated by flexion, extension, standing, coughing, sneezing and taking deep breaths. Petitioner appeared to be in severe distress. He displayed guarding with side bending, flexion and extension. He had decreased range of motion of the trunk. Palpation of Petitioner's spine at T6, T7 and T8 was positive for pain. Petitioner was taken off work and told to return the next day. Petitioner informed Dr. Galeano that he had prior surgery to his low back and neck. Dr. Galeano took Petitioner off work and prescribed Naproxen, Skelaxin, and Vicodin. (PX 2)

Petitioner followed up at Concentra on April 17, 2013 and was seen by Dr. Catanzaro regarding his back pain, thoracic strain and left rib pain sustained at work on April 16, 2013. Petitioner commented that the medication had not helped his pain at all and he was in considerable pain; however, in general, it was somewhat less acute. He denied any pain radiating down his legs. He expressed difficulty bending or twisting due to pain and muscle spasms. X-rays of the thoracic spine and ribs were negative. The doctor noted that Petitioner did not appear acutely ill. He moved slowly with obvious back pain and his gait was very slow and guarded. On exam of Petitioner's back, the doctor noted a well-healed lumbar incisional scar from a prior surgery. Palpation revealed moderate tenderness and 1+ muscle spasm of T5 through L2. Flexion, extension, lateral bending and rotation were limited. He could not perform a knee bend or do a squat. He could not walk on his heels or toes because of pain. His left lower rib was moderately tender. Petitioner's diagnoses were listed as a severe thoracic strain, moderate left rib pain and severe back pain. Petitioner was to continue medication, but Norco was switched for the Vicodin. Petitioner was restricted to no lifting, pushing, bending, or commercial driving. Physical therapy was ordered. (PX 2)

Petitioner was next seen at Concentra on April 19, 2013 when he was again seen by Dr. Galeano. The mechanism of injury was described as "pushing of cases and a slip on a slippery surface, landing on." According to the office visit note, Petitioner complained of pain located on the left mid-back and thoracic regions. The pain was described as moderate and aching at a pain intensity level of 6/10. Petitioner's pain did not radiate and his symptoms were exacerbated by flexion or twisting. Petitioner denied any paresthesia in the leg. Petitioner was restricted from no bending more than five times per hour, no pushing/pulling over one pound, no lifting over one pound, and no driving a company vehicle. Petitioner's diagnosis was listed as thoracic strain and back strain. Petitioner was told to discontinue the previous medications and he was prescribed Ibuprofen 600 mgs and Cyclobenzaprine. (PX 2)

Petitioner returned to Concentra on April 23, 2013 and was seen by Dr. Keesal. Petitioner reported that he has not been working because there was no light duty available for him. It is reported that Petitioner continued to have pain in the left posterior chest on movement, deep breathing, and coughing. It was reported that Petitioner's pain was at a level 7 and can be intense. It was also reported that the pain is located on the left posterior chest and that the pain radiated to the anterior aspect of the left chest and hip. It was reported that symptoms were exacerbated by twisting, coughing, sneezing, or a deep breath. Petitioner's lumbar range of motion was decreased to flexion, extension, and right/left side bending. He had moderate pain in the left flank. The assessment on that day was chest wall contusion and fracture of rib, unspecified. Petitioner was restricted from bending and the one pound lifting restriction was maintained, as well as the inability to drive a company vehicle. Physical therapy had not yet been approved. (PX 2)

Petitioner signed his Application for Adjustment of Claim herein on April 24, 2013. (AX 2)

Petitioner returned to Concentra on April 26, 2013 and was seen by Dr. Galeano. Petitioner stated he felt the pattern of symptoms was improving but he still was having some pain his left mid-back and the left

posterior medial intrascapular region and described as moderate, dull, and sharp at times with a pain intensity of 6/10. It was also reported that the pain radiated to the lower portion of the left side of Petitioner's back and buttock area and his symptoms were exacerbated by flexion, extension, or pushing. The assessment on that day was chest wall contusion and back pain. He appeared in no apparent distress. The restrictions placed upon Petitioner at that time were no lifting over one pound, and no bending more than one time per hour. A CT scan of the chest was ordered, done on May 6, 2013, and the results were negative. (PX 2)

A First Report of Injury was completed on April 30, 2013. Petitioner reported an accident occurring on April 16, 2013 when he was coming down a truck ramp with a loaded 2 wheel dolly and he slipped injuring his middle and left side of his back as he tried to hang on. He noted he felt "something pull in his back." (PX 17)

Petitioner returned to see Dr. Galeano at Concentra on May 7, 2013 and Petitioner was following up on a chest wall contusion and there to discuss the CT report. Petitioner reported that he felt the pattern of symptoms was stable with little improvement. Petitioner's pain intensity level was "7/10." He reported pain radiating to the lower lumbar portion of his back. Petitioner has been working within light duty restrictions and had not undergone physical therapy. He reported that his pain was located on the left posterior mid-chest and radiated to the lower portion of the left side his lumbar spine. The assessment at that time was chest wall contusion and back pain. Restrictions were maintained on his activities. A pain drawing of that date indicated left mid-back pain and "at times" pain down his left side. His left leg was marked on the pain drawing. (PX 2, PX 9)

Petitioner began physical therapy on May 9, 2013. Petitioner's low back findings included paresthesia in Petitioner's lower limb. Petitioner's active movement tests, directed to Petitioner's low back on that date, were positive in all respects and were measured as a level of "severe difficulty." It was noted that Petitioner had intermittent radicular symptoms into his left lower extremity as of that date as well. (PX 9)

Dr. Galeano re-examined Petitioner on May 10, 2013. Petitioner reported his symptoms were stable/improved at 25%. He had been working within his duty restrictions, taking his medication, and attending physical therapy. Petitioner's back pain was in the left mid-back and thoracic regions. It was not radiating. Petitioner's range of motion of his trunk was decreased to the left with rotation, side bending and flexion. Palpation of the spine was negative for pain but tenderness in the lumbar left parapsinous area laterally was noted. Petitioner's assessment was back strain, contusion of the thorax, and back pain. (PX 2)

Petitioner was again seen by Dr. Galeano on May 15, 2013. His chief complaint was pain located on the left mid-back and thoracic region midline. Physical therapy wasn't helping. The pain was reported as radiating to the upper portion of the thoracic spine. The assessment on that day was lumbar radiculopathy, lumbar strain, back pain, back strain, and contusion of the thorax. He was referred to Dr. Mirkin. (PX. 2)

Petitioner attended physical therapy on May 21, 2013. He reported stretching with his home exercise program and feeling a loud pop in his thoracic spine that provided immediate relief of his pain and he was feeling mostly pain free since that event. (PX 9)

Petitioner was seen by Dr. Mirkin, an orthopedic surgeon, on May 22, 2013 at Concentra. Petitioner completed a questionnaire in conjunction with the visit stating he had "slipped coming down dolly ramp" on April 16, 2013. His chief complaint was "mid back left side." Same was reflected ono his pain drawing. Dr. Mirkin reported that Petitioner had been referred to him for a strain injury and that he had twisted his back and felt pain at the thoracolumbar junction and been off work since that time. It was reported that Petitioner stated he was much better, but did not think he could return to full duty work. Petitioner told the doctor about a previous neck and back injury. Dr. Mirkin's impression was that Petitioner had a strain injury with no signs of radicular symptoms, and, at that point in time, he felt Petitioner could not return back to full work; however, he

recommended a work restriction of 40 pounds and six hours of work a day. Dr. Mirkin also thought Petitioner would benefit from two weeks of half day work hardening at which point he wished to re-examine him and anticipated a full duty return to work. No other complaints or symptoms were noted. (PX 2, 3)

Petitioner continued attending physical therapy on May 23, 28, and 29, 2013 reporting that his spine was continuing to improve. (PX 9)

Petitioner completed physical therapy on June 7, 2013. The therapy records refer to back pain and indicating Petitioner displayed difficulty with certain low back extensions and flexions described "as consistent with a twisting strain." There was also reference to intermittent left lower extremity radiating symptoms. When last seen on June 7th Petitioner had no difficulty with back mobility, could lift 65 lbs. floor to waist, performed all work-related tasks, reported his highest level of pain was a "5/10" and only had pain only at the end ranges of active lumbar extension and lumbar flexion. While pain was noted he was deemed fit to return to work. (PX 9)

Petitioner next saw Dr. Mirkin on June 10, 2013. According to Dr. Mirkin's office notes Petitioner reported pain in the left thoracolumbar junction and that he had been undergoing therapy but could not complete any of his therapy. Dr. Mirkin noted that when he walked into the room, Petitioner was sitting on the table moving his legs back and forth with no sign of abnormality and that he was walking with a normal, non-antalgic gait. Dr. Mirkin noted that the range of motion of the lumbar spine was 90% normal and the straight leg raise was negative. Dr. Mirkin also noted that the deep tendon reflexes were intact. Dr. Mirkin noted that x-rays of the lumbar spine including the thoracolumbar junction showed a solid fusion at L5-S1. Dr. Mirkin reported he saw no evidence of any significant abnormality and he thought it was time for Petitioner to return back to full work. Dr. Mirkin commented that he really had nothing to offer him from a surgical point of view. Dr. Mirkin also noted that Petitioner wasn't happy with Dr. Mirkin's assessment, but Dr. Mirkin noted Petitioner was exhibiting severe signs of symptom magnification behavior. Dr. Mirkin reported that Petitioner stated he could not lift even thirty to thirty-five pounds; however, he also noted that Petitioner appeared to be in no discomfort whatsoever. (PX. 3)

Dr. Mirkin issued a note to Respondent's insurer on June 11, 2013 stating that he had reviewed the physical therapy records which noted mild subjective complaints of pain when Petitioner performed a "dead lift." The findings note also stated that Petitioner had a history of neck fusion and lumbar fusion. He was noted to be lifting 60 lbs. Two weeks of work hardening had been recommended. The doctor stated that the records were consistent with his findings on Petitioner and Petitioner could, if he so desired, return to his work activities. (PX 3)

The nurse case manager assigned to Petitioner's case, Debbie Nemeth, issued a report on June 13, 2013 stating Petitioner had been released to full duty work as of June 10, 2013 and was at maximum medical improvement as a result of a thoracic spine sprain/strain. The file was to be formally closed as of June 25th if Petitioner had not reported any exacerbation of symptoms. (PX 15)

On July 3, 2013, Respondent's workers' compensation carrier forwarded a letter to Dr. Mirkin. Mr. Mendenhall, the Claims Manager, stated, "[Petitioner] is advising that he is having continued medical issues regarding his lumbar spine and wishes to follow up for another examination. I am hereby authorizing a follow up examination for his above related injury." (PX 3)

Petitioner returned to see Dr. Mirkin on July 12, 2013 at the doctor's orthopedic center. Dr. Mirkin noted that he had previously released Petitioner on June 11, 2013. Petitioner was reporting pain in his low back, mid-thoracic spine, and, occasionally, in his neck and "tells me he has decided he wants to have further treatment for this." Upon examination Petitioner was described as an obese male, walking with an upright gait and having

range of motion 90 percent of normal. Straight leg raise elicited back pain. Motor and sensory examinations were intact. X-rays revealed a fusion at L5/S1. The only suggestion the doctor had was to get a myelogram. Petitioner was to return thereafter. Present at the exam was nurse Gwen Rogers on behalf of Debbie Nemeth, the nurse case manager assigned to the claim. No specific mention of the April 16, 2013 work accident was made. (PX 3)

On July 15, 2013 Debbie Nemeth issued a report for MMI inc. She noted that the file had been closed on June 27th and re-opened on July 3, 2017. Petitioner had reported working for another employer. He was scheduled the see Dr. Mirkin on July 26, 2013. (PX 15)

Petitioner underwent a thoracic spine CT myelogram on July 19, 2013 which showed a mild broad-based central disc protrusion at T6-7 without significant stenosis, a broad-based central disc protrusion at L4-5 contributing to moderate central canal stenosis, and facet arthropathy at L3-4. (RX 1, dep. ex.3) Petitioner also underwent a CT scan of his lumbar spine that day. According to the radiologist, there had been post-surgical complete osseous fusion across L5/S1 with left L5/S1 pedicle screw and rod fixation of L5 and S1. There was complete osseous fusion across the bilateral L5/S1 facet joints with no evidence of hardware failure. At L4-5 there was a broad-based central disc protrusion contributing to moderate central canal stenosis. Bilateral L3/4 facet arthropathy was also noted. Included in the findings was an L2/3 diffuse annular disc bulge partially effacing the ventral surface of the thecal sac without significant central canal stenosis or neural foraminal exit stenosis. (RX 1, dep. ex. 3)

When Petitioner was seen again by Dr. Mirkin on July 26, 2013, he was complaining of back pain going down his left leg. Petitioner did not feel he could drive safely and was afraid of getting in an accident. Dr. Mirkin recommended an epidural steroid injection to be followed by surgery, if there was no improvement. Dr. Mirkin further noted that Petitioner needed to start thinking about a lighter occupation as he had to do heavy lifting and had already undergone one spine surgery. He was given restrictions of no commercial driving and a 15 lb. lifting restriction. (PX. 3)

Petitioner was seen by Dr. Boedefeld on August 1, 2013 for pain management. It was reported that Petitioner was complaining of low back, left hip, and left leg pain. Dr. Boedefeld felt Petitioner had disc protrusions at L4-5 and L2-3 consistent with L4 and L2 radiculopathy. He provided a left L2 and L4 transforaminal injection. Petitioner followed up with Dr. Boedefeld on August 15, 2013 reporting that he had no relief with the last injection. Dr. Boedefeld prescribed Hydrocodone and Vicodin. Dr. Boedefeld also provided an epidural steroid injection at L4 and L5. Petitioner returned to see Dr. Boedefeld on August 29, 2013 still complaining of low back pain into his left leg with minimal improvement from the injections. Dr. Boedefeld recommended continued medication. (PX. 5)

Petitioner returned to see Dr. Mirkin on September 6, 2013 complaining of severe pain in his back going down both legs. He further reported having convulsions and his eyes rolling back into his head when in pain. He was walking with an upright gait and had limited range of motion and positive straight leg raising. Surgery was recommended. In the interim, he could work with the previous restrictions. (PX. 3)

On September 9, 2013 Petitioner requested a refill of his Flexeril. Dr. Mirkin denied the request. It was noted that Petitioner was being sent for an IME with some other doctor on October 21, 2013. Dr. Mirkin was not going to keep Petitioner on all this medication "while Work Comp figured out what it was going to do." (PX 3)

On September 16, 2013 and in connection with an upcoming Section 12 examination, Ms. Nemeth, a nurse case manager for MMI, inc., forwarded a detailed letter to Dr. Wilkey. In her letter she noted that on April 16, 2013 Petitioner slipped on a ramp while exiting out of the back of a delivery truck pushing a dolly and

twisted to catch the dolly. Petitioner reported immediate pain in his chest that wrapped around to his back. The letter also stated that records from 2003 through 2006 and 2012 were included. Other records were not specifically listed. Ms. Nemth also provided Dr. Wilkey with an outline of the treatment undertaken to date. The letter requested that Dr. Wilkey answer eight questions and that Dr. Wilkey take a thorough history and note both Petitioner's objective and subjective findings. (RX 1, dep. ex. 3)

On September 20, 2013 a refill for Vicodin was denied by Dr. Mirkin's office. (PX 3)

On September 25, 2013 Dr. Mirkin re-examined Petitioner. Petitioner advised the doctor that he was scheduled for a second opinion at the end of October. Petitioner was complaining of severe pain in his back and down his legs. He had been calling and asking for pain medication. The doctor had told him it was unlikely he would continue to give him narcotics as they wait for a second opinion for a long period of time. Petitioner reported he could no longer live with the problem and was having severe pain in his back and down his legs. He was walking with a limp and had a positive straight leg raise test. Dr. Mirkin further stated that is was unreasonable for Petitioner to wait for a second opinion under these circumstances. He recommended to Petitioner that he speak with his legal counsel. He was given some non-narcotic pain medication. (PX 3)

Petitioner underwent the Section 12 examination with Dr. Wilkey on October 7, 2013 and a report followed. Dr. Wilkey reported that Petitioner stated that, after the work accident "wherein he twisted and bent, he immediately developed low back, groin, and leg pain." Based on that history, Dr. Wilkey opined that the symptoms were due to the work-related injury. Dr. Wilkey stated he agreed with Dr. Mirkin's recommendation for surgery. Dr. Wilkey was asked to indicate whether Petitioner's objective findings correlated with the mechanism of injury and whether the subjective findings correlated with Petitioner's objective findings. Out of the remaining seven questions, four of the questions addressed medical causation. Only one of the questions presented to Dr. Wilkey at that time requested that he express an opinion as to Petitioner's need for the surgery as recommended by Dr. Mirkin. Dr. Wilkey diagnosed Petitioner with an L4-5disc herniation, left leg radiculopathy, status post-fusion L5-S1 and no evidence of ongoing thoracic disease. Dr. Wilkey concluded that Petitioner's thoracic issues had resolved by the time of his evaluation and that Petitioner's low back condition was in need of further treatment. Dr. Wilkey concluded that "the prevailing factor with regard to this patient's current symptoms is the work-related injury he sustained on April 16, 2013 while delivering liquor. He has a mechanism of injury that is consistent with his current complaints." Dr. Wilkey further noted that the diagnostic studies provided objective evidence in support of Petitioner's current complaints. Dr. Wilkey concluded that Dr. Mirkin's plan for surgery was reasonable, necessary and causally related to Petitioner's accident of April 16, 2013. Dr. Wilkey answered each of the questions posed to him confirming that Petitioner's objective findings, current complaints and diagnoses were each related to Petitioner's accident of April 16, 2013. (RX. 1, dep. ex. 2)

Petitioner underwent surgery per of Dr. Mirkin on October 22, 2013 which involved removal of prior instrumentation, decompression of nerve roots bilaterally at L4, L5, and S1, and interbody fusion at L4-5 with placement of a cage, and posterolateral fusion at L4, L5, and S1 with segmental instrumentation. (PX. 4)

Petitioner was seen at the ER on October 24, 2013 after feeling faint while getting a bandage change and falling face down in the ground from sitting in a chair. He was unresponsive and his whole body was shaking. Petitioner's right shoulder hurt and he thought he might have fallen on it. This was the second episode of loss of consciousness that Petitioner had experienced in the last couple of months. By x-ray a right shoulder nondisplaced fracture was suspected. (RX 1, dep. ex. 5)

Petitioner followed up with Dr. Mirkin on October 25, 2013. Petitioner had been seen at the ER after passing out while his wife was changing his dressing. Everything looked okay and Petitioner was told to resume

his exercise. Dr. Mirkin felt Petitioner had passed out or tripped and fallen at home but hadn't done any major damage to his back. (PX 3)

On November 4, 2013, Petitioner returned to Dr. Mirkin's office. Petitioner reported his back was doing well and he was walking independently. Dr. Mirkin ordered physical therapy and the use of a bone stimulator. He anticipated that Petitioner would be able to return to light duty in about six weeks. (PX 3)

Petitioner began treating with Dr. Maylack for his right shoulder on November 4, 2013. (RX 1, dep. ex. 5)

Petitioner began physical therapy on November 7, 2013. (PX 9)

While undergoing physical therapy Petitioner was also undergoing treatment for his right shoulder injury. At times, restrictions from that injury were affecting back therapy. Aquatic therapy was tried in order to continue with back therapy. (PX 9)

Petitioner was re-examined by Dr. Maylack regarding his shoulder and hand complaints on November 20, 2013. (RX 1, dep. ex. 5)

When Petitioner was seen by Dr. Mirkin on December 16, 2013, Petitioner reported that his back pain was doing well but "he doubled up on his narcotics." Petitioner was also reporting ongoing pain in his right shoulder which was in a sling. Petitioner denied the ability to do "anything" with his right shoulder. Dr. Mirkin noted Petitioner was using a cane to walk, had an exaggerated pain response, and evidence of significant symptom magnification behavior. X-rays taken that day showed excellent position of hardware. Petitioner's weight was recorded at 321 lbs. and he was advised to pursue aggressive weight loss. Dr. Mirkin reported that Petitioner should pursue aggressive weight loss. Dr. Mirkin also reported that Petitioner could lift up to fifteen pounds and there was no medical need for the use of a cane to ambulate. Therapy was continued. (PX 3)

Petitioner attended therapy on December 17, 2013. The therapist noted that Petitioner was expressing displeasure with his last doctor's visit and was waiting to hear from his attorney. The therapist was consistently noting poor tolerance to all work conditioning. (PX 9)

Petitioner underwent an examination with Dr. Lehman on December 17, 2013 stemming from an injury on October 24, 2013. By history, Petitioner had undergone a right shoulder x-ray on October 25, 2013 and a right shoulder MRI on November 13, 2013. In his report Dr. Lehman mentioned that Petitioner had been involved in a work accident on April 6, 2013 when he twisted to catch a dolly and had chest and back pain. Dr. Lehman noted that a right shoulder MRI revealed significant degenerative arthritis and possible instability of Petitioner's right shoulder. Dr. Lehman was of the opinion that Petitioner's low back did not cause him to pass out. Dr. Lehman did not feel there was a risk of blacking out and falling associated with the anesthesia or post-anesthesia. Dr. Lehman opined there was no causal connection between the work accident of April 16, 2013 and any medications he was taking as a result of that accident. Dr. Lehman further commented that Petitioner "had significant care and treatment of his back dating back to 2003 and does appear to be a predisposition in etiology and can diagnosis to determine these epsiodes." (RX 1, dep. ex. 5)

Petitioner returned to see Dr. Mirkin on January 8, 2014, and it was reported that Petitioner was crying due to pain in his back going down both legs. Petitioner believed he had an L2-3 disc problem. Dr. Mirkin noted that Petitioner was complaining of pain when lightly palpated and noted that, when Petitioner was seen in the parking lot of Dr. Mirkin's office building, he was barely putting any weight on his cane, but had a severe limp when Petitioner was in the office. Dr. Mirkin recommended a myelogram. (PX 3)

The CT myelogram took place on January 15, 2014 and showed an L2-3 extradural defect and grade I retrolisthesis resulting in moderate canal stenosis and posterior element hypertrophy at L3-4 contributing to mild central canal and bilateral foraminal stenosis. (PX 3)

When Petitioner returned to see Dr. Mirkin on January 27, 2014, Petitioner reported that he was doing slightly better and wanted to go back to physical therapy. The CT revealed no compression of nerve roots and the radiologist and Dr. Mirkin disagreed as to whether Petitioner had a failed fusion or a fusion still in progress. Dr. Mirkin noted that Petitioner was walking upright. He had no back or leg pain with straight leg raising. He ordered physical therapy and opined that Petitioner could work light duty. Weight management was again stressed. (PX. 3)

On February 12, 2014 Petitioner attended physical therapy. The therapist noted that Petitioner had reportedly slipped and fallen on ice the day before landing on his buttocks. (PX 9)

On February 27, 2014, Petitioner began seeing another orthopedic surgeon, Dr. Lee, per the referral of his attorney. In a letter to Petitioner's attorney Dr. Lee noted Petitioner's description of his accident, stating "He was running out of the back of the truck and twisted to get control of it, dropped it and fell to the ground." (PX 6) Petitioner's pain drawing reflected stabbing pain and a pins and needles sensation in his mid-low back (belt line) and numbness and a pins and needles sensation in his right groin. (PX 6) On that day, Petitioner complained of pain in his groin, the right side more than the left, and low back pain. Petitioner reported that he could only walk one block due to back pain. Dr. Lee opined that Petitioner's complaints were consistent with dysesthetic pain from the screw at S1. Dr. Lee recommended revising the hardware and an exploration of the fusion at L4-5. Dr. Lee restricted Petitioner from lifting no more than 30 pounds. (PX. 6)

When Petitioner was seen by Dr. Mirkin on March 10, 2014, he complained of persistent pain and expressed the desire to return to work as a truck driver. His ongoing weight gain was noted. Dr. Mirkin reported that Petitioner might need to consider a career change and should not lift more than 25 pounds. X-rays showed a solid fusion. Dr. Mirkin wanted physical therapy to continue. (PX 3)

When Petitioner was seen by Dr. Mirkin on April 7, 2014, he reported nothing had helped him and he had pain in his left leg and back and couldn't move without experiencing pain. Dr. Mirkin noted positive Waddell's signs. Dr. Mirkin placed Petitioner at maximum medical improvement and opined that Petitioner could lift up to 35 pounds. (PX. 3)

Before authorizing further surgery with Dr. Lee, Respondent had Petitioner seen for a second Section 12 examination by Dr. Wilkey. This occurred on May 6, 2014. In conjunction with the examination, the nurse case manager forwarded Dr. Wilkey an outline of Petitioner's treatment to date along with copies of Petitioner's updated treatment records. She requested that Dr. Wilkey answer eight questions, a number of which continued to request that Dr. Wilkey specifically address medical causation.

In Dr. Wilkey's second report, dated May 6, 2014, Dr. Wilkey noted that Petitioner's primary problem was a hardware mal-position of the right S1 screw which was then likely causing Petitioner's ongoing complaints. Dr. Wilkey confirmed that Petitioner could not return to work as of the date of his second evaluation and that Petitioner needed further surgery. Dr. Wilkey also noted that Petitioner's prognosis with respect to his ability to return to work, following this additional surgery, was guarded as a result of the delay in treatment caused by the "medical/legal issues now involved." In confirming medical causation, Dr. Wilkey stated that Petitioner's "current complaints with regard to his back and leg are related to the April 16, 2013 injury and there is ample objective data to support these conclusions." (RX 1, dep. ex. 4)

Following that Section 12 examination, Respondent authorized Petitioner's second lumbar surgery associated with this claim.

Petitioner returned to see Dr. Lee on June 30, 2014 reporting low back pain down into his hips and groin. The leg pain had worsened, especially on the right side. He reported a burning component to his symptoms and numbness and tingling bilaterally. Surgery was to proceed as previously discussed. (PX 6)

Dr. Lee re-examined Petitioner on July 28, 2014. He noted Petitioner's ongoing low back and bilateral lower extremity symptoms. Petitioner had gained 50 lbs. citing inactivity. His diagnosis remained a possible L4-5 nonunion and right S1 screw penetration. He was kept on the same restrictions and the surgical procedure was discussed in depth. (PX 6)

Petitioner underwent surgery at the hands of Dr. Lee on October 9, 2014 which involved an L2-3 laminectomy and discectomy with fusion using PLIF and a cage. Petitioner underwent another surgery on November 21, 2014 which involved an L3-4 lateral interbody fusion with the use of a cage and allograft. (PX 7)

Petitioner was examined by Dr. Yazdi from Dr. Lee's office on January 6, 2015. Petitioner's right symptoms prior to surgery had really resolved and Petitioner was now having issues with his left leg. He had recently switched from a walker to a quad cane. Sensation was decreased in the left anterior and left thigh as well as the lateral and posterior calf and left foot. He walked slowing. He was told to start taking the TLSO off for short periods of time but to wear it when having back pain. He was given a script for physical therapy and prescriptions for pain. (PX 6)

Dr. Lee performed a third surgery on January 12, 2015 which involved an interbody fusion at L4-5. (PX. 4 & 7.)

When Petitioner was seen by Dr. Lee on February 17, 2015, Petitioner reported that the numbness in his leg had resolved, but he was still having tingling. Petitioner reported that he could stand for thirty minutes and walk 100 yards before he had SI joint pain. Petitioner reported that he needed a cane to walk distances. Dr. Lee recommended continued use of Oxycodone for breakthrough pain and prescribed Chlorzoxazone 500 mgs. Dr. Lee also reported that Petitioner should wean out of the back brace and continue physical therapy. Dr. Lee referred Petitioner to Dr. Boutwell for pain management. (PX. 6)

Petitioner saw Dr. Boutwell on March 19, 2015 complaining of low back pain going into his left leg. Dr. Boutwell reported that Petitioner should wean from using narcotics. Dr. Boutwell prescribed OxyContin 10 mgs., Baclofen 20 mgs., and Gabapentin 600 mgs. Dr. Boutwell reported that Petitioner should stop using Chlorzoxazone and Petitioner was given a small amount of Lidocaine patches. (PX. 8)

Petitioner returned to see Dr. Lee on March 31, 2015 reporting that he was doing better, but still had some tingling in his left leg which was worse when he walked. Petitioner was still using a single point cane. Dr. Lee wanted Petitioner to continue physical therapy. He anticipated maximum medical improvement as early as May or June. (PX. 6)

Petitioner returned to Dr. Boutwell on April 17, 2015. Dr. Boutwell increased the dose of Tizanidine and Petitioner was to continue taking Gabapentin and using Lidocaine patches. Petitioner was to discontinue OxyContin and a weaning prescription was provided. (PX. 8)

Petitioner returned to see Dr. Lee on May 12, 2015 reporting mid and low back pain, but improvement in his leg symptoms. Petitioner reported left hip pain started when he stopped using a cane, so he went back to using a cane to walk. Dr. Lee requested an SI joint injection from Dr. Boutwell. All in all, he was showing continued improvement. (PX. 6)

Petitioner saw Dr. Boutwell again on May 19, 2015, and Dr. Boutwell discontinued the use of the Lidocaine patches. Dr. Boutwell added Diclofenac Sodium and a TENS unit. Dr. Boutwell also wanted Petitioner to start home exercises. (PX 8)

Dr. Lee re-examined Petitioner on July 7, 2015. He was doing well except for his left hip. Only with activity would he get any pain radiating and he demonstrated that it went from the anterior thigh to the knee. Therapy and the TENS unit had helped. He was to undergo a sacroiliac injection and had successfully weaned the medications. He did have a cane. He was tender in the left sacroiliac region. Range of motion was 35 to 40 degrees of flexion and he extended to neutral. He was to be advanced through work hardening. (PX 8)

Petitioner returned to see Dr. Boutwell on July 15, 2015 and Dr. Boutwell scheduled SI joint injections. The first SI joint injection was provided on July 16, 2015 and the second injection was done on July 30, 2015. The third and final SI joint injection was done on August 13, 2015. (PX. 8)

Petitioner underwent a functional capacity evaluation on September 16, 2015. No formal job description was available. The evaluator had to rely on Petitioner's job description and Petitioner reported that he had to function at a very heavy work level with up to sixty pounds of frequent lifting. The DOT listing for his job as a truck driver was described as "medium." The evaluator noted an inconsistent performance and an unacceptable effort on the part of Petitioner stating that he could have performed at a markedly higher level than he was willing to do. (PX. 1)

On September 29, 2015, Dr. Lee ordered a CT scan of the lumbar spine. Petitioner was complaining of worsening pain in the left hip and left side of his low back. He described severe pain of an aching quality. He also reported right buttock pain. (PX 6)

The CT scan of Petitioner's lumbar spine was performed on October 20, 2015, and it was negative. (PX. 11) On November 12, 2015, Dr. Lee recommended an external bone growth stimulator to address what he felt was coming from Petitioner's L3-4 level. He didn't think Petitioner would be able to return to work as a commercial truck driver due to a need to change positions frequently but he thought the bone stimulator would help with better function. (PX. 12)

Petitioner underwent another FCE at a different facility on December 20, 2016. Petitioner gave a description of his work accident. He denied falling. He reported being seen at Concentra and diagnosed with a rib fracture and then "continuing to have pain [in his] low back and legs" and being referred to Dr. Mirkin. The examiner noted an acceptable effort but inconsistencies of the part of Petitioner. Petitioner was evaluated as being able to lift up to 25 pounds and push/pull up to 60 pounds with occasional bending, sitting, and walking, as well as, frequent standing, but he needed to change positions. (PX. 12)

By letter dated December 22, 2016 Respondent's counsel forwarded correspondence to Dr. Wilkey, advising him that it did not appear as if Dr. Wilkey had Petitioner's initial treatment records available to him at the time of his first Section 12 examination on October 7, 2013. Respondent's counsel enclosed Petitioner's initial treatment records from Concentra, Dr. Mirkin and Dr. Boedefeld. (RX 1)

Dr. Lee continued to follow up with Petitioner through January 5, 2017. As of January 5, 2017, Dr. Lee concluded that Petitioner was at maximum medical improvement, had permanent work restrictions and was released from Dr. Lee's care. Dr. Lee placed permanent work restrictions on Petitioner as follows:

- no lifting more than 30 to 35 pounds
- no pushing or pulling of more than 60 pounds
- only occasional bending, sitting and walking
- can stand frequently, but with frequent changes of position
- can only drive a light category truck (under 3 tons) (PX 6)

Dr. Wilkey provided a narrative report, dated January 15, 2017, that included Dr. Wilkey's summary of the "new records" provided to him by Respondent's counsel. Dr. Wilkey's review of these "new" records lead Dr. Wilkey to the conclusion that Petitioner did not have any lower back complaints until July 12, 2013 or any leg complaints until July 26, 2013, in clear contravention of the information contained in Petitioner's initial treatment records. Since it was then apparent to Dr. Wilkey that Petitioner did not have any low back complaints or left leg symptoms until some three months after Petitioner's accident, Dr. Wilkey concluded that his initial opinions were in error. (RX 1, dep. ex 7)

Based upon his review of these "new" records D. Wilkey questioned Petitioner's diagnoses and concluded that Petitioner's only diagnoses were that of a disc bulge and mild stenosis at L4-5, as opposed to the frank herniation Dr. Wilkey had previously diagnosed at L4-5. Dr. Wilkey further concluded that these diagnoses were now related to Petitioner's adjacent segmental deterioration as a result of Petitioner's fusion in 2003 and not to Petitioner's accident of April 16, 2013, even without any indication of complaints or difficulties during the ten years between the prior surgery and Petitioner's current injury. (RX 1, dep. ex. 7)

When Petitioner was seen by Dr. Boutwell on February 7, 2017, it was reported that Petitioner's back and left lower extremity symptoms were stable. At that time, Petitioner's chief complaint was left hip joint pain which was improved with the TENS unit and rest. Dr. Boutwell recommended Petitioner taking herbs for anti-inflammation, exercising as tolerated, and continued use of Gabapentin and Tizanidine. Petitioner was also to continue using the TENS unit. (PX 8)

When Petitioner was seen by Dr. Boutwell on June 23, 2017, Petitioner reported a worsening low back pain radiating down his left leg. Dr. Boutwell noted that the hip pain in February was not related to the work accident. Dr. Boutwell recommended injections at L5 and the SI joint, as well as, continued use of the TENS unit. (PX 8)

Petitioner had injections at L5 and the S1 joint on July 21, 2017, August 10, 2017, and August 24, 2017. (PX. 8)

Petitioner was seen by Dr. Boutwell on September 12, 2017. He reported unchanged pain in his low back on the right side, tightness in his upper back with some numbness, and pain, at times, in his right groin. He had a copy of his voc assessment that had been completed per his attorney. Petitioner was reporting his case was going to court in early October. Petitioner did report some improvement after the injections and improved range of motion was noted by the doctor. She stated there would be no further injections for six months and then they would be repeated, if necessary. His Gabapentin and Tizanadine were continued. Petitioner was advised in proper diet. (PX 15)

Additional Depositions and Reports

Dr. Wilkey's deposition was taken on April 7, 2017. On direct examination, Dr. Wilkey testified that when he performed his first IME of Petitioner in October 2013, he would have only looked at the records of the treating surgeon at that time, Dr. Mirkin. Dr. Wilkey testified that the records of medical treatment rendered to Petitioner from the date of accident through first seeing Dr. Mirkin did not support the history that Petitioner gave Dr. Wilkey at the time of the IME in October 2013. Dr. Wilkey testified that 95% of the opinion contained in his October 2013 IME report was based on Petitioner's history that Petitioner had an "immediate onset of low back, left groin, and leg pain after the work accident." Dr. Wilkey testified on direct examination that in October of 2013, he was asked to provide a second opinion with regard to surgery and causation was a sub-question of that. Dr. Wilkey also testified that he was subsequently requested by Respondent's attorney to come up with a more definitive statement with regard to causation. Dr. Wilkey testified that the records of treatment between the date of accident and when Petitioner saw Dr. Mirkin for the first time did document leg tingling, but no leg pain or back pain until July 12, 2013. Dr. Wilkey testified that the need for surgery in 2013 was not causally connected to the work accident. Dr. Wilkey testified that after spending more time looking through the treatment medical records, his causation opinion changed from that of his IME report from October 2013. Dr. Wilkey testified that Petitioner had a pre-existing condition prior to the work accident, specifically, a degenerative condition at L4-5. (PX. 1, pp. 18-22.)

On re-direct examination, Dr. Wilkey testified that, based on Petitioner having lumbar spine surgery prior to the work accident, it would be expected that Petitioner would have occasional lumbar pain and tingling in his leg. Dr. Wilkey testified that the office visit note from Concentra for May 15, 2013 which reported there was a diagnosis of lumbar radiculopathy was unsupported because there was no mention in the record of any radiculopathy complaints. Dr. Wilkey testified that Dr. Mirkin's last note (before the first IME) stated that Petitioner had leg radiculopathy and he wanted to operate on him. Petitioner then gave Dr. Wilkey his history stating he hurt "right away" but "that's just not the facts." According to Dr. Wilkey the facts were that Petitioner had a thoracolumbar problem and didn't develop any true leg radiculopathy documentation of that until almost the very end in July. (RX. 1, pp. 63-67.) Dr. Wilkey went on to explain that a true radicular pattern happens within 48 -72 hours, maybe a week at most. They don't complain of thoracic pain. It's the buttocks, leg and numbness and tingling. (RX 1, p. 68) Dr. Wilkey acknowledged that he initially trusted Petitioner and it turned out Petitioner's initial statement/history to him was wrong. (RX 1, p. 68)

During his deposition, Dr. Wilkey testified that, on second thought, he might have had the records which were forwarded to him by way of Respondent's counsel's letter of December 22, 2016, at the time of his initial evaluation but, that while he wasn't sure, it was apparent that he had not reviewed those records because, according to Dr. Wilkey, causation was not an issue he was asked to address. When confronted with the letter from the nurse case manager that made clear that causation was an issue at hand, Dr. Wilkey proffered that it wasn't a very important issue, because he was really only being asked to provide a second opinion as to Dr. Mirkin's proposed surgery.

Dr. Wilkey confirmed that he had performed defense Section 12 examinations on a number of occasions before his initial evaluation of Petitioner in October of 2013. When asked as to the importance of reviewing the initial treatment records in order to address medical causation questions, Dr. Wilkey replied that would depend upon the information contained in those initial records. Dr. Wilkey had no answer when presented with the follow up question as to how he would know if the records were important in addressing causation when he had, according to him, failed to review them, having determined they weren't important for the questions asked of him.

Thereafter, Dr. Wilkey testified as follows:

Q But you cannot rule out that his accident on April 16, 2013, might have at least

at least been a causative factor in aggravating that underlying deterioration.

A That could be. I would consent that or I would condede that, yes.

Q And you would also concede that it might have been at least something of a causative factor in his need for the subsequent treatment undertaken by Dr. Mirkin and Dr. Lee?

A Yes.

(Dr. Wilkey deposition, page 26)

Dr. Wilkey did not dispute the reasonableness or necessity of any of the treatment afforded Petitioner under the care of Dr. Mirkin and Dr. Lee from the date of Petitioner's accident through the treatment proposed at the time of Dr. Wilkey's second Section 12 examination in May of 2014.

On redirect examination Dr. Wilkey was asked if it was more likely than not that the work accident aggravated Petitioner's lumbar spine condition and he replied "If you believe that he did not have leg radicular complaints until three months after the accident, the answer to that is No, …." (RX 1, p. 72) He added that if Petitioner had some radicular symptoms within 3 -4 days he would find it more likely but longer than a week, "probably not." (RX 1, p. 72)

The deposition of Dr. Lee was taken on May 25, 2017 and June 1, 2017. (PX 1) On direct examination, Dr. Lee testified that he initially examined Petitioner on February 27, 2014. At that time Petitioner told him he was delivering liquor on April 16, 2013 using a two-wheeled dolly and he was "running out of the back of the truck, twisted, got control of it, dropped and fell to the ground." (PX 1, p. 5) He felt Petitioner was status post L4-5 discectomy and fusion and wished to rule out a delayed union or issue with placement of a right S1 screw. He recommended exploratory surgery to check the fusion at L4-5 and revise the hardware. (PX 1, p. 7) Dr. Lee was asked if there was a causal connection between Petitioner's reported accident and the doctor's diagnosis and treatment recommendation and he replied, "Certainly, yes. I mean, I don't know that I made note of that in that particular note, but it does appear from the start that this was related to the work accident." (PX 1, p. 7) Dr. Lee then proceeded to testify consistent with his office notes as discussed above. (PX 1, pp. 7 – 10) He performed surgery on Petitioner on October 9, 2014 and his post-operative diagnosis was an L4-5 incomplete fusion, medial position right screw, left L3-4 neurofibrosis, L3-4 hypermobility, and L2-3 spondylolisthesis. As a result of the surgery, Petitioner had a fusion from L2 – L5. After that surgery, Petitioner underwent a third one on November 22, 2014 to address scar tissue around nerve roots at L3-4. Dr. Lee testified that Petitioner was doing well thereafter and they proceeded to wean him off medications, placed him in physical therapy, and referred him to Dr. Boutwell for additional pain management. (PX 1, pp. 10 -16)

Dr. Lee testified that Petitioner has remained off work throughout his treatment with the doctor. He was allowed to return to work on a light duty basis on November 12, 2015. He was in the medium demand category of work. Dr. Lee did not believe Petitioner could return to truck driving. (PX 1, pp. 16 – 18)

Dr. Lee continued to treat Petitioner. As of January 27, 2016, the doctor's diagnosis of Petitioner's condition was described as pseudoarthrosis at L3-4 or a failed/not fully united fusion. Adjustments were made to his bone stimulator and work restrictions remained in effect. Dr. Lee testified that Petitioner continued to complaint of low back and bilateral hip pain into his groin region. Aquatic therapy was recommended. Dr. Lee continued to monitor Petitioner's condition and last saw him on January 5, 2017 at which point he had low back

pain, paresthesias in the left leg, left leg pain and left hip pain. Two FCEs had been completed by that time. (PX 1, pp. 18 – 22)

Dr. Lee testified that after this final visit with Petitioner he received correspondence and medical records from Petitioner's attorney. The records included ones from Concentra, Dr. Mirkin and Dr. Wilke. Dr. Lee testified that the records from Concentra dated 5/7/13 showed reports of pain radiating to the lower portion of the left side of Petitioner's lumbar spine. He also reviewed a July 19, 2031 CT scan. Dr. Lee testified that Dr. Mirkin's record of 9/5/13 noted severe pain in Petitioner's back and down his legs. He noted findings including a herniated disc at L4/5. Dr. Lee also noted that Dr. Wilke, on 10/7/13, noted a herniated disc at L4-5 with stenosis at L2-3. Dr. Lee also pointed out entries in Dr. Mirkin's 10/22/13 and 5/6/14 office notes regarding low back issues. Based upon his review of the records, Petitioner's presenting complaints to him, and his treatment of Petitioner, Dr. Lee was of the opinion that Petitioner had pseudoarthrosis of his lumbar spine, a herniated disc at L4-5, screw penetration at S1 (an incomplete fusion at L4-5), L3-4 hypermobility, left-sided L3-4 neurofibrosis and L2-3 spondylolisthesis. Dr. Lee further opined that Petitioner's work accident caused those conditions. (PX. 1, pp. 22-25, 61-62)

Dr. Lee also testified that, as a result of his condition, Petitioner has permanent work restrictions of no lifting more than 35 pounds and no pushing or pulling more than 60 pounds of force and only occasional bending, sitting, and walking and that these restrictions are causally connected to the work accident. He felt Petitioner was very motivated and would maintain his level of conditioning that's been achieved. He also felt Petitioner would have some problems over time, including a deterioration in function. He also felt Petitioner would need pain management indefinitely. (PX. 1, pp. 26-28)

On cross-examination, Dr. Lee testified that Petitioner was referred to him through his attorney. He had no idea if he had done other examinations at the request of Petitioner's attorney. Dr. Lee testified that he could not state whether he agreed that Petitioner had inconsistent effort at his first FCE as he would have to do it himself. He had no idea what Mr. Burello meant by inconsistent effort or unacceptable effort. He further testified that at the time of the second FCE, done at a different facility, Petitioner demonstrated acceptable effort but inconsistencies. He did not feel that necessarily meant inconsistencies in performance and he disagreed that the Oswestry showed inconsistencies. (PX 1, pp. 28 – 36) Thereafter the deposition had to be adjourned.

Dr. Lee's deposition resumed on June 1, 2017. At that time Dr. Lee was questioned at length regarding entries in the Concentra records from April 16, 2013 and whether those records refer specifically to low back pain. He acknowledged there was no specific reference to low back pain. He agreed there was a reference to tingling in the left leg. He acknowledged that in his letter of April 12, 2017 he stated that the records indicated petitioner had symptoms corresponding to the doctor's diagnosis on the day of his accident. When asked if the only symptom that would correspond to a herniation at L4-5 and a protrusion at L2-3 would be tingling in the left leg, the doctor responded "No." (PX 1, p. 40) Dr. Lee then testified that he hurt his middle back and that is what he saw Petitioner for in 2014. When asked if the lumbar spine was different than the mid-back, Dr. Lee testified that "L2-3 in most patients way of thinking is their middle back." (PX 1, p. 42) Dr. Lee agreed that the chest and thoracic spine are not the low back. He was then asked if a thoracic strain and left rib pain would be symptoms corresponding to lumbar spine pathology and he replied that they can be symptoms as a thoracic strain can be a compensation trying to protect your lower back. He did agree that the 4/16/13 note stated Petitioner had back pain but didn't specify its location (upper, mid, or lower). Dr. Lee also acknowledged that there were no x-rays taken of Petitioner's lumbar spine early on. When asked if it would have made sense for lumbar spine x-rays to be taken if the doctors felt Petitioner had injured his lumbar spine, he replied that "you would have to ask them." (PX 1, p. 43)

Dr. Lee further testified that, in his opinion, Petitioner's diagnosis of a thoracic strain was "compensatory due to his lumbar spine injury." (PX 1, p. 44) Dr. Lee was also asked about the 4/19/13 office note from Concentra. Noting that it showed Petitioner denied any paresthesia in his leg, Dr. Lee, nonetheless, felt the office note reflected a low back problem stating that the note references pain in Petitioner's left mid-back and thoracic region suggesting differentiation. Therefore, he felt Dr. Galeano was referencing the upper lumbar spine, including L2. Dr. Lee also felt Petitioner's complaints of pain in the left posterior chest suggested compensation for the lumbar spine injury. (PX 1, p. 46) In response to questions about the April 23rd, April 26th May 7th, and May 15th Concentra visits and the interpretations of the notes, Dr. Lee essentially told counsel he needed to ask the doctors writing those notes what they meant. (PX 1, pp. 46 – 50) Dr. Lee agreed that the physical therapist's initial evaluation indicates Petitioner was being referred for left mid-back, rib and chest wall complaints. (PX 1, p. 53) Upon further questioning regarding the therapist's notes, the doctor suggested that the therapist be questioned about what he meant rather than the doctor. (PX 1, p. 54) He also testified that Dr. Mirkin would have to explain what he meant in his office notes. (PX 1, p. 55)

Dr. Lee agreed that the first office note of April 16, 2013 made no reference to leg pain and that, having reviewed Dr. Wilkey's initial report, Petitioner told Dr. Wilkey that he immediately developed low back, groin, and leg pain after the accident. (PX 1, p. 56)

On redirect examination Dr. Lee testified that his opinions remained unchanged despite the cross-examination. He also testified that he believed the notes Respondent's attorney asked him about on cross-examination "in some manner" referenced Petitioner's low back, mid-back, or left lower extremity. (PX 1, pp. 60-61)

At the request of his attorney, Petitioner was seen by a vocational expert, J. Stephen Dolan, on July 25, 2017. After taking a detailed history of Petitioner's educational background, felony conviction, employment history[1] and medical restrictions, and reviewing relevant information with respect to same; and after conducting testing in order to assess Petitioner's educational abilities, Mr. Dolan came to the conclusion that Petitioner no longer has access to a reasonably stable labor market. (PX 14, px. 2)

The deposition of Petitioner's vocational counselor, J. Stephen Dolan, took place on August 29, 2017. On direct examination, Mr. Dolan testified that Petitioner did not have access to a reasonably stable labor market. Mr. Dolan testified that his opinion was based on the restrictions from the December 2016 FCE which eliminates all of the jobs that Petitioner has ever done and the fact that he is being treated by a pain management physician. Mr. Dolan testified that Petitioner does not have the skills to work at a job that would meet the restrictions placed upon him by Dr. Lee. (PX. 14, pp.13-14.) On cross examination, Mr. Dolan testified that Petitioner never told him that he worked for Dennis driving a truck in June and July of 2013. (PX. 14, p.15.) Also on cross examination, Mr. Dolan testified that there are jobs within the restrictions placed upon Petitioner, but Petitioner is not going to be able to do the jobs very long because he has a chronic pain problem. Also on cross examination, Mr. Dolan testified that a person does not have to be pain free to go back to work. Also on cross examination, Mr. Dolan testified he did not perform a labor market survey and did not provide any assistance to Petitioner to find a job. Mr. Dolan also testified that he had a problem with the fact that Petitioner was inquiring about jobs that were outside of Petitioner's restrictions. Also on cross examination, Mr. Dolan agreed that the best way to determine if an individual can be gainfully employed would be to find a job and attempt to work the job. (PX. 14, pp.22-26.)

At some point after Dr. Wilkey's deposition and prior to the arbitration hearing Petitioner prepared a Petition for Penalties and Attorney's Fees. (PX 18)

[1] He noted that Petitioner legally changed his name from Breeding to Spear several years earlier. (PX 14, dep. ex. 2)

The Arbitration Hearing

Petitioner testified that he began working as a liquor delivery driver for Respondent on March 22, 2013. Petitioner's job duties involved delivering cases of liquor. He began his work day in Mt. Vernon, Illinois. Petitioner's day would begin by loading his truck using a pallet jack and performing a pre-trip inspection. Petitioner testified that on April 16, 2013 he had made two prior drop-offs before proceeding to Charleston for another drop-off. Petitioner testified that it was raining and he had loaded his dolly up inside the truck and was getting ready to go down the dolly ramp when the dolly just started getting away from him and sliding. He testified that he tried to hold on to it and it "kind of jerked him" and he "kind of twisted" and at that point felt a lot of pain throughout his back, legs, and chest. Petitioner had manually loaded his dolly, made two trips into the store and unloaded his dolly inside the store successfully. Petitioner estimated the loaded dolly to weigh between 200 to 250 pounds.

Petitioner further testified that he then proceeded to push the dolly inside. He told the owner of the store where the delivery was being made that his back was hurting him really bad and his leg was tingling. Petitioner also testified he was walking kind of funny and told the owner of the store that he did not think he could do anymore work. Petitioner testified that the owner of the store unloaded the rest of the delivery while Petitioner got into his truck and called his employer to inform them of what happened. Petitioner also testified that his employer told him to bring the truck down to Mt. Vernon as it was unable to come to Charleston to pick him up. Petitioner testified that he drove back to Mt. Vernon, but it was very difficult. Petitioner also testified that he spoke on the phone to a woman at Respondent's office asking to see a doctor, and he was told to go to Concentra in St. Louis. Petitioner testified that he drove directly from Mt. Vernon to the Concentra office in St. Louis.

Petitioner testified that he was seen at Concentra multiple times and that he underwent some physical therapy at its direction. When he initiated care at Concentra he had, "to the best of his recollection," low back pain, a little tingling sensation in his left leg, some abdominal pain, left-sided chest and upper back pain, and a general feeling of his muscles being all twisted up "like a cork screw." He was "pretty sure" he was taken off work but couldn't totally recall.

Petitioner testified that he believed his last evaluation at Concentra was on May 22nd when he saw Dr. Mirkin.

Petitioner further testified that, thereafter, he pursued a course of treatment with Dr. Mirkin. He also testified that a nurse case manager was involved in his treatment and she helped schedule appointments and secure authorization for treatment. Petitioner denied that he chose to treat with Dr. Mirkin and that Dr. Mirkin was Concentra's in-house doctor who Respondent chose to continue seeing Petitioner. Petitioner testified that he treated with Dr. Mirkin between May of 2013 and April 7, 2014.

Petitioner testified that Dr. Lee released him with a long list of permanent restrictions. He also continued to see Dr. Boutwell for about two years for pain management. Throughout this time he continued to receive TTD benefits. However, they stopped around January 27, 2017. He last saw Dr. Boutwell a couple of weeks before the arbitration hearing. Petitioner further testified that the injections were all approved by the insurance company and nurse case manager continues to participate in his care by showing up at every doctor's appointment.

Petitioner testified that he has been complaint with the doctor's treatment recommendations to date and wants to continue with Dr. Boutwell's treatment plans.

Petitioner testified he undertook an "extensive" job search after being released by Dr. Lee. Petitioner's job search logs were admitted into evidence as PX. 16. Petitioner testified to going on a few interviews but not being offered any employment. He further testified that Respondent has not helped him in any way with his job search and that he was told three days after the accident that his services were no longer needed. Some of the job searches he has done have been on-line through "Indeed."

Petitioner testified that he met with a vocational counselor, Steve Dolan, in July of 2017 as requested by his attorney. He testified that he discussed his background with Mr. Dolan, including the fact he has a GED and received a vocational degree in heating and air conditioning. Since high school, he has worked in kitchens, completed heating and air conditioning school, worked as an installer, gone through trucking school, and began working as a truck driver in 2007. He continues to look for work as much as he can in light of financial difficulties. He has applied for Social Security and Medicaid and been approved for it.

Petitioner testified he continues to have low back pain, mostly in his hip, and tingling in his left leg. He testified he also has occasional pain in his groin and tightness in his mid and upper back. Petitioner testified that the pressure of sitting makes him uncomfortable. Petitioner testified that on a good day, he rates his pain at a 5 and a bad day at a 9 on a scale of 10. He takes Gabapentin for nerve pain and Tizanidine for muscle relaxation. He recently began taking an anti-depressant. Petitioner testified that he drove to Quincy for the hearing the day before. He had to stop three times during the three hour drive from his home to the hearing site due to being very uncomfortable.

Petitioner testified that he underwent L4-5 lumbar spine surgery with Dr. Lange in 2003. He further testified that he did wonderfully after the surgery and returned right back to work with no problems at all. Petitioner denied any problems between 2003 and 2013 as a result of low or mid back or left leg difficulties.

Petitioner also denied being able to perform his job since April of 2013.

Petitioner testified that he has been a truck driver since 2007 and could do so without any back difficulties.

On cross-examination, Petitioner testified that, after he was returned to full-duty work by Dr. Mirkin, he found a job working for a gentleman named "Dennis" hauling intermodal trucks and he did some drop and hook jobs for him with no manual labor, just backing up to a trailer, hooking up to an air line, and dropping it back off at a dock. Petitioner testified that he probably pulled two to three loads for Dennis and was paid in cash. Petitioner further testified that he continued to complain to Gwen, a nurse case manager, the entire time he worked for "Dennis" and told "him" that he needed to go back to the doctor. Petitioner also testified that the last time he worked for "Dennis" he was driving a truck and his entire leg went numb and he couldn't shift the truck. Petitioner testified he had to pull the truck over to the side of the road, put the truck into park, and left the truck there. Petitioner testified that this incident occurred not long before he went back to Dr. Mirkin on July 12, 2013.

Petitioner testified that after the accident he had no contact from his employer. Rather, he would be contacted by "Gwen and Gwen," the case manager. It was the case manager who told him he was seeing Dr. Mirkin at that facility. Petitioner testified that he made calls to him telling him he needed to get back in to a doctor.

Petitioner also testified that he didn't continue working for "Dennis."

Petitioner denied belonging to any athletic clubs or engaging in regular exercise. Other than working for "Dennis" Petitioner hasn't worked anywhere else since the accident.

Petitioner acknowledged being injured in a motor vehicle accident in January of 2012. At that time he was working as an independent contractor and driving a flatbed 18 wheeler. He only injured his neck in that accident but ended up having to undergo surgery to his neck. He returned to full duty work around July 19, 2012. He then went to work for a different company, PI & I Motor Express, and stayed there until the end of the year when he went to work for ProDriver. He was only employed by it for a week or two because he wasn't getting enough work. He then went to work for Respondent.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his back is not causally connected to his accident of April 16, 2013. Petitioner failed to prove that his condition of ill-being in his low back after June 11, 2013 was causally connected to the work accident.

Initially, the Arbitrator addresses Petitioner's credibility as she did not find Petitioner to be a credible witness. Petitioner testified that he had no problems in his low back whatsoever after his surgery with Dr. Lange. Medical records show to the contrary as Petitioner followed up with Dr. Lange in 2006 for additional complaints. It is unclear if treatment was abandoned or records could not be found. Either way, Petitioner did not address this treatment in the course of his testimony. Despite his testimony of doing "wonderfully after the surgery and having no further problems," the records show otherwise.

Petitioner also misrepresented the mechanism of his injury to Dr. Lee when first presenting to him. He was not forthright with the doctor as he told him he fell to the ground at the time of the accident and experienced immediate low back, groin, and left leg pain. That history is not corroborated in the accident report or any of the medical records immediately following the accident. Petitioner misled Dr. Lee as to the details of the accident which, in turn, not only affects Petitioner's credibility but also undermines Dr. Lee's causation opinions. Petitioner also did not tell Dr. Lee that he had been released by Dr. Mirkin and had worked for someone else at which point he did "drop and hook" work and had a day when he was working and driving and his entire leg went numb and he stopped truck driving altogether. Dr. Lee was also unaware that Petitioner, prior to initially being seen by him, had fallen on ice on February 11, 2014 and landed on his buttocks.

Petitioner also misrepresented the details of the accident to Dr. Wilkey claiming he sustained immediate low back, groin and leg pain after the accident. The Concentra records don't corroborate that.

The treating records from Concentra reveal that Petitioner did not have any pain symptoms generated in his low back or radiculopathy into his legs until after he was discharged from treatment by Dr. Mirkin on June 11, 2013 and Petitioner had worked for "Dennis" driving trucks. The medical records from Concentra show that Petitioner's complaints of pain were primarily limited to pain generated in the thoracic spine and chest area. While there is documentation that pain was radiating from the chest and thoracic spine down to the low back and hips, it is clear from the records that the pain generator at that time was in the mid-back and chest. The initial diagnostic tests were limited to the chest and thoracic spine. When last seen in therapy on June 7, 2013 Petitioner's difficulties with certain low back extensions and flexions was described as "consistent with a twisting sprain." (PX 9) While there was a reference to tingling in Petitioner's leg on April 16, 2013, in subsequent visits Petitioner denied any further tingling, thus, suggesting that the initial reference was an isolated

complaint. Thus, both Dr. Lee and Dr. Wilkey were misled by Petitioner as to the onset of his low back/radicular complaints.

The Arbitrator also finds it significant that Petitioner did not attempt to present the owner of the business where he was making the delivery on April 16th as a corroborating witness. Petitioner testified that after the accident he proceeded to push the dolly inside the store and he told the owner of the store that his back was hurting him really bad and his leg was tingling. Petitioner knew causation for his low back condition was in dispute at the time of the hearing and he purportedly knew he had so conversed with the store owner. It does not appear that Respondent knew of this alleged conversation prior to the arbitration hearing. Petitioner could have presented the owner as a witness but did not. Petitioner could have also deposed the doctors at Concentra regarding their reports and Petitioner's complaints. He did not.

Petitioner was also somewhat misleading regarding the nature of his treatment with Dr. Mirkin. On direct examination he essentially testified that he saw Dr. Mirkin on a number of dates between May of 2013 and April of 2014. He did not volunteer any testimony regarding being released to return to work in June of 2013 and how he came to once again see the doctor in July of 2013.

Petitioner also testified that he had repeated conversations with "Gwen;" however, the nurse case management reports do not document any conversations with Gwen or other evidence of Petitioner's alleged symptoms. Petitioner could have subpoenaed this person to testify but he didn't.

Dr. Wilkey admitted that he initially did not carefully review the medical records and relied upon Petitioner's history of complaints that Petitioner had immediately after the accident. Upon further investigation of the treating medical records, Dr. Wilkey credibly testified that there is no indication in the initial treating medical records of an injury to the lumbar spine. The Arbitrator has considered the concessions made by Dr. Wilkey during his deposition cross-examination. She does not consider them to be viable opinions based upon a reasonable degree of medical certainty, only possibilities. Furthermore, on redirect examination Dr. Wilkey was asked if it was more likely than not that the work accident aggravated Petitioner's lumbar spine condition and he replied "If you believe that he did not have leg radicular complaints until three months after the accident, the answer to that is No, …." (RX 1, p. 72) He added that if Petitioner had some radicular symptoms within 3 -4 days he would find it more likely but longer than a week, "probably not." (RX 1, p. 72)

Furthermore, Dr. Mirkin repeatedly noted that Petitioner's pain complaints were exaggerated and that Petitioner was engaged in symptom magnification. Dr. Mirkin, who saw Petitioner before and after the gap in treatment in June and July of 2013 never rendered a causation opinion on Petitioner's behalf. In his presentation to Dr. Mirkin on July 12, 2013 Petitioner did not state anything about the April 16, 2013 work accident or what happened to him between June 10, 2013 and July 12, 2013 or his alleged repeated attempts to get in to see a doctor. Petitioner simply told the doctor he wanted further treatment for his mid-thoracic spine, low back and neck (the last of which was never claimed to have been injured in the accident).

Petitioner has the burden of proof on the issue of causation. Petitioner relies upon the opinions of Dr. Lee to establish causation. The Arbitrator has specifically found that Petitioner did not have true low back and radicular pain complaints prior to his visit with Dr. Mirkin in July of 2013. In the end, the Arbitrator was not persuaded by Dr. Lee's opinions as they were based upon an inaccurate understanding and knowledge of the details of Petitioner's accident and an incomplete and accurate understanding of Petitioner's initial treatment between April 16, 2013 and June 10, 2013. Dr. Lee's testimony that the initial treating records support that Petitioner suffered a lumbar spine injury was not persuasive and the doctor repeatedly stated that if one wished to interpret the records from those visits one needed to ask the doctors who wrote them. Furthermore, in stating his "belief" that these records indicated pain complaints compensating for a low back injury and a lumbar spine

injury, Dr. Lee was under the erroneous impression Petitioner had fallen on the 16th. By his own admissions at his deposition, he was, essentially, speculating and/or merely expressing his "belief "as to what entries in the records from that time period meant. He repeatedly stated one needed to ask the doctors who wrote the notes for those visits what they meant. Those doctors never were asked.

ISSUE J. Medical Bills
ISSUE K. Maintenance
ISSUE M. Penalties and Fees

Based on the preceding finding that Petitioner's condition of ill-being after June 11, 2013 is not causally connected to the work accident, Petitioner is not entitled to an award of medical bills for the treatment rendered after June 11, 2013. Likewise, Petitioner is not entitled to maintenance benefits for the period of time claimed, that being, January 27, 2017- October 5, 2017. Finally, Petitioner is not entitled to penalties or attorney fees.

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

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

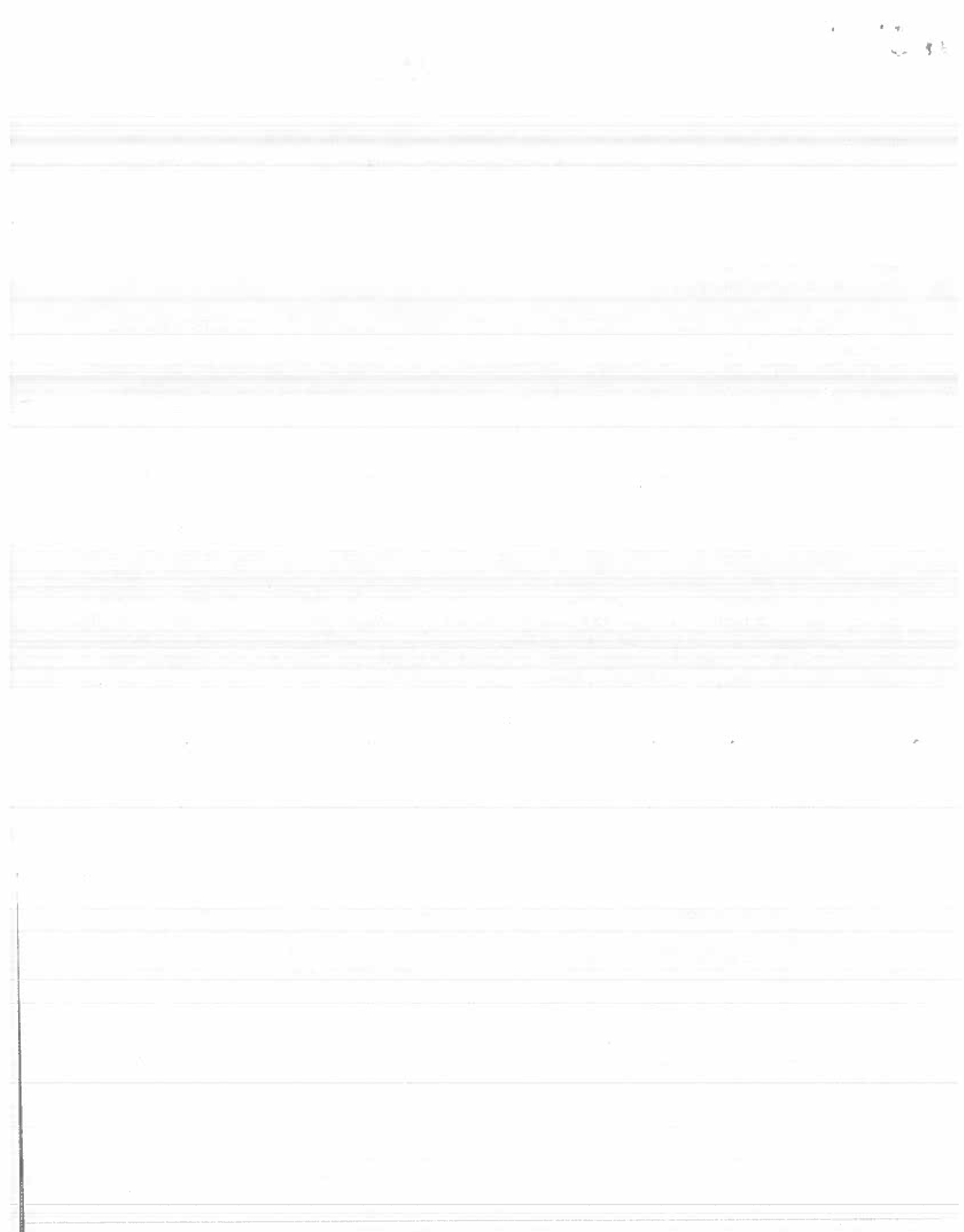
With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a delivery truck driver at the time of the accident and that he is not able to return to work in his prior capacity. However, Petitioner's inability to return back to work as a delivery truck driver is not the result of an injury. In fact, on June 11, 2013, Petitioner was returned to work full duty. Subsequently, Petitioner found a job working as a truck driver until he had an apparent intervening incident. Because Petitioner's inability to work as a truck driver presently is not a result of said injury, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of Section 8.1b(b) the Arbitrator notes that the Petitioner was 31 years old at the time of the accident. Because Petitioner has more years while having permanent partial disability, the Arbitrator, therefore, gives greater weight to this factor.

With regard to Section (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner is no longer employed; however, Petitioner's unemployment is not a result of any work-related injury. Because Petitioner's diminished future earning capacity was not caused by the accident herein, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability as corroborated by the treating medical records, the Arbitrator notes that, as a result of the work accident, Petitioner was treated conservatively until he was released to full duty work by Dr. Mirkin on June 10, 2013. At that time, Dr. Mirkin noted that Petitioner appeared to be in no distress and was engaged in significant symptom magnification. Dr. Mirkin reported that Petitioner was not a surgical candidate. Petitioner was treated with prescription medications and approximately five weeks of physical therapy. He sustained a thoracic sprain/strain, back strain, and chest contusion. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 3% loss of a person-as-a-whole pursuant to Section 8(d)(2) of the Act.

****



STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elijah C. Crusoe,

Petitioner,

vs.

NO: 13 WC 37568

Harper College,

19IWCC0149

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 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.

In affirming the Arbitrator's decision, the Commission wishes to emphasize the fact that Petitioner suffered from an idiopathic condition, which was the genesis of his knee condition. As such, Petitioner was exposed to a personal risk of injury unrelated to his employment, and the Arbitrator properly denied compensation accordingly.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/6/17 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.

19IWCC0149

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

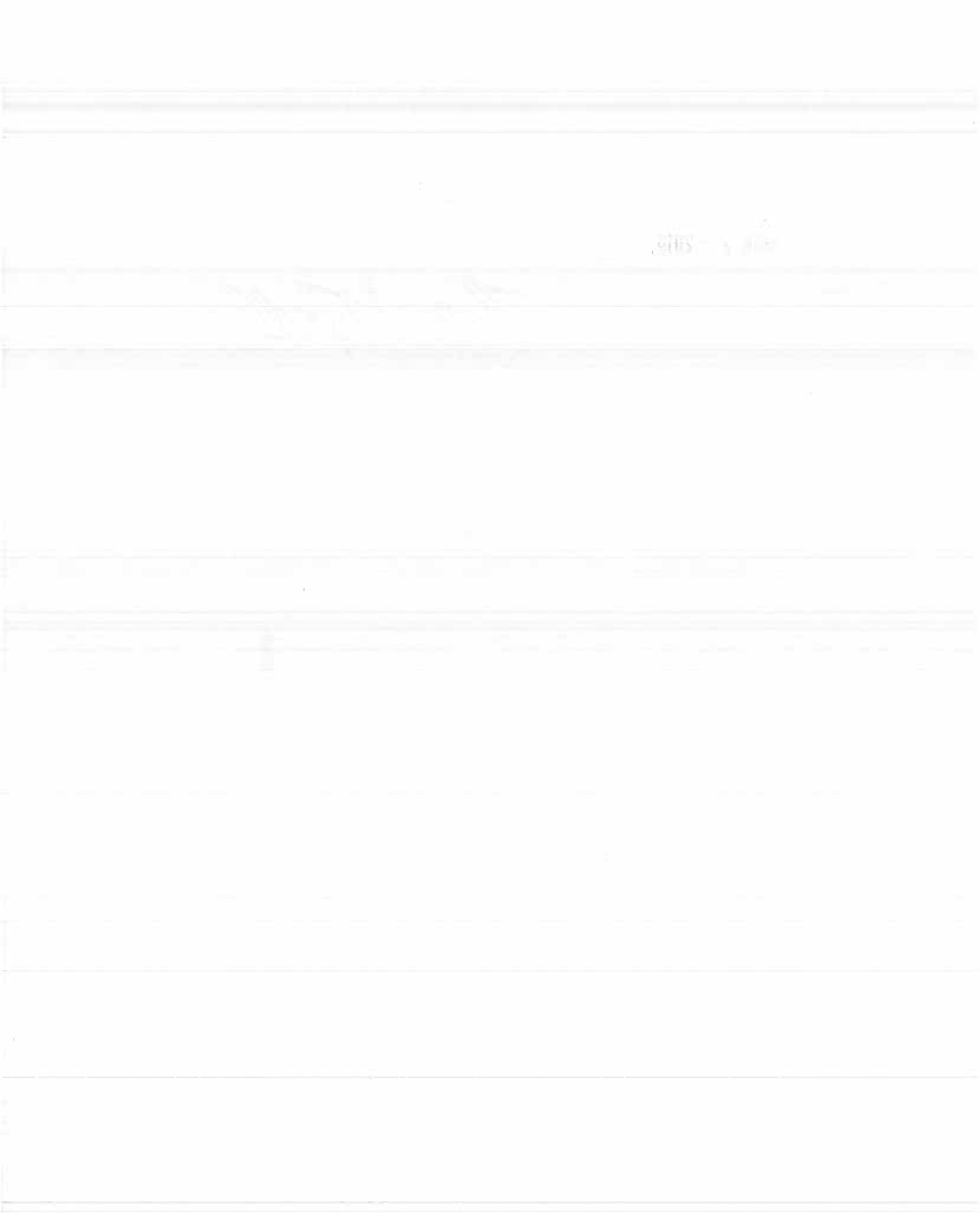
The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 7 - 2019
o: 1/29/19
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRUSOE, ELIJAH C
Employee/Petitioner

Case# **13WC037568**

HARPER COLLEGE
Employer/Respondent

19IWCC0149

On 1/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.63% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2998 MARKER & ASSOCIATES
JASON A MARKER
4015 PLANFIELD-NAPERVILLE RD
NAPERVILLE, IL 60564

0560 WIEDNER & McAULIFFE LTD
CATHERINE M LEVINE
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ELIJAH C. CRUSOE
Employee/Petitioner

v.

HARPER COLLEGE
Employer/Respondent

Case # **13** WC **37568**

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **MAY 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 **AUGUST 23, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**83,460.00**; the average weekly wage was $**1,605.00**.

On the date of accident, Petitioner was **61** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

ORDER

THE PETITIONER FAILED TO PROVE HE SUSTAINED AN ACCIDENTAL INJURY THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT. ACCORDINGLY, HIS CLAIM FOR BENEFITS IS DENIED.

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

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

Signature of Arbitrator

DECEMBER 30, 2016
Date

JAN 6 - 2017

ELIJAH CRUSOE v. HARPER COLLEGE

13 WC 37568

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on May 3, 2016. The issues in dispute were accident, causal connection, medical bills, TTD benefits, Respondent's credit, and the nature and extent of the injury.

FINDINGS OF FACT

The Petitioner is a 64-year-old male who began working for Harper College on October 30, 2012. The Petitioner testified that his job title was Custodial Services Supervisor. (*Transcript* at 15-16). The Petitioner testified that his job duties consisted of supervising a crew of 70 employees and his primary function was to provide operation and support for the custodial department. (*Transcript* (hereinafter, *T.*) at 16-17). The Petitioner testified that his job duties also included training employees, inspecting areas within the College, inspecting buildings on the campus, completing work orders, hiring employees, dealing with disciplinary issues, termination issues, performing annual performance reviews, attending in-service meetings, all purchasing, all recycling for the College, set-ups and break-downs, essentially managing the entire custodial department and performing whatever duties were assigned by the Director of the physical plant. (*T.* at 17). The Petitioner testified that he worked the third shift and his typical hours were from 1:00 a.m. to 9:30 a.m., Monday through Saturday. (*T.* at 18-19). The Petitioner testified that Darryl Knight was the Director of the physical plant for Harper College in 2013. (*T.* at 20). Prior to that, Jim Ma was the Director of the physical plan. (*T.* at 20). The Petitioner testified that Harper College is approximately 200 acres with 25 buildings. The Petitioner testified that on a normal work shift, he would walk the grounds of the College anywhere from 10-25 times. (*T.* at 22). The Petitioner testified that his office was located in the Building Y and his supervisor's office (Darryl Knight), was located in the Administration Office which was in Building B. (*T.* at 23-24). The Petitioner testified that the route from his office to his supervisor's office in the Administration building was a route that could be traveled inside through inter-connected buildings. (*T.* at 24-25).

19IWCC0149

The Petitioner testified that prior to August 2013, he had arthroscopic surgery on his left knee in 2008 and was off for approximately five and a half weeks. (*T.* at26-27). The Petitioner testified that he returned to work for Harper College after his left knee surgery and did not have any issues with his knee after that time. (*T.* at 27).

The Petitioner testified that at approximately 6:00 a.m. on the morning of August 23, 2013, he was called by his crew to check their work on a carpet cleaning project that was being performed in a new administrative office in Building W. (*T.* at28-30). The Petitioner testified that the work order for this particular job involved cleaning a strong "perfumery fragrance" that was used to clean the carpet the previous night. (*T.* at 29). The Petitioner testified that he made between three or four trips to Building W on the night of August 23, 2013 to determine if the smell was gone. (*T.* at 33). The Petitioner testified that his crew called him on his Nextel walkie-talkie phone, to notify him that they were finished and ready for him to inspect the carpet again. (*T.* at 34). The Petitioner testified that while walking through the P-2 hallway on his way to the administrative building, he suddenly noticed that his left leg got stuck in the carpet; his knee buckled and momentarily, he could not move. The Petitioner testified that he was hoping someone would come and give him some assistance but no one came. (*T.* at 34-40). The Petitioner testified that he was carrying a phone, a clipboard and a pen and wearing black Stacy Adams dress shoes with a rubber sole. (*T.* at 37-38). The Petitioner testified that the incident occurred in front of Karen Stossel's office. (*T.* at 39-40). The Petitioner testified that at the time of the incident, he did not really notice anything unusual about the carpet such as any holes or rips. (*T.* at 41-42). The Petitioner also testified that he did not notice any imperfection in the grading of the floor. (*T.* at 42). The Petitioner testified that he twisted his left leg but did not fall to the ground. (*T.* at 43). The Petitioner testified that he was walking briskly but was not running. (*T.* at 44). The Petitioner testified that he felt rushed to finish the job before the occupants arrived. (*T.* at 45).

After the incident, the Petitioner completed his work day. The Petitioner testified that when he came back to work Friday night/Saturday morning, he completed an injury report. (*T.* at 46). The Petitioner testified that per College policy, when there was an injury, he would prepare an injury report electronically. The Petitioner testified that he completed an injury report if any of his custodial staff ever had an injury. (*T.* at 46). The Petitioner testified that on the following Monday, either called Sara Gibson, the Safety Manager or she called him to let him know that she received the injury report. The Petitioner testified that he advised Sara Gibson that he was walking in the hallway and his left knee got stuck somehow in the carpet. (*T.* at 48). The Petitioner testified that on Tuesday morning, he went to Sara Gibson's office and she reportedly advised him that this was a workers' compensation case. (*T.* at 48-49).

19IWCC0149

The Petitioner testified that the incident report he completed electronically was brief and something to the effect of his "knee buckled" or something like that. (*T.* at 50). The Petitioner testified that he did not officially go back to look at the P-2 hallway until January, 2014 and then again on Saturday, April 30, 2016. (*T.* at 51-52). The Petitioner testified that he received a letter from "Kathy" stating his workman's compensation claim was being denied. (*T.* at 52-53). Thereafter, the Petitioner conferred with Angela Bowling, the Manager of Benefits and Compensation and was approved for FMLA leave. (*T.* at 52-53).

The Petitioner testified that he first sought medical treatment on August 29, 2013 with a doctor at Midwest Orthopedics in Winfield. (*T.* at 56). The Petitioner testified that he eventually resumed treatment with his previous knee surgeon, Dr. Bach. (*T.* at 57-58). The Petitioner testified that he told his doctors that he was walking, performing his duties at work when his knee buckled in the carpet and twisted. (*T.* at 58). The Petitioner testified that he was authorized off work by Dr. Bach from October 2, 2013 through December 2, 2013, a period of eight weeks. The Petitioner testified that he sent his off-work note to Angela Bowling. (*T.* at 60). The Petitioner testified that he had knee surgery followed by physical therapy and was ultimately released to return to work on December 2, 2013. (*T.* at 60-61).

The Petitioner testified that the first time he went back to look at the area in the P-2 hallway was January of 2014. (*T.* at 51-52 and 65). The Petitioner testified that when he went back the second time, he observed new carpeting but still saw ridges and bumps which he did not observe at the time of the incident. (*T.* at 66). The Petitioner testified that when he observed the P-2 hallway floor in January, 2014, he did not take any measurements. The Petitioner testified that when he went back in April, 2016, he took some measurements with a level. (*T.* at 74).

The Petitioner testified that he started thinking about the flooring in the P-2 hallway "immediately" after the incident; at the time it was over. (*T.* at 75). The Petitioner again testified that he did not inspect or go back to look at the P-2 hallway floor until January, 2014 but noted that it was on his mind. (*T.* at 77, 75-76).

The Petitioner testified that in approximately 2012, the College decided to put carpeting in the hallway over the tile floor. (*T.* at 77). The Petitioner explained that in approximately 2011, the College embarked on a campus-wide abatement process which included abatement of some asbestos tile and some exposed pipe. (*T.* at 77-78). The Petitioner testified that he participated in a meeting with the Jim Ma, (the director at that time) and Ms. Gibson, the Safety Manager. The Petitioner testified that Sara Gibson wanted everything to be ripped up. (*T.* at 77-78). The Petitioner testified that he provided input which included his objection to the notion of gluing carpet squares down over ceramic tile. The Petitioner testified that his reasoning was that many of the tiles were defective, broken and/or cracked. The Petitioner

19IWCC0149

also testified that when the tile was first laid 30 years prior, it was not level and there were ridges and bumps in the floor. (*T.* at 80-81). The Petitioner testified the tile in the P-2 hallway was not level prior to carpet being put down in 2011. The Petitioner testified that the concrete beneath the floor was never level and as a result, the tile under the carpet eventually buckled up. (*T.* at 82-83). During his direct examination testimony, the Petitioner identified a picture of tile in the A-3 hallway that was taken on the previous Saturday, April 30, 2016. (*T.* at 83-84 and *Petitioner's Exhibit* 2). The Petitioner did not offer a picture of any tile from the P-2 hallway.

The Petitioner testified that when he returned to the P-2 hallway on Saturday, April 30, 2016, he noticed that the carpet was different from the carpet he observed during his visit in January, 2014. (*T.* at 88). The Petitioner testified that he felt a ridge in the same area where his knee buckled. (*T.* at 89). The Petitioner testified that he took photographs of the P-2 hallway on April 30, 2016 and conducted measurements using a level. The Arbitrator noted that the pictures in question as contained in *Petitioner's Exhibit* 2, were not taken of the accident location with the same carpeting in place on August 23, 2013. (*T.* at 92).

The Petitioner testified that his left knee still hurts today and that he has problems with ambulating. The Petitioner testified that he takes over-the-counter Motrin approximately six tablets per week when the pain gets severe. (*T.* at 101-102). The Petitioner testified that he is still receiving treatment for his right knee. The Petitioner testified that his mobility is limited, walking is laborious and he has issues climbing stairs and ambulating. (*T.* at 102-103). The Petitioner testified that he used a cane once his doctor told him he could use it around December of 2013 when he was released to return to work. (*T.* at 103). The Petitioner testified that he held several previous jobs before working for Harper College, all of which were within custodial or maintenance fields. (*T.* at 104-105). The Petitioner testified that he has been looking for employment and has not found anything. (*T.* at 105).

On cross-examination, the Petitioner testified that his job duties as a custodial supervisor included making sure work orders were completed. The Petitioner testified that his job also included reporting any type of problems that he observed within the facility. (*T.* at 107-108). The Petitioner testified that while employed by Harper College and after the incident on August 23, 2013, he never told anyone there was something wrong with the carpet that needed to be fixed. The Petitioner further testified that he never filled out a work order regarding an issue with the P-2 hallway carpet. (*T.* at 135). The Petitioner testified that at no time prior to August 23, 2013, did he trip or twist on anything in the P-2 hallway. The Petitioner testified that he could not recall twisting his foot on any carpeting in the hallway. (*T.* at 111).

The Petitioner testified that after he felt his knee pop, he had his Nextel phone in his hand but did not call anyone to come and assist him. (*T.* at 109-110). The Petitioner testified that when he came back to work that night, he filled out an incident report per policy, and sent

it to Sara Gibson and Darryl Knight. (*T.* at 112-113 and *Respondent's Exhibit* 1). The Petitioner identified the email he sent to Sara Gibson on August 24, 2013 at 3:14 a.m. (*T.* at 114). The Petitioner testified that in Incident Investigation Report he personally prepared, he described the incident on August 23, 2013 as follows: *"I was walking in P-2 on my way to do an inspection in the W Building when I hear my right knee pop. It stopped me in my tracks and I couldn't lift and/or move my right leg."* The Petitioner testified that in terms of the cause of the incident, the answer he provided on the Incident Investigation Report was *"Clueless." Didn't do anything. I was just walking when this happened."* (*T.* at 115-116 and *Respondent's Exhibit* (hereinafter, *RX*) 1).

During his testimony, the Petitioner reviewed the Illinois Form 45 prepared by Sara Gibson and agreed that the description written therein was consistent with the information contained in the incident report he prepared. (*T.* at 117-118). The Petitioner testified that he recalled receiving a call from Kathy Kallas from workman's comp or CCMSI on or about September 10, 2013 and that she requested his permission to take a recorded statement. (*T.* at 120-122, *RX* 3). The Petitioner testified that during the conversation with Kathy Kallas, she asked him questions about what occurred on August 23, 2013. The Petitioner testified that he told Ms. Kallas he had a project going that night that had to do with carpet cleaning. The Petitioner testified that when asked when he was asked what occurred, he responded that he was "walking, just walking." (*RX* 3). The Petitioner recalled Ms. Kallas asking him what type of flooring he was walking on and he responded that it was carpet. The Petitioner recalled that Ms. Kallas asked him what type of shoes he was wearing and he responded that he was wearing hard rubber sole shoes. The Petitioner testified that he recalled Ms. Kallas asking him what type of lighting was in the area and he responded that it was morning so it was moderate lighting and that he could definitely see. The Petitioner testified that he recalled Ms. Kallas asking him if there was anything on the floor or anything that he noticed in the area that caused the fall and he responded that there was "nothing". The Petitioner also recalled telling Ms. Kallas that he was walking at a normal, brisk pace and felt he had enough time to get to his destination to make sure things were completed before 7:30 or 8:00. The Petitioner also recalled advising Ms. Kallas that based on his training in safety and reporting procedures, to prepare a report since the incident occurred on the job. (*T.* at 124-129 and *RX* 3).

The Petitioner testified that he had a previous incident of the same knee (left) giving away at home that necessitated surgery by Dr. Bernard Bach on December 28, 2007. (*T.* at 130). The Petitioner testified that the makeup of the P-2 hallway consisted of a cement floor, followed by tile and then carpet on top of tile that was never removed. (*T.* at 134).

The Petitioner testified that he retained the services of attorney Mr. Marker in November of 2013 and an Application was filed on his behalf on November 14, 2013. (*T.* at

137). The Petitioner testified that two months after his Application was filed, he went back to the P-2 hallway and took pictures which he shared with his attorney. (*T.* at 137). The Petitioner testified that he did not take any pictures of the P-2 hallway after his incident and before January 14, 2014, (*T.* at 136). The Petitioner testified that he never showed the pictures of the P-2 hallway to Sara Gibson or Darryl Knight. (*T.* at 137). The Petitioner testified that he never requested an opportunity to revise the 5.3 Incident Investigation Report he prepared or his recorded statement regarding an issue with the carpet in the P-2 hallway. (*T.* at 138).

The Petitioner testified that he went back to Harper College on Saturday, April 30, 2016 and took a variety of pictures which make up *Petitioner's Exhibit* 2 in preparation for the Arbitration hearing. (*T.* at 139). The Petitioner testified that carpet was laid over tile in the P-2 hallway within a six month period between 2012 and 2013. (*T.* at 140). The Petitioner testified that he thought about the flooring and that the issue of the flooring was on his mind right after the incident occurred. (*T.* at 149-151).

Darryl Knight testified he is the Director of the Physical Plant for Harper College and he began his tenure in that position on October 11, 2011. (*T.* at 155–156). Mr. Knight testified that he is responsible for the overall functioning of the campus, the cleanliness of the buildings, the infrastructure, heating and cooling. He also testified that he manages several foremen and managers that have positions unique to certain areas of the campus. (*T.* at 156). Mr. Knight testified that the Petitioner was the custodial supervisor for Harper College when he arrived on October 2011. (*T.* at 156). Mr. Knight testified that he was the Petitioner's direct supervisor. (*T.* at 157). Mr. Knight testified that during the time frame he worked with the Petitioner from October 2011 until the Petitioner's retirement in October 2013, he did not receive any work orders regarding a defect in the flooring in the P–2 hallway. He also testified that during the time frame from October 2011 until August 2013, he did not receive any complaints, or reports about any individual falling, tripping or twisting on anything as a result of the carpet in the P–2 hallway. (*T.* at 158). Mr. Knight testified that at no time after August 23, 2013 and up to the present date, did The Petitioner advise him of a defect related to carpeting in the P–2 hallway. (*T.* at 160–161).

Mr. Knight testified that as the Director of the physical plant, he has an understanding of asbestos abatement procedures as it relates to tile. (*T.* at 161–162). Mr. Knight testified that since his employment began with Harper College in 2011, there has not been a practice of placing carpet on top of tile. With respect to the P–2 hallway Mr. Knight testified that there was not an asbestos abatement project between 2011 and 2012 whereby carpet was placed on top of tile. (*T.* at 163). Mr. Knight also testified that there is no tile in the P–2 hallway underneath the carpet, only a concrete floor. (*T.* at 174).

19IWCC0149

Sara Gibson testified that she was hired by Harper College on December 11, 2000 as the Manager of Environmental Health and Safety. Ms. Gibson testified that her job duties include overseeing all of the OSHA compliance, the EPA compliance, all risk management issues including property, general liability, workers' compensation and any kind of environmental or safety issues for the College. (*T.* at 177–178). She testified that if any individual, whether an employee, student or general public, is injured on the College premises, there is a written reporting procedure that should be documented immediately in a 5.3 Incident Investigation Report. (*T.* at 178). Ms. Gibson testified that as part of her job, she does not make compensability determinations and that these issues are made by the College's third-party administrator. (*T.* at 179). She also testified that her job is to collect all the information given to her on the incident report and try to identify if there was something that could be prevented or fixed in the workplace to prevent the incident from occurring again. (*T.* at 179).

Ms. Gibson testified that she has a personal recollection of the Petitioner and worked with him since the onset of her employment as he was hired a couple of months before her. (*T.* at 178–180). Ms. Gibson testified that she became aware of a workplace incident involving the Petitioner through an email he sent her on August 24, 2013 at 3:14 a.m. (*T.* at 181 and *RX* 1). She then testified that the Petitioner completed an incident report and emailed it to her, which was appropriate procedure. (*T.* at 182). Ms. Gibson testified that the report completed by the Petitioner included the date of the incident, the time, the location and a description which was *"I was walking in the P–2 hallway on my way to do an inspection in the W building when I hear my right knee pop. It stopped me in my tracks and I couldn't lift and/or move my right leg to walk."* (*T.* at 183–184 and *RX* 1). Ms. Gibson testified that the explanation recorded by the Petitioner on the incident report was *"Clueless. Didn't do anything. I was just walking when this happened."* She testified that her standard procedure after receiving an incident report would be to contact the individual and obtain more details as needed if there was anything in the report that led her to believe there was an issue with the work environment or that something needed to be fixed in the workplace. (*T.* at 184–185).

Ms. Gibson testified that at no time after she received the 5.3 Incident Investigation Report from the Petitioner, did he indicate that there was something defective about the floor, carpeting, concrete or tile in the P–2 hallway. (*T.* at 185–186). Ms. Gibson testified that there was nothing in the incident report or her conversations with the Petitioner which necessitated an investigation of the P–2 hallway. (*T.* at 185–186). She also testified that if the Petitioner would have raised an issue with a defect in the hallway carpet, concrete or tile she would have worked on it because her overall goal is to correct issues in the workplace so people don't get injured. (*T.* at 186–187). Ms. Gibson testified that at no time from August 23, 2013 to the present date, has she received any complaints from any individuals about a defect in the P–2 hallway related to the carpet, sloping, slanting or ridges. (*T.* at 187).

Ms. Gibson testified that she prepared an Illinois Form 45 on August 29, 2013. (*T.* at 187–188 and *RX* 2). Ms. Gibson testified that the information she used to prepare this report was taken directly from the Petitioner's description of the incident as contained in the 5.3 Incident Investigation Report. (*T.* at 188).

Ms. Gibson also testified that as the Safety Director for the College, she has been involved in asbestos abatement which falls under her job responsibilities. (*T.* at 188–189). Ms. Gibson testified that there was an asbestos abatement project involving the P–2 hallway which took place in 2005 whereby all asbestos tiles were removed down to the concrete floor. (*T.* at 189). Ms. Gibson testified that since the abatement procedure in 2005, there is no tile under carpet in the P–2 hallway. (*T.* at 189–190). Ms. Gibson testified that since 2000, the College has had a goal to remove all asbestos out of the buildings and not leave it hidden or hid under carpet or behind walls. She further testified that when dealing with asbestos abatement, Harper College does not follow a practice of placing carpet on top of asbestos tile. (*T.* at 190–191). Ms. Gibson testified that the carpeting in the P–2 hallway was replaced in 2016 and if the carpet was lifted up today, there would be concrete underneath. (*T.* at 191). Ms. Gibson testified that she has not received any reports related to defective or cracked concrete under the carpet in the P–2 hallway. (*T.* at 191–192).

Ms. Gibson testified that she could not recall any safety meetings involving the Petitioner whereby the college was advocating placing carpet on top of asbestos tile rather than removing the tile. (*T.* at 193). Ms. Gibson testified that in her position as the Safety Director since 2000, she has not received any complaints from any students, faculty members, employees or the general public about tripping on carpeted areas in any of the hallways or walkways due to sloping or uneven ground. (*T.* at 193).

Ms. Gibson testified that she attempted to measure the floor in the P–2 hallway using her own level and according to her measurements, the floor was level. Ms. Gibson testified that in order to take a proper study of the hallway, you would need to perform a line or elevation test with a level big enough to cover the entire width of the hallway. (*T.* at 200).

Ms. Gibson testified that she did not perform an accident investigation after receiving the Incident Investigation Report because the information provided by the Petitioner did not suggest there was a safety hazard. Ms. Gibson testified that the Petitioner has completed many incident reports based on his position as a custodial supervisor so he is familiar with filing out the form and how to complete the questions asked. She testified that the Petitioner's description on the form he completed himself was that he was simply walking when his knee popped. (*T.* at 206–207 and *RX* 1).

Ms. Gibson testified that she had no recollection of a meeting involving the Petitioner and Jim Ma whereby Jim Ma was advocating placing carpet over asbestos tile in A – 3. Ms. Gibson testified that Jim Ma left Harper College approximately 6 to 7 years ago and she did not recall any meeting with him to this effect prior to his departure. (*T.* at 210). Ms. Gibson testified that the general consensus when dealing with asbestos abatement was that the tile should be removed and that carpet would never be placed over tile. (*T.* at 111–112).

Ms. Gibson testified that if there was a hazard detected in the concrete foundation of a hallway within the College, the issue would be remedied. (*T.* at 212). Ms. Gibson testified that since she has held her position of Safety Director at Harper College since 2000, she has not received any complaints about a sloped or slanted area in the P–2 hallway. (*T.* at 215).

Ms. Gibson testified that there was nothing in the Petitioner's description in the Incident Investigation Report that led her to believe there was a safety hazard involved. (*T.* at 216). Ms. Gibson testified that the Petitioner never advised her he was doing something other than walking. Ms. Gibson testified that the Petitioner never advised her that he twisted his foot in the carpet. Ms. Gibson testified that the Petitioner never indicated that the hallway was sloped or that there was an issue with uneven concrete in the P–2 hallways. (*T.* at 217). Ms. Gibson testified that the P–2 hallway is fully ADA compliant. (*T.* at 218).

CONCLUSIONS OF LAW

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

Issue C:

It is well settled that it is the employee's burden to establish all elements of his claim by a preponderance of the credible evidence. *Illinois Bell Telephone Company v. Industrial Comm'n*, 265 Ill. App. 3d 681; 638 N.E.2d 307 (1st Dist. 1994). The claimant has the burden of proving that his injury arose out of and in the course. *County of Cook v. Industrial Comm'n*, 68 Ill. 2d 24; 368 N.E.2d 1292 (1977). A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *Caterpillar Tractor Co. v. Industrial Comm'n*, 83 Ill. 2d 213; 414 N.E.2d 740 (1980).

Merely being at the place of employment when an accident occurs is not sufficient to establish compensability. *Brady v. Industrial Comm'n*, 143 Ill. 2d 542; 578 N.E.2d 921 (1991). *"Arising out of"* means the origin or cause of the accident presupposes a causal connection between the employment and the accidental injury. *Jones v. Industrial Comm'n*, 78 Ill. 2d 284;

399 N.E.2d 1314 (1980). In order for an injury to arise of one's employment, the risk must be: (1) a risk to which the public is generally not exposed but that is peculiar to the employee's work, or (2) a risk to which the general public is exposed but the employee is exposed to a greater degree. A peculiar risk is one that is specific to a line of work and not common to other kinds of work. *Carastamatis v. Industrial Comm'n*, 306 Ill App. 3d 206; 713 N.E.2d 161 (1st Dist. 1999); *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38; 509 N.E.2d 1005 (1987). Illinois case law has established that the act of standing and walking does not constitute a risk greater than that to which the general public is exposed. *Caterpillar v. Industrial Comm'n*, 129 Ill. 2d 52; 541N.E.2d 665 (1989); *Oldham v. Industrial Comm'n*, 139 Ill. App. 3d 594; 487 N.E.2d 693 (1985); *Elliott v. Industrial Comm'n*, 153 Ill. App. 3d 238; 505 N.E.2d 1062 (1st Dist. 1987); *Prince v. Industrial Comm'n*, 15 Ill. 2d 607; 155 N.E.2d 552 (1959), and *Karlman v. Citibank*, 101 IIC 0570. By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public. *First Cash Fin. Servs. v. Industrial Comm'n*, 356 Ill. App.3d 102, 105, 853 N.E.2d 799, 803 (2006).

In the present case, Petitioner testified that on August 23, 2013, he was walking through the P-2 hallway and suddenly noticed that his left knee got stuck in the carpet and buckled, and momentarily, he could not move. (*T.* at 34-40). On the very next day, the Petitioner completed an Incident Investigation Report and emailed it to the Safety Director, Sara Gibson and his supervisor, Darryl Knight. (*RX* 1). The Arbitrator notes that in the report, the Petitioner's description of the incident was that he "walking" in the P-2 hallway on his way to make an inspection in the W-Building when he heard his right knee pop. In terms of a cause, the Arbitrator notes that the Petitioner's answer in the Incident Report was that he was "clueless" about a cause, and that he "didn't do anything" and "was just walking when it happened." (*RX* 1). At trial, the Petitioner did not deny any of the explanations or answers he provided in the report never asked the Respondent if he could revise or add to the report.

The Arbitrator points out that the Form 45 prepared by Sara Gibson is consistent with the information provided by the Petitioner in the 5.3 Incident Investigation Report. (*RX* 2).

The Arbitrator also notes that the Petitioner's recorded statement was taken by Kathy Kallas on September 10, 2013, (just 19 days after the incident), with the Petitioner's oral permission. (*RX* 3). The Arbitrator finds that during the recorded statement, the Petitioner was asked a series of questions related to the incident on August 23, 2013 and had an opportunity to elaborate on any details surrounding the incident. His answers in the recorded statement with respect to what he was doing when the incident occurred are consistent with his statement in the 5.3 Incident Investigation Report he prepared on August 24, 2013. Specifically, the Petitioner stated that he "was walking, just walking" on P2 when he heard his knee pop. He advised Ms. Kallas that the flooring he was walking on was carpet but he offered nothing more

about the condition of the carpet. The Petitioner also told Ms. Kallas that he was walking at a normal pace and wasn't in a rush as he felt he had enough time to make sure the work was done before 7:30 – 8:00 am. (*RX* 3 at 4-5).

The Arbitrator further notes that when the Petitioner presented to Dr. Blomgren for initial medical treatment on August 29, 2013, the history recorded was: "The patient was walking to work and felt a pop and had immediate pain." (*Petitioner's Exhibit* (hereinafter, *PX*) 4). There is no mention of the Petitioner's left knee getting stuck in carpet or buckling. His history to Dr. Blomgren is consistent with the description of the incident he personally typed on the electronic 5.3 Incident Investigation Report, as well as the description contained in the Form 45 and the description petitioner provided in his recorded statement, which was that he was just 'walking."

The Arbitrator notes that although the Petitioner testified that he started thinking about the condition of the floor "immediately", he did not go back to the P-2 hallway until January 14, 2014, which was approximately 5 months after the incident and 2 months after he retained an attorney and filed an Application with the Commission. At trial, the Petitioner admitted that he shared the photographs he took on January 14, 2014 with his attorney but he has never shown them to Sara Gibson or Darryl Knight. (*T.* at 75–76, 77 and 138). The Arbitrator notes that on April 30, 2016, he took additional photographs of the P-2 hallway in anticipation of trial and used a level to measure the area where he claimed his foot got stuck in the carpet. The Arbitrator finds this evidence not credible as it was not gathered in close proximity to the alleged August 23, 2013, accident date, but rather, well over 2 ½ years after that date. Moreover, the Petitioner admitted that the carpet in the P-2 hallway had been changed since August 2013. The Arbitrator finds that the photographs and measurements taken by petitioner on April 30, 2016, do not accurately reflect the condition of floor in the P-2 hallway as it existed on August 23, 2013.

The Petitioner testified that although job duties included reporting any problems he observed within the facility, he never prepared a work order to address any concerns he may have had with the condition of the P-2 hallway floor. (*T.* at 107-108 and 135). The Arbitrator finds that if the petitioner felt there was an issue with the P-2 hallway floor that caused the incident on August 23, 2013, he had ample opportunity to bring it to the Respondent's attention, that of its third party administrator, or fill out a work order on his own given his position as a custodial supervisor for the Respondent.

The Arbitrator finds the Petitioner's testimony not credible regarding the Colleges' asbestos removal procedures and the make-up of the floor in the P-2 hallway. At trial, the Petitioner testified that in approximately 2012 – 2013, carpet was installed in the P-2 hallway on top of asbestos tile and that concrete was underneath the tile. (*T.* at 140). The Petitioner

19IWCC0149

also testified that when the Respondent first laid tile 30 years prior, the floor wasn't level and there were ridges and bumps. (*T.* at 80-81). The Arbitrator notes that the Petitioner was not employed by the Respondent some 30 years ago when the tile he referenced may have been laid as his employment with the College started on October 30, 2000. As such, the Arbitrator finds the Petitioner's testimony not credible regarding the make-up of the concrete floor. The Arbitrator notes that the Petitioner did not produce any convincing and credible evidence to support his theory that the tile or concrete floor under the carpet in the P-2 hallway had ridges or bumps.

Instead, the Arbitrator finds the testimony of Darryl Knight and Sara Gibson more credible regarding the composition of the floor in the P-2 hallway. The Arbitrator notes that Sara Gibson has been the Manager of Environmental Safety and Health for Harper College since 2000 and the issue of asbestos abatement fell within her job duties. (*T.* at 188-189). The Arbitrator finds Ms. Gibson's testimony credible regarding the Respondent not having a practice of installing carpet over asbestos tile. (*T.* at 190-191). The Arbitrator further finds that Ms. Gibson credibly testified that an asbestos abatement project took place in the P-2 hallway in 2005 whereby all asbestos tiles were removed down to the concrete floor of that hallway. The Arbitrator finds Ms. Gibson's testimony credible that there has not been tile underneath the carpet in the P-2 hallway since the 2005 asbestos abatement project. (*T.* at 190-191).

The Arbitrator finds that Darryl Knight credibly testified that there was not an asbestos abatement project involving the P-2 hallway between 2012 and 2013 as testified by the Petitioner. (*T.* at 163). Darryl Knight also credibly testified that there is only concrete under the carpet in the P-2 hallway and no tile as claimed by the Petitioner. (*T.* at 174).

The Arbitrator finds that the evidence presented at trial reveals that the Petitioner simply was walking through the P-2 hallway on his way to the W Building on August 23, 20013 when he heard his left knee pop. The Arbitrator does not find any credible evidence that supports the Petitioner's claim that his left knee got stuck in carpet or that there was an issue with the carpet or the floor in the P-2 hallway that caused the incident. The Arbitrator finds that his claim that there was an issue with the flooring of the P-2 hallway appears to have been developed after he retained an attorney in November 2013. The Arbitrator also finds it suspect that the Petitioner never raised an issue with the Respondent regarding the P-2 hallway floor after the incident in 2013 or before trial.

The Arbitrator finds that the act of "walking" is not a unique risk associated with the Petitioner's employment. In the case of *Nabisco Brands v. Industrial Comm'n*, 266 Ill. App. 3d 1103, 641 N.E.2d 578 (1st Dist. 1994), the Commission concluded that the "act of walking down the stairs at the employer's place of business by itself does not establish a risk greater than those faced outside the workplace." Moreover, in *Joy Mikeworth v. Quail Creek Country Club*,

05 IWCC 0807 (October 20, 2005), the employee had preexisting knee problems and was walking down a hallway carrying 3 letter envelopes when her knee popped. After noting there was no evidence of a defect in the floor or hurried activity on her part, the Commission concluded that the "act of walking while carrying little to nothing in one's hands does not establish a risk greater than that to which members of the general public confront. The Commission then concluded that the claimant's accident did not arise out of or on the course of her employment.

After carefully reviewing all of the testimony and documentary evidence presented at trial, in addition to reviewing the corresponding case law, the Arbitrator finds the Petitioner failed to meet his burden of proving that he sustained an accidental injury which arose out of and in the course of his employment with Respondent on August 23, 2013. The Arbitrator finds that the although the Petitioner was at work, he was not exposed to an increased risk in comparison to members of the general public by virtue of his employment. Based on the foregoing, all compensation is hereby denied.

Issues F, J, K, L and N:

Incorporating the aforementioned findings that Petitioner did not sustain an accidental injury on August 23, 2013 which arose out of and in the course of his employment, the Arbitrator finds the remaining issues of causal connection, medical bills, TTD, Respondent's credit, and the nature and extent of the injury to be moot.

Signature of Arbitrator

DECEMBER 30, 2016
Date

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF MADISON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Justin Pruitt,

Petitioner,

vs.

NO: 14 WC 25036

19IWCC0150

Pepsi Co.,

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, causation, medical expenses, temporary total disability and nature and extent, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

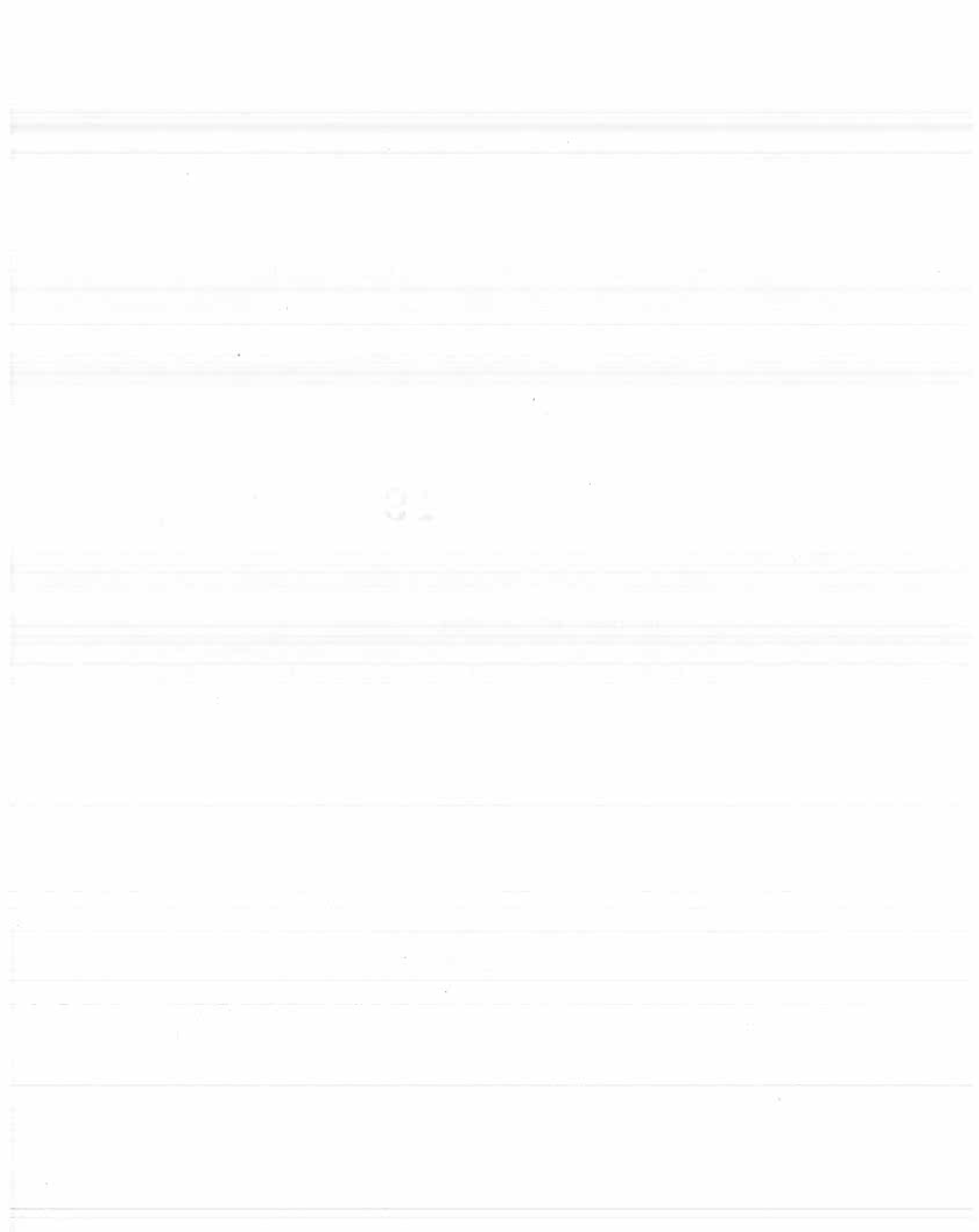
The Commission corrects the decision of the Arbitrator at p.2 of the form decision to show that Petitioner is entitled to temporary total disability from 2/26/14 through 8/26/15, for a period of 78-1/7 weeks (not 78 weeks).

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 10/19/17, with corrections, 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.



19IWCC0150

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: MAR 7 - 2019
o: 1/14/19
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRUITT, JUSTIN
Employee/Petitioner

Case# **14WC025036**

19IWCC0150

PEPSI CO
Employer/Respondent

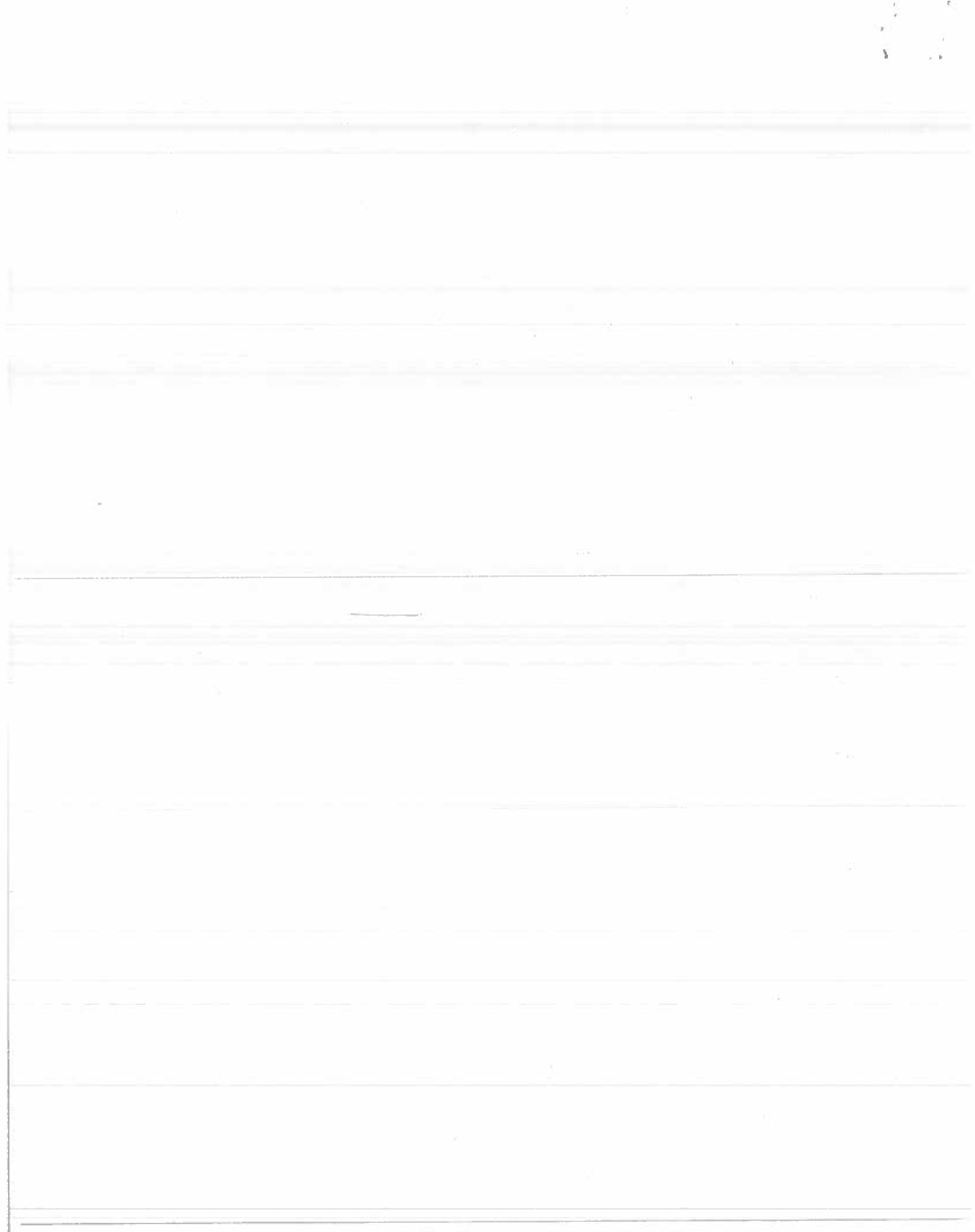
On 10/19/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62082

5001 GAIDO & FINTZEN
MICHAEL CHALCRAFT II
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602



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

JUSTIN PRUITT
Employee/Petitioner

v.

PEPSI CO.
Employer/Respondent

Case # **14** WC **25036**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 25, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**50,654.24**; the average weekly wage was $**974.12**.

On the date of accident, Petitioner was **26** 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**.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries which arise out of and in the course of his employment with the Respondent on February 25, 2014. The Petitioner's right shoulder condition is causally related to the February 25, 2014 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$649.41 per week for 78 weeks**, commencing **February 26, 2014 through August 26, 2015**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$477.14** to Petitioner (out-of-pocket payments), **$950.00** to Medical Associates of Jerseyville, **$1,269.56** to Advanced Imaging Consultants, L.L.C., **$25,498.00** to Jersey Community Hospital & Therapy, **$2,267.00** to Dr. Jonathan Blake, **$22,702.00** to Dr. Aaron Chamberlain, and **$38,462.23** to Barnes-Jewish Hospital Cam Surgery Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$584.47 per week for 70 weeks**, because the injuries sustained caused the loss of **14% of the person as a whole**, as provided in Section 8(d)2 of the Act.

Penalties and Fees pursuant to Sections 19(k), 19(l) and 16 of the Act are denied.

Respondent shall pay Petitioner compensation that has accrued from **August 25, 2015** through **October 21, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

October 12, 2017
Date

OCT 19 2017

STATEMENT OF FACTS

Petitioner is 28 years old, right hand dominant, and was employed by Respondent from November 2007 through 2/25/14. Petitioner worked in Respondent's warehouse where he loaded pallets and trucks with cases of soda through 2010. In the process, he would lift, stack and load approximately 1000 to 3000 cases of soda per shift. In 2010, Petitioner became a delivery driver. As a delivery driver, Petitioner operated a tractor-trailer for Respondent. The trailer had side load bays with roll-up side doors enclosing shelves of the product to be delivered. Petitioner testified these products included six, twelve and twenty-four packs of soda, CO2 containers, soda mix for fountain machines, twelve and sixteen packs of juices and 1 and 2 liter bottles, with weights ranging from 1 to 50 pounds. Petitioner testified he is 5'8" tall and he estimated that the delivery truck he drove is about 12' to 13' tall with half of the shelves being at or above his shoulder height.

His delivery route would begin at 5:30 a.m., and he would work 8 to 12 hours per day, 5 to 6 days per week. He would drive to retail stores, unloading the product, bringing the product into the stores and stocking the product as desired by the individual retailer. He would climb up and down the side of the truck, including reaching overhead, to pull the cases of soda and other products out of the truck. He estimated that he would deliver about 400 to 600 cases of soda per day. Additionally, Petitioner was responsible for rotating Respondent's products within the customer stores. He was a union member with Respondent and had group health coverage.

Petitioner is the owner of JP Auto Body & Detailing, which he described as a company that details automobiles for customers. He started the business in early 2014 and currently has three employees working in a four thousand foot shop, where the company details 3 to 4 vehicles per day. Sometime around February 2014, before he formally started the business, Petitioner testified he would detail cars in his father's garage, mostly on weekends and primarily for family and friends.

Petitioner testified he had never had any right shoulder injuries or treatment prior to November 2007.

While working for the Respondent as a delivery driver in the fall of 2013, Petitioner began to notice popping, pulling, burning and soreness in his right shoulder when he would pull overhead cases from the truck shelves. He testified he continued to work despite ongoing symptoms until 2/25/14. On that date, Petitioner testified his right shoulder popped while he was pulling an approximate 35 pound case of soda from an overhead shelf when it slipped, causing his right arm to be pulled towards his back while in abduction. He felt an immediate burning sensation in his shoulder and his right arm went numb. Petitioner sought treatment that day at his primary care provider, Medical Associates of Jerseyville, testifying he called his supervisor Frank Pesha that evening to

report the incident. The Respondent did not offer evidence to dispute Petitioner's testimony regarding the reporting of the injury to Mr. Pesha.

Dr. Giovanelli's 2/25/14 report states: "When it got cold this fall of 2013, he was taking a coke box off the top of the truck and heard a very loud pop and was unable to do further muscular motion with the right arm. He answers that he has had numbness since then." Petitioner testified that he told Dr. Giovanelli he began to develop right shoulder problems in the fall of 2013 but was able to continue working until his arm was wrenched backwards earlier that day, and he had no idea how the doctor's understanding was that he was unable to use his right arm since the fall of 2013 given he had worked that day. Petitioner testified as follows:

Q. What did you tell him?
A. I told him that it started kind of aggravating in the fall of 2013 but that was – that was it.

Q. Did you tell him about the -- that it was popping and you felt the burning since the fall?
A. Yes.

Q. And what did you tell him specifically happened on February 25, 2014?
A. I told him what I was doing, I was pulling a case of two-liter bottles out of the top bay and when I pulled it down it slipped off the top case and I tried to catch it and when I did it pushed my arm back to where it popped it, made it start burning and went numb.

Q. Did you tell him that you were unable to use your right arm since that accident happened that day?
A. Yes.

The report noted Petitioner also performed some auto detailing on weekends. The diagnosis was acute tendonitis. Petitioner was taken off work through 3/2/14, to return with restrictions as of 3/3/14, which Petitioner testified the Respondent did not accommodate. (Px2). He hasn't worked for Respondent since 2/25/14.

A right shoulder MRI was also prescribed, and the 3/4/14 films showed impingement syndrome from the AC joint and coracoid process respectively, mild AC joint hypertrophy and degenerative changes and moderate narrowing of the subacromial space with no discrete rotator cuff tear. In his 3/8/14 review of the films, Dr. Giovanelli indicated Petitioner would need to be referred to orthopedics, but on 3/7/14 indicated he could return to restricted work on 3/10/14 (no lifting over 50 pounds and no overhead work or lifting). (Px2). Petitioner testified that the Respondent did not accommodate these restrictions, that his activities in detailing cars did not exceed these restrictions, and he had employees to perform any tasks that would. He denied performing detailing work during times he was medically held off work.

Petitioner initially saw Dr. Blake on 3/13/14. (Px3). Petitioner completed a "New Patient" intake sheet that day noting complaints of "Right shoulder sever [sic] pain in it. Can't lift with weight or move certain direction," with an onset of: "Hurt while lifting something above my head." Petitioner testified he told Dr. Blake about the 2/25/14 incident and that he had begun to develop symptoms that day. Dr. Blake's report of 3/13/14 notes persistent right shoulder pain "since he had an injury while lifting some soft drinks and has been going on for three months despite activity precautions, icing, anti-inflammatories." Right shoulder x-rays on 3/13/14 showed no evidence of bone or joint disease. Dr. Blake noted Petitioner had good strength and function, but had a pain syndrome which he did not think would be amendable to therapy. He diagnosed AC joint arthrosis and a questionable labral tear, and he injected the right shoulder. (Px3).

Petitioner testified the injection did not help. Dr. Blake's 3/28/14 report notes Petitioner had 3 days of relief before his pain returned, and right MR arthrogram was prescribed. The 4/9/14 contrast films noted a strain and/or degenerative changes to the supraspinatus tendon with no rotator cuff tear visualized, AC joint hypertrophy and moderate inflammation of the AC joint with minimal narrowing of the subacromial joint space consistent with mild impingement syndrome. No rotator cuff or labral tears were identified. On 4/11/14, Dr. Blake indicated Petitioner's options were conservative care of lateral clavicle excision. (Px3).

On 3/31/14, Dr. Giovanelli increased Petitioner's restrictions to only 25 pounds. Again, Petitioner testified Respondent did not accommodate them. On 4/11/14, Dr. Giovanelli noted Petitioner was to undergo shoulder surgery the following week and was there "for disability papers." In the disability paperwork for Sedgwick, a Dr. Murray at Medical Associates of Jerseyville checked boxes indicating Petitioner's condition was not work or accident related, and that Petitioner had been referred to Dr. Blake and was to undergo surgery. (Px2).

On 5/1/14, Dr. Blake performed the right lateral clavicle excision surgery, and Petitioner was held off work. On 5/14/14, Dr. Blake noted Petitioner was progressing very well and allowed Petitioner to work with restrictions of no heavy, overt or vigorous activity. Petitioner again testified that the restrictions were not accommodated by Respondent. On 5/20/14, Dr. Blake prescribed physical therapy, which was initiated on 5/22/14 at Jersey Community Hospital. On that date, the therapist recorded that in the fall of 2013, Petitioner felt a pop in his right shoulder after picking up an object, after which he began to notice pain in his shoulder with overhead reaching and lifting. Earlier in the week, the therapist recorded, Petitioner felt a pop in his shoulder while cleaning a window with a return of significant pain. (Px5). Petitioner explained that his shoulder did pop while wiping a window, but that the popping occurred while he was following Dr. Blake's restrictions of no heavy, overt or vigorous activity, as noted by the May 22, 2014 physical therapy record. He testified that he was advised by Dr. Blake to gradually increase his activities.

Petitioner testified that the surgery and post-surgical therapy did not resolve his shoulder symptoms, and he continued to feel popping in the shoulder with everyday activities. On 6/11/14, Dr. Blake noted slow progress in therapy with complaints of intermittent, sometimes severe, ongoing pain. On 7/9/14, Petitioner reported he was done with therapy and had continued symptoms with overhead lifting. Petitioner requested an injection, which Dr. Blake performed on 7/9/14, but Petitioner testified the injection made his shoulder condition worse. Dr. Blake also reduced Petitioner's restrictions to no working above shoulder level on that date, but Petitioner testified Respondent still had no work available for him. (Px3). A disability slip completed by Dr. Blake was left blank as to whether the condition was work related, but noted it was not "accident related." (Px3).

On 8/7/14, Petitioner reported his symptoms were aggravated by daily activities, sometimes radiating into the neck, and nothing relieved his symptoms. At that point, Dr. Blake noted it appeared Petitioner was evidencing glenohumeral instability and referred him for a second opinion.

Petitioner next sought treatment with Dr. Chamberlain of Washington University on 8/18/14. Intake forms indicate a 6 month history of right shoulder pain, and that he got worse when the shoulder popped and gave out about 3 months ago. Dr. Chamberlain's note states Petitioner reported a 6 month history of right shoulder pain "after an episode where he felt that the shoulder popped and gave out and was painful." Petitioner testified he told Dr. Chamberlain about his work accident, and that he felt better until about a month after surgery when he felt the shoulder pop again with increased pain. Petitioner testified the shoulder pop occurred while he was wiping a window and that this activity was not in excess of his work restrictions from Dr. Blake. Petitioner complained to Dr. Chamberlain of activity related pain and difficulty sleeping. Exam was essentially normal other than mildly positive impingement with pain lateral to the acromion. X-ray was also relatively benign. Dr. Chamberlain noted the pain was of "unclear etiology", with possible rotator cuff tendonitis/bursitis versus

possible labral injury. (Px6). He recommended an injection, which was performed on 9/2/14 into the glenohumeral joint. (Px7).

Petitioner testified that Dr. Chamberlain's injection also did not help. On 9/29/14, Dr. Chamberlain noted Petitioner reported about 50% relief for 4 days, after which the pain returned, and Chamberlain then prescribed a repeat MR arthrogram to evaluate the labrum, noting "He had a previous MRI that was attempted but was unsuccessful due to technical difficulties at another location." (Px6).

The 10/6/14 testing showed a nondisplaced type II SLAP lesion, a short partial-thickness undersurface tear of the right anterior distal supraspinatus tendon and the prior clavicle resection. There was no full thickness tendon tear, retraction or muscle atrophy. (Px7). At the follow up with Dr. Chamberlain, Petitioner indicated he had more pain than he wanted to live with, and a SLAP repair was prescribed. Dr. Chamberlain stated: "We discussed that this may provide some stability at the biceps anchor it may help some of his pain. However, it is not guaranteed to relieve all the pain in the shoulder as it is difficult to understand which SLAP tears are clinically pathologic or not." The clinical suspicion, however, was high enough to proceed. (Px6).

On 11/7/14, Dr. Chamberlain performed a second surgery involving an arthroscopic SLAP repair with subacromial bursectomy. He noted the biceps anchor was unstable and consistent with a large type II SLAP tear. The rotator cuff was intact with healthy appearing humeral head and glenoid cartilage. Some subdeltoid adhesions were also divided. Petitioner was held off work. (Px6 & 7).

Following surgery, Petitioner was referred to physical therapy on 11/7/14. He developed the flu while rehabilitating his shoulder. A report notes he became violently ill and felt something pull in his shoulder during a vomiting episode. Dr. Chamberlain noted this incident in his 1/8/15 report, and that Petitioner reported his pain had been stable since then.

Petitioner continued to follow up with Dr. Chamberlain post-surgery with improved range of motion and strength, but Petitioner continued to report pain and ache in the shoulder. Dr. Chamberlain noted on 2/19/15 that Petitioner "had a couple setbacks during his postoperative period." Another injection was performed in the glenohumeral joint on 2/24/15, which Dr. Chamberlain reported provided noticeable improvement. On 5/15/15, however, Dr. Chamberlain noted Petitioner reported continued significant pain, particularly with activities over the shoulder and reaching across his body. Dr. Chamberlain believed the pain was likely still due to the superior labrum construct, and a third surgery was performed on 5/26/15 involving arthroscopic biceps tenodesis and subacromial bursectomy. The report notes the SLAP repair was still intact, but was somewhat loose with unstable tissue. Petitioner was released from the hospital with a sling, instructed to bear weight as tolerated, and excused from work. He was then referred back for additional therapy on 7/14/15. At the last visit with Dr. Chamberlain on 8/25/15, Petitioner stated that he was very pleased with the result. Dr. Chamberlain indicated he could continue to return to activities as tolerated. He recommended some additional strengthening and conditioning therapy, but this was not authorized by the insurance company. (Px6).

During the course of his treatment by Dr. Chamberlain, Respondent informed Petitioner that his employment had been terminated. During the periods of time he has been excused from work, or the periods of time Respondent has been unable to accommodate his work restrictions, which was not rebutted by Respondent. Petitioner testified he received no temporary total disability benefits and that Respondent had never advised him why. Following the third surgery, Petitioner testified that Respondent notified him he was terminated, and his group medical benefits then ended. Px1 indicates the termination was effective on 3/4/16. He was released from care by Dr. Chamberlain on 8/25/15.

Pursuant to Section 12 of the Act, the Respondent had Petitioner examined by orthopedic surgeon Dr. Rotman on 12/21/15. Dr. Rotman reviewed Petitioner's related medical records, correspondence from Respondent's attorney and surveillance video (Rx2) obtained by Respondent. His examination of Petitioner, which took place subsequent to his last surgery and release from Dr. Chamberlain's care, indicated a loss of right shoulder range of motion. Dr. Rotman indicated he saw no signs of symptom magnification or malingering with Petitioner. Petitioner told Dr. Rotman that he injured his right shoulder while working at Pepsi unloading an eight, two-liter case from the side bay shelf of his truck, when he wrenched his shoulder into external rotation and felt a pop in the joint.

Via information from Petitioner and Respondent's counsel, Dr. Rotman's understanding was that Petitioner started his employment with Respondent in 2008 working in the company's warehouse where he loaded pallets with cases of soda and loaded trucks. This job required Petitioner to lift, stack and load 1,000 to 3,000 cases of soda a night, a job Petitioner performed from 2008 through 2010 before becoming a delivery driver. Dr. Rotman recorded that the delivery driver job required Petitioner to make deliveries to customers where he would unload cases of soda from the side bins of the truck, bring the product into the stores and stock the product. This involved climbing up and down the side of the truck, reaching overhead and retrieving cases of soda weighing from one to fifty pounds. Throughout the day, Petitioner would unload, deliver and stack about 400 to 600 cases of soda per day. (Px8; Rx1).

In his report, Dr. Rotman indicated Petitioner's treatment was somewhat prolonged. He questioned whether the pain he had prior to the initial surgery was actually from the SLAP lesion, noting it would not have been discovered during the initial open decompression surgery. He questioned the use of only one anchor to repair the SLAP tear at the second surgery, but also noted: "It is actually fairly common for superior labral lesions to heal poorly or partially, such as in this case, even if two or three anchors are placed." He indicated the generally recommended treatment is debridement and biceps tenodesis, particularly with patients over age 40, which is what Dr. Chamberlain performed at the third surgery. He believed Petitioner had a good overall outcome, but it took a long time to get there. He opined it would be unlikely for one lifting incident to cause a SLAP lesion, and such an incident would not have caused the AC joint injury, and wouldn't have necessitated the need for distal clavicle resection. Any type of torqueing injury would have triggered discomfort form someone with these preexisting conditions. He noted SLAP tears were generally chronic and related to throwing or sports at a younger age, and to heavy shoulder use or lifting over a prolonged time in older patients. Dr. Rotman indicated that a lot of people have asymptomatic SLAP lesions where the pain is triggered "by an event like this or from chronic, repetitive shoulder activities that necessitate eventually treatment." He noted surveillance video showed Petitioner using his right shoulder "pretty well at work." He indicated it was not surprising that people can do well even with partially healed SLAP tears, and most people can continue full duty with them. He felt it was obvious that Petitioner was working and not just supervising his detailing business based on the video, and "in fact, this may have had a lot to do with the overall condition in his shoulder just as much as in anything he may have been doing while working (for Respondent)." In Dr. Rotman's opinion, Petitioner's pain was "triggered by his activities at work only." Thus, it was impossible for him to say whether Petitioner's treatment and surgeries were truly related to the 2/25/14 incident. He could have easily aggravated the shoulder with his detailing work, which Dr. Giovanelli noted he was doing at the time of his initial evaluation. The "pop" the Petitioner had at the time of the incident was clicking that occurs with SLAP lesions. The report concludes: "It is also clear here that if he did aggravate his shoulder after surgery, it might have been from his detailing and work activities outside of his work at (Respondent) since he never returned to work for (Respondent)." (Px8; Rx1).

Dr. Rotman opined that it is unlikely that the underlying pathology found in Petitioner's right shoulder, AC joint arthritis and a SLAP tear, was caused by the one lifting incident of 2/25/14. Rather, Dr. Rotman testified that the type of repetitive, overhead lifting that Petitioner performed in the course of his job as a delivery driver

could have caused the superior labral lesions and underlying AC joint arthritis that led to the triggering event of pain on 2/25/14, which in turn necessitated the surgical procedures. In summary, Dr. Rotman opined that Petitioner's labral lesions and AC joint arthritis became symptomatic either through a single lifting incident, as described by Petitioner, or through the repetitive overhead lifting required by his job as a delivery driver for Respondent. (Px8).

In addition to Petitioner informing Dr. Rotman of his detailing business, Dr. Rotman reviewed the noted surveillance video from 3/25/15 and 5/5/15. Dr. Rotman testified that the Petitioner's activities as depicted on the video would not have caused injury to the superior labrum or the AC joint. Dr. Rotman testified: "all [he] can really glean from the videotape is that he's doing fine." He testified that it would be speculative to say that anything specifically associated with Petitioner's auto detailing business had anything to do with his shoulder condition.

While he testified that he would have performed a different arthroscopic procedure initially, Dr. Rotman agreed that the pre-operative and surgical treatment Petitioner received for the right shoulder was reasonable and necessary. With respect to the surgeries, Dr. Rotman explained that at that time of the first surgery, only a distal clavicle resection was performed, and that it was likely the Petitioner had the SLAP tear at the time of that surgery, but it was not visualized arthroscopically. The second surgery was arthroscopic, which revealed the SLAP tear, and that was repaired using an anchor. When that failed to heal properly, it led to the third surgery to correct the condition.

Dr. Rotman does not disagree with the periods of time Drs. Giovanelli, Blake and Chamberlain excused Petitioner from work, nor did he disagree with the periods of time Petitioner was placed under work restrictions by those physicians. At the time of his examination by Dr. Rotman, Petitioner had complaints of occasional discomfort, deep in the shoulder joint, but the pain would abate quickly. He had minimal stiffness in movement of his right arm in all directions and slight pain with rotation to the outer shoulder. Dr. Rotman testified that Petitioner has evidence of permanent impairment by virtue of his loss of motion with abduction and flexion and external and internal rotation. Specifically, Dr. Rotman found 30 degrees less external rotation in Petitioner's right shoulder compared with the left, 10 degrees loss of abduction and flexion on the right compared with the left and loss of internal rotation on the right compared with the left. Dr. Rotman agreed with Dr. Chamberlain that Petitioner had reached maximum medical improvement and was able to work without permanent restrictions.

With regard to the 12/21/15 exam with Dr. Rotman, Petitioner testified he did report the initial onset of his symptoms and the 2/25/14 work accident. They discussed his job duties with the Respondent and in his detailing business.

Currently, the Petitioner testified his right shoulder feels the same as it did when he saw Dr. Rotman on 12/21/15. He has occasional shoulder pain, usually with overhead lifting or prolonged use. He has tightness and stiffness in the shoulder, usually in the morning or at the end of the day. His strength is still lacking versus prior to the development of symptoms. He doesn't always sleep comfortably, especially on his right side. He can reach around to tuck his shirt in, but can't lift a gallon of milk to head level without bending his arm. He reported ongoing problems with heavy lifting and overhead lifting. He can get a locking feeling even just from washing his hair in the shower.

On cross examination, Petitioner testified he started JP Auto Detailing in the early part of 2014 – he could not recall the exact date, but it was not prior to the last day he worked for Respondent, 2/25/14. The business is housed in a 4000 square foot pole barn, and he can fit about 4 cars there at one time. There are a few bays and a

showroom. He agreed he did auto detailing on weekends in his dad's garage before that while he was working for Respondent, but he couldn't recall if it went back to the fall of 2013 or not. He testified that in the summer of 2014 and spring of 2015 he didn't really detail cars himself, as he had employees and "I more supervised than anything," though he would and does help when needed. The business details three to four cars per day. His day to day duties include answering phones, ordering parts and scheduling, but again he does help with detailing when his employees need help. He agreed he told Dr. Giovanelli on 2/25/14 that he was detailing cars, but at that time it was just for family or his personal vehicles.

Petitioner testified his 8/25/15 release by Dr. Chamberlain was to unrestricted duty. As to his assisting his employees as needed, Petitioner reiterated that at no point while he worked under restrictions did he go beyond those restrictions.

The Arbitrator reviewed the video surveillance submitted into evidence by Respondent (Rx2), and notes that the description of the video by Dr. Rotman in his report was an accurate description. (Rx1).

Petitioner testified he reviewed the billing information in Px9, and indicated it is accurate as to the bills he's received, and what has been paid and what remains outstanding.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained his burden or proof that he sustained accidental injuries arising out of and in the course of his employment on 2/25/14.

Petitioner's original Application for Adjustment of Claim alleged injury to his right shoulder and body as a whole as a result of the 2/25/14 injury. Following the deposition of Dr. Rotman and, based on his opinions, Petitioner filed an amended Application pleading alternative theories of recovery including the 2/25/14 accident "and/or repetitive trauma." Upon review of the evidence, the Arbitrator notes that both theories hold water in this case, but that something occurred on 2/25/14 that altered the condition to the point where Petitioner developed numbness and an inability to continue working.

Petitioner testified that his right shoulder began popping when he would pull product from the overhead bins of his delivery truck in the fall of 2013 while performing his job as a delivery driver, and his right arm became sore with a burning sensation in the arm. Nevertheless, he continued performing his regular job for Respondent until 2/25/14. On that day, he credibly testified that while unloading a case of soda from an overhead bin of the truck his right shoulder was wrenched into external rotation, he felt a pop in his shoulder, he felt an immediate burning sensation in his shoulder and his right arm went numb. Petitioner sought medical attention for his shoulder injury on the day of his accident and notified his supervisor, Frank Pesha, of the accident on that date as well.

The Arbitrator puts significant weight on the fact that Respondent did not dispute that the Petitioner reported the 2/25/14 incident, or even that his testimony at hearing was factually incorrect in some fashion. Additionally,

while Dr. Giovanelli recorded that Petitioner hurt his shoulder removing a box of soda from the top of his truck in the fall of 2013, he also recorded that Petitioner had been "unable to do further muscular motion with the right arm," which is clearly not the case. The Arbitrator also acknowledges that Dr. Blake and Jersey Community Hospital therapy recorded that Petitioner complained of a three month history of right shoulder pain after lifting some soft drinks.

Despite these histories, the evidence indicates the Petitioner continued to work in a job that the Arbitrator considers to be extremely heavy and grueling to his shoulders, with significant amounts of unloading, lifting and moving particularly heavy soft drink and soft drink related items.

Respondent's Section 12 examiner, Dr. Rotman, considered the entire history of the onset of Petitioner's shoulder problems. His understanding of the Petitioner's job duties comports with the Petitioner's testimony. Dr. Rotman opined that it is unlikely that the underlying pathology found in Petitioner's right shoulder was caused by the one lifting incident of 2/25/14. However, he also testified that the Petitioner's job duties as a delivery driver with repetitive, overhead lifting of soft drink products, are the type of activities that can cause a SLAP tear and contribute to AC joint arthritis. While he disputed any causal relationship of the 2/25/14 injury to the Petitioner's SLAP tear and AC joint arthritis, he also testified that the incident on that date could have triggered symptoms, which in turn necessitated the surgical procedures. The underlying conditions themselves would not require surgery in and of themselves. It would be the symptoms themselves that would lead to consideration of surgery.

Despite Respondent's assertion to the contrary, there is no evidence in the record to suggest that Petitioner injured his right shoulder while working at his auto detailing business. While the activities there very likely involve a reasonably significant amount of shoulder use, he testified that he had employees to perform activities that went beyond his work restrictions, the activities clearly would not have involved the same amount of force or overhead work as unloading and moving hundreds of cases of soda, and, even if the detailing activities were causative, that does not take away from the fact that the Petitioner's work duties are causative. Respondent's own Section 12 examining physician, Dr. Rotman testified that it would be "speculative" to say that anything specifically associated with Petitioner's auto detailing business had anything to do with his shoulder condition.

Overall, regardless of whether the Petitioner's work duties for his detailing business, the Arbitrator believes it would be very difficult to realistically find that the Petitioner's work duties with Respondent were not at least a competent cause of his right shoulder condition. It certainly is arguable by Respondent that the Petitioner sustained an accident in the fall of 2013 which resulted in internal derangement in his right shoulder, and failed to report same. However, the distinguishing factor against this argument is that there is no evidence the Petitioner sought treatment at that time, and he instead continued to perform his work duties which, again, appear to the Arbitrator to extraordinarily involve heavy use of his shoulders. Additionally, the Petitioner was honest about the start of his symptoms, but that he had a significant incident on 2/25/14 which changed his condition in a significant way. Also, again, the fact that the Petitioner testified in unrebutted fashion that he reported a specific incident occurring that day carries weight here in the credibility of the Petitioner. The Arbitrator believes that the Petitioner may well have suffered an injury prior to 2/25/14, but 2/25/14 strongly appears to be the proverbial straw that broke the camel's back.

By the preponderance of the credible evidence, the Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 2/25/14, and that the Petitioner's right shoulder condition is causally related to the 2/25/14 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:

With regard to the issue of medical expenses, the Respondent stipulated at the time of hearing that the Respondent's defense with regard to this issue rested on liability, and that Respondent did not dispute the reasonableness and necessity of the treatment received by Petitioner relative to his right shoulder. There is no evidence of unreasonable or unnecessary medical treatment found in the record by the Arbitrator. There were questioned by Dr. Rotman as to whether he would have proceeded with the same surgeries as those initially attempted by Dr. Blake and Dr. Chamberlain, but he also did not dispute that the choices made by those surgeons were reasonable given the findings at the time. Respondent also did not dispute the reasonableness of the medical expenses billed, or that the bills in evidence are the result of the medical treatment Petitioner received for his shoulder. Rather, Respondent's dispute is based solely on its liability for the underlying claim of injury, which has been addressed above.

Respondent is therefore ordered to pay the following medical bills to the corresponding medical providers pursuant to Sections 8(a) and 8.2 of the Act as follows: $477.14 for out-of-pocket medical expenses; Medical Associates of Jerseyville: $950.00; Advanced Imaging Consultants, L.L.C: $1,269.56. Jersey Community Hospital & Therapy: $25,498.00; Dr. Jonathan Blake, D.O: $2,267.00; Dr. Aaron Chamberlain, Washington University School of Medicine Department of Orthopedic Surgery: $22,702.00; Barnes-Jewish Hospital Cam Surgery Center: $38,462.23.

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 Respondent in this case, as with medical expenses, stipulated prior to hearing that the dispute regarding this issue is based on liability for TTD rather than the claimed period of temporary total disability. As liability in this case has been determined by the Arbitrator in Petitioner's favor, the Arbitrator finds that the Petitioner is entitled to TTD benefits from 2/26/14 through 8/26/15. Additionally, the Arbitrator notes that Respondent's Section 12 examining physician, Dr. Rotman, testified that he did not disagree with the periods of time Drs. Giovanelli, Blake and Chamberlain excused Petitioner from work or held him to work restrictions. Again, Respondent also did not present any evidence that Respondent was able to or offered to accommodate Petitioner's work restrictions. Petitioner testified that while he was under restrictions imposed by his treating physicians, he supervised the work of his employees and assisted only when the tasks he performed were within his restrictions. While video was presented indicating the Petitioner was performing work for his detailing business, nothing depicted, in the Arbitrator's view, invalidated the Petitioner's testimony in this regard.

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

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

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

injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment report and/or opinion was submitted into evidence by either party. As such, this factor carries no weight.

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 delivery driver at the time of the accident. He no longer works in that position because he was terminated by Respondent prior to his release. However, he has been released to unrestricted work duties, and in early 2014 had already started his own auto detailing business. Thus, while the Petitioner has not returned to the job he had at the time of the accident, the job change was, at least in part, voluntary. It is clear that the Petitioner's shoulder would have been heavily involved in his work duties had he returned to work for Respondent, but it is also clear that, at least when it comes to his part in actually detailing cars, the shoulder would also have more significant use than a more sedentary position. Overall, the Arbitrator finds that this factor supports a somewhat higher degree of permanency than would be typical for this type of injury.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 26 years old at the time of the accident. Neither party has submitted any real evidence of how the Petitioner's age may impact his permanent partial disability relative to this accident and injury.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no real evidence was presented with regard to what the Petitioner is earning in his detailing business. He does have several employees, and it appears that, based on the evidence presented, this is now the Petitioner's full time position. Again, the Petitioner has been released to unrestricted work duties. Given that there is no real way to ascertain the Petitioner's earning capacity or exactly how it might be impacted by the injury based on the evidence in the record, the Arbitrator gives this factor minimal weight.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner testified that he experiences occasional, activity related pain associated with overhead activity or overuse of his right arm. He feels tightness and stiffness in his shoulder when he awakens in the morning and at the end of a strenuous workday. He has less strength in his right extremity compared to what he had before the onset of his condition and has trouble sleeping on his right side. Petitioner feels that his shoulder "locks up" when he overuses the shoulder, so he avoids heavy lifting.

Dr. Rotman testified that Petitioner has evidence of permanent impairment by virtue of his loss of motion with abduction and flexion and external and internal rotation. Specifically, Dr. Rotman found 30 degrees less external rotation in Petitioner's right shoulder compared with the left, 10 degrees loss of abduction and flexion on the right compared with the left, and loss of internal rotation on the right compared with the left. The treatment medical records corroborate this testimony and that of the Petitioner.

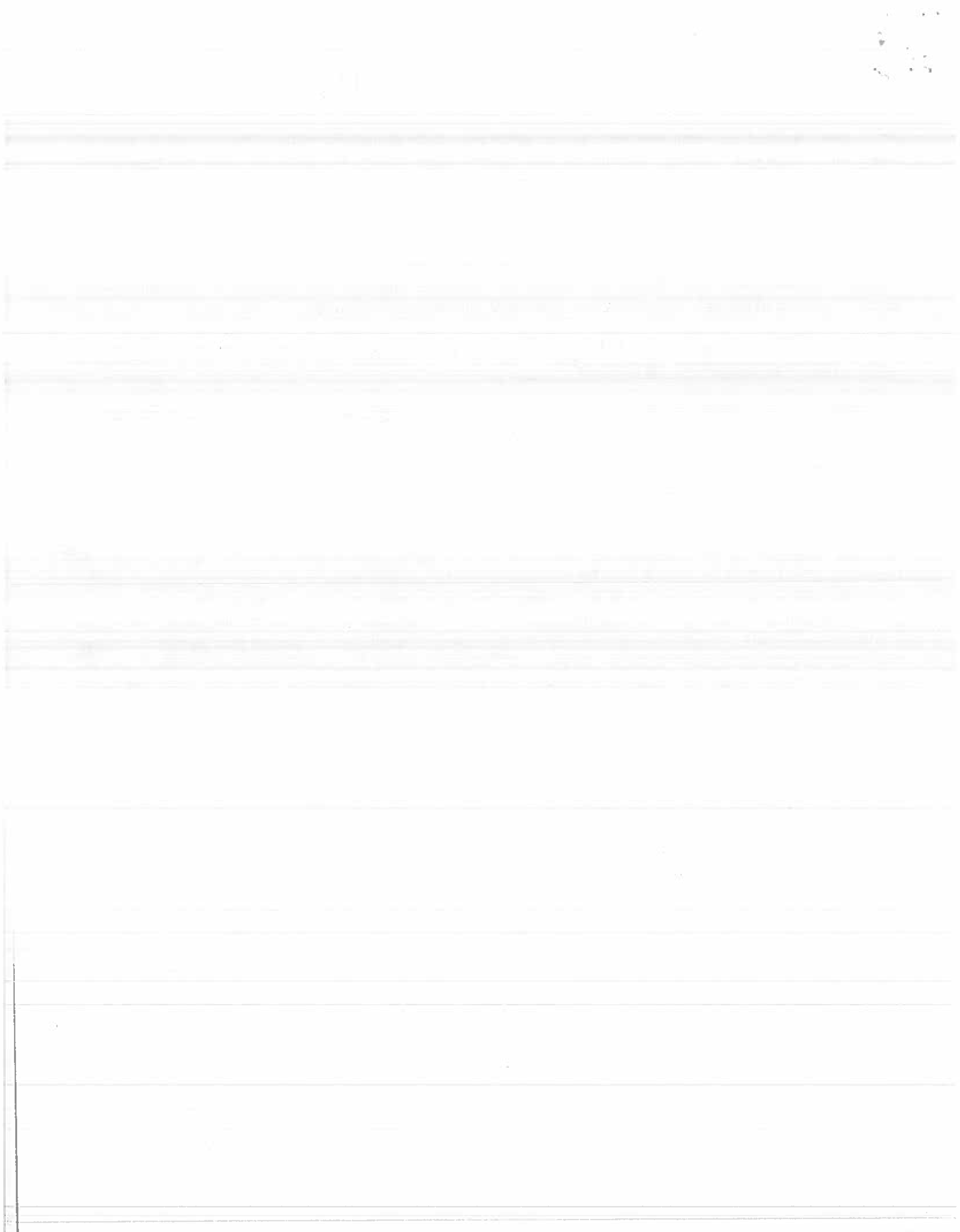
Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries and similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of the loss of use of 14% of the person as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner failed to prove entitlement to penalties and fees in this case pursuant to Sections 19(k), 19(l) and 16.

While the Petitioner testified that he never received a reason from Respondent for its failure to pay benefits in this case, the record reflects that there were multiple discrepancies in this case that provided the Respondent with reasons to dispute the compensability of this case.

First, the Petitioner is arguing alternate theories of recovery, while initially Respondent only alleged the specific trauma of 2/25/14. The records of both Dr. Giovanelli and Dr. Blake reference injury occurred three months before the alleged accident date. While the Arbitrator has determined that, in his view, the Petitioner testified credibly regarding the 2/25/14 injury, at the time the Respondent's dispute was reasonable. Additionally, the Petitioner has clearly engaged in work activity for his business detailing cars during periods where he was restricted from returning to work for the Respondent, including during the period between Petitioner's second and third surgeries. While the Petitioner testified he did not work beyond his restrictions while performing such activities, the surveillance video clearly depicts the Petitioner performing such work. Until the report and testimony of Dr. Rotman were obtained by Respondent, the Arbitrator has reviewed no specific causation opinion in the records of Dr. Giovanelli/Dr. Murray or Dr. Blake. While it may be argued that penalties may apply subsequent to the deposition of Dr. Rotman and the opinions he provided, the same facts still existed at that time as noted above, and thus the Arbitrator does not find that the defenses presented by Respondent in this case were unreasonable, vexatious or without cause. As such, Sections 19(k), 19(l) and 16 are not applicable in the Arbitrator's view. Penalties and fees are therefore denied.



STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF MCLEAN	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Stanford,
Petitioner,

vs.

NO: 14WC 37195

19IWCC0151

State of Illinois/Illinois State University,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 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.

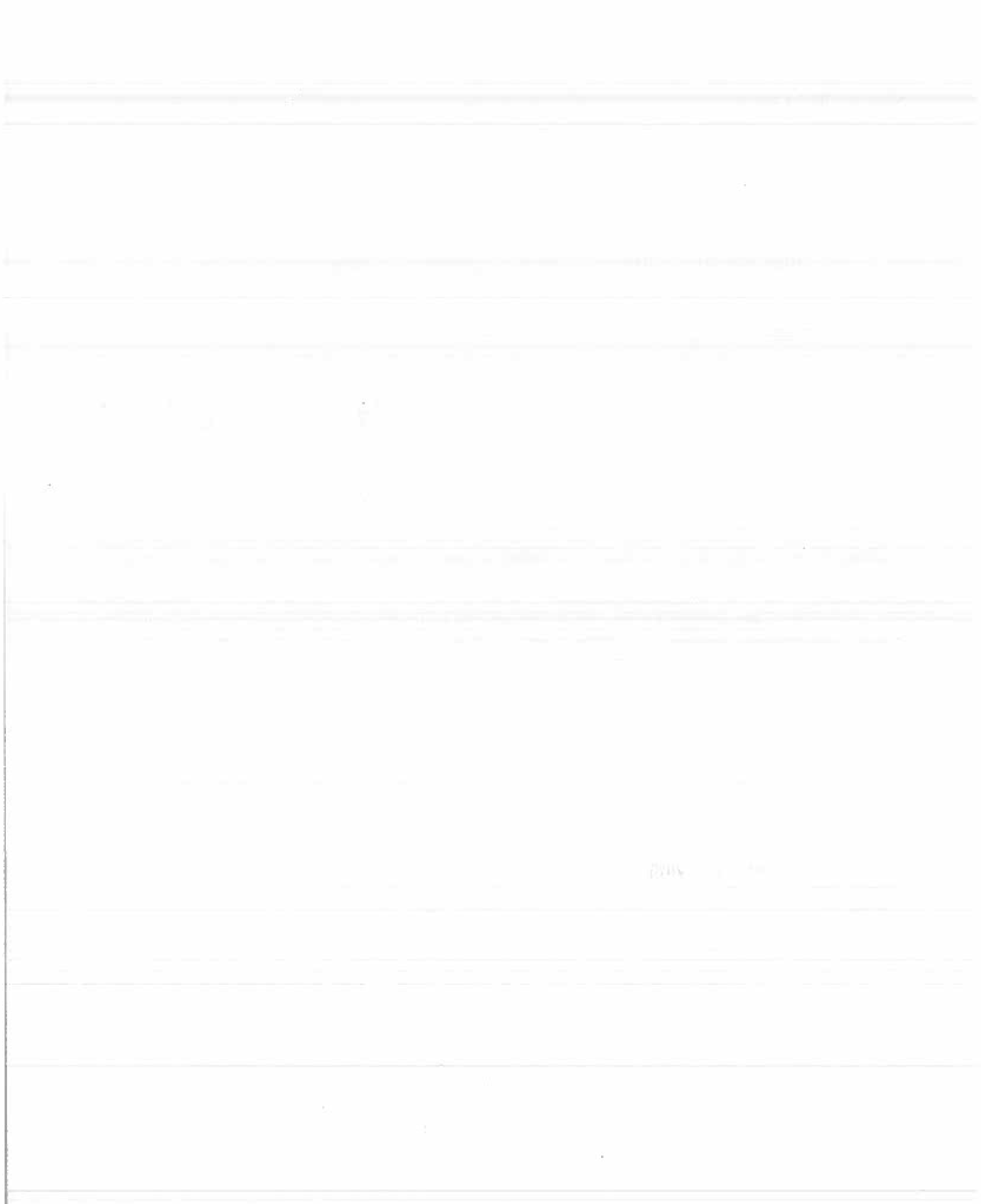
No bond or summons required for State of Illinois cases.

DATED: MAR 7 - 2019
O011419
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STANFORD, CHRIS
Employee/Petitioner

Case# **14WC037195**

14WC039395

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

19IWCC0151

On 3/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

0988 ASSISTANT ATTORNEY GENERAL
JORDAN A HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

MAR 2 - 2018

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

19IWCC0151

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Stanford
Employee/Petitioner

v.

State of Illinois/Illinois State University
Employer/Respondent

Case # 14 WC 37195

Consolidated cases: 14 WC 39395

An *Application for Adjustment 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 **Bloomington**, on **January 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 15, 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.

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

In the year preceding the injury, Petitioner earned **$15,806.82**; the average weekly wage was **$303.98**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services in the amount of **$79,490.75** (as included in Petitioner's Exhibit 10) as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$253.00/week** for **17 1/7** weeks, for the timeframe of **August 11, 2014** through **December 9, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$253.00/week** for a further period of **110.75 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **12.5% loss of use of the left hand, 12.5% loss of use of the right hand, 12.5% loss of use of the left arm and 12.5% loss of use of the right arm.**

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

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

3/1/18
Date

MAR 2 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Stanford Case # 14 WC 37195
Employee/Petitioner

v. Consolidated cases: 14 WC 39395

State of Illinois/Illinois State University
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on April 15, 2014, he was employed at Illinois State University (hereinafter "ISU") and that he started at ISU in January of 2013. He testified that his job title was Food Service Worker II, that he worked 37.5 hours a week, that he worked five days a week and that he worked 7.5 hours per day. He testified that his job duties as a Food Service Worker II followed the usual school schedule, that he would work January through May and would then work again August through December.

Petitioner testified that his job duties included chopping fruit, cutting potatoes and cooking on the grill. He testified that he would have to temperature the food, that he would stock the freezer, that he did lifting and that he did a lot of chopping, slicing, dicing, stocking the salad bar and going out and cleaning the grill. He also testified that as part of his job duties he would grill 3-4 days a week, and that he would use tongs, a spatula and a thermometer.

Petitioner testified that he would cook hamburgers, turkey burgers, chicken and steak. He testified that he would prepare close to 100 steaks per night. He testified that he grilled 60-80 pounds of chicken in a night, that he would use a spatula and tongs to hold the chicken and that he would have a probe to stick into the chicken to check the temperature.

Petitioner testified that as part of his job duties, he would grill hamburgers, that there were probably 60 hamburgers in a case and that he would easily cook two cases per night. He testified that he would use a spatula, that he would turn and flip the hamburger and that then he would use the tongs again to hold and then use the probe to check the temperature of every single burger. He testified that he also cooked 60-100 turkey burgers a night as well.

Petitioner testified that as part of his job duties he would chop vegetables and fruit. He testified that he would chop 3-4 cases of watermelons per night and that there would be 7-8 watermelons in a case. He testified that he also chopped cantaloupes, that he did 3-4 cases of cantaloupes per night and that there were approximately 14 cantaloupes per case. Petitioner described that his wrist and arm would be twisted as he would cut the cantaloupe. He testified that he also cut pineapples. He described that as he was cutting watermelon, cantaloupe or pineapple, his elbows would be bent. He also testified that he cut peppers, onions, and potatoes as well.

Petitioner testified that as part of his job duties, he would handle, finger and grip objects and would spend about 75-85% of his day doing these particular types of activities. He testified that as part of his of his job duties, he would twist, flex and extend his wrists and elbows. He testified that as he performed

these job duties, he noticed that his hands, wrists, fingers and elbows would tingle, especially in his fingertips. He testified that he had difficulty with grip and that he would drop things.

Petitioner testified that his pain started in April of 2013, which was not too long after he started. He testified that he was working as a Food Service Worker II and that he then went on summer break. He testified that over the summer, his hands got better. He testified that when he returned in the fall, his hands started to become bothersome a little more but it was not too bad and was manageable. He testified that due to a shift change, he had to switch back to the shift that he was on before, which was 2:30 to 10:30. He testified that when he returned back to the 2:30 to 10:30 shift, he noticed that not too long after that his hands started to hurt.

Petitioner testified that prior to working at ISU, the condition of his hands was "great." He testified that he had had an EMG in 2013, but did not tell his supervisor. He testified that after the EMG in 2013, his hands got better and that he did physical therapy. He testified that he first told his supervisor on April 4, 2014 about his having issues with his hands. He testified that he was examined at Occupational Medicine, was told it was tennis elbow and was given wrist braces.

Petitioner testified that he is currently 39 and is not working. He testified that his last occupation was a kitchen manager at the jail. When asked whether the injury had affected his wages at all, Petitioner responded affirmatively and stated that he did not feel like he could continue cooking because his wrists hurt. He testified that his right hand and arm are not as strong as they were before, that it still hurts in his wrist and that he has numbness at the elbow. As to the left wrist and arm, Petitioner testified that he still has pain in the hand and that his whole elbow is completely numb.

On cross examination, Petitioner testified that his job history prior to working at ISU was in food service. He testified that he was not under any permanent restrictions and that the last time he treated for his hands and elbows was in November of 2016 with Dr. Li.

On cross examination, Petitioner testified that when he was the kitchen manager at the jail, his approximate salary was $11/hour and that he typically worked 40-60 hours per week. He testified that he was being treated for anxiety and nerve pain, that he was taking medications his primary care physician, that one of the side effects was hypersomnia and that he slept through his shifts lost his job because of it.

The transcript of the deposition of Dr. Lawrence Li was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Li testified that his specialty is orthopedic surgery and that he has been board-certified since 1995. (PX1).

Dr. Li testified that when he saw Petitioner on July 11, 2014, he stated that he started working for ISU as a prep cook in early 2013 and that in April of 2013 he started having bilateral elbow pain, numbness and tingling in his hands. He testified that Petitioner had had an EMG study that showed carpal tunnel syndrome. He testified that after ISU was out of session during the summer and he was off Petitioner's symptoms improved and that in the fall, he was working a lighter shift. He testified that Petitioner reported that the symptoms returned when he went back on second shift. He testified that when he saw Petitioner, he had pain in his elbows, numbness and tingling in both hands, in both the median and ulnar nerve distribution, and that his pain was worse with work activities. He testified that he thought that Petitioner had bilateral cubital tunnel syndrome, carpal tunnel syndrome and epicondylitis. (PX1).

He testified that he next saw Petitioner on August 11, 2014 after the EMG was performed by Dr. Trudeau. He testified that the EMG showed that Petitioner had bilateral cubital and carpal tunnel syndrome. He testified that the EMG of August 4, 2014 showed more severe carpal tunnel syndrome and also the presence of bilateral cubital tunnel syndrome, and that the first EMG had not shown cubital tunnel syndrome. He testified that at the time of the August 11th visit, Petitioner continued to have the same

symptoms and continued to have numbness and tingling. He testified that he recommended that Petitioner have a cubital tunnel release and carpal tunnel release and that since the left was the worst side, they decided to treat the left side first. He testified that Petitioner's work status as of August 11, 2014 was that he was unable to work. He testified that surgery was performed on August 26, 2014, which was that of a left cubital tunnel release and anterior transposition of the ulnar nerve and a left carpal tunnel release. He testified that Petitioner would have been unable to work as of August 26, 2014. (PX1).

Dr. Li testified that he next saw Petitioner on September 4, 2014, at which time his numbness and tingling was better but he still had pain from surgery. He testified that Petitioner continued to have some swelling and bruising reflective of the surgery and that he remained unable to work. He testified that he recommended physical therapy. He testified that when he saw Petitioner on September 15th, he had concerns about his left-hand incision that was opening a little. He testified that Petitioner was continued on therapy and would have been unable to work. He testified that when he saw Petitioner on October 2, 2014, Petitioner's numbness and tingling of his fingers was improved and he was progressing as expected with therapy. He testified that Petitioner had some numbness at the elbow incision and that the vasopneumatic compression therapy continued to reduce the swelling and pain. He testified that they decided to proceed with a right cubital tunnel release and anterior transposition of the ulnar nerve. He testified that Petitioner would have been unable to work as of that date. He testified that surgery was performed on October 7, 2014, which consisted of right cubital tunnel release with anterior transposition of the ulnar nerve and right carpal tunnel release. He testified that Petitioner would have been unable to work as of the date of surgery. He testified that the right-sided procedure was necessary given the continued symptoms of numbness and tingling and the supportive findings of the EMG that showed carpal and cubital tunnel syndrome, as well as the examination findings. He also testified that the surgery of August 26, 2014 was necessary because Petitioner had continued complaints of numbness and tingling in the median and ulnar nerve distribution, that the pain was aggravated by his work activities, that he had difficulty functioning and that they were supported by his physical examination as well as the EMG and nerve conduction studies. (PX1).

Dr. Li testified that when he saw him on October 15, 2014, Petitioner indicated that his numbness and tingling was improved and that he had moderate swelling and bruising. He testified that he prescribed Norco and Dendracin and recommended physical therapy, and that Petitioner was unable to work as of that date. He testified that when he saw Petitioner on October 23rd, he had some swelling, pain and redness over his elbow incision and that he had seen a small amount of pus coming out of his right elbow incision. He testified that he prescribed an antibiotic and observation, and that Petitioner would have been unable to work as of that date. He testified that he saw Petitioner on November 11, 2014, at which time he indicated that his numbness and tingling was improved but that he was still having some thumb pain. He testified that Petitioner continued to have some mild swelling, that his range of motion was still slightly limited and that his strength was moderately limited. He testified that Petitioner needed more therapy and some anti-inflammatories to decrease the inflammation. He testified that he kept Petitioner off work on that date. He testified that he saw Petitioner on December 9, 2014, at which time he reported some pain with gripping of his right hand. He testified that Petitioner's numbness and tingling was improved and that he was given some Dendracin for the discomfort. He testified that Petitioner was to continue a home exercise program and was cleared to return to work. (PX1).

When given a hypothetical as to Petitioner's work history and job duties, Dr. Li testified that these job duties would have caused the cubital and carpal tunnel syndrome bilaterally as well as the epicondylitis. He testified that the chopping of different vegetables and fruits such as watermelons required a significant amount of force, that this was repetitious and that the cold temperatures he would have been exposed to were all significant. (PX1).

On cross examination, Dr. Li agreed that the EMG from 2013 did not reveal cubital tunnel syndrome. He agreed that Petitioner went from having no cubital tunnel to mild cubital tunnel syndrome

and then almost severe carpal tunnel syndrome. He testified that he did not consider this to be quick progression. (PX1).

On cross examination, Dr. Li agreed that Petitioner never told him what he did before working for Illinois State University and that he would not be able to comment on any prior job duties. He testified that Petitioner was released to return to work full duty and that he had reached maximum medical improvement. (PX1).

On cross examination, Dr. Li testified that he did not think there were any studies that correlated BMI and carpal tunnel syndrome on any type of scale, but testified that individuals who were morbidly obese had a higher incidence. He agreed that smoking was a comorbidity and he further agreed that Petitioner smoked. He testified that he did not, however, know how much he smoked. He testified that he did not review any medical records from Dr. Mary Yee Chow. He agreed that Petitioner's weight was a comorbidity. (PX1).

On cross examination, Dr. Li testified that he did not know the rate of idiopathic development of carpal tunnel syndrome in the general population, but agreed that it was a relatively common occurrence within the distribution of idiopathic versus non-idiopathic at somewhere near 50%. He testified that cubital tunnel was more associated with work activities because there was not really an idiopathic cubital tunnel syndrome. He testified that activities where one bent the elbow typically caused cubital tunnel and that frequent extension and flexion was going to affect it just as much as holding it in a flexed position. He testified that to the extent there would be force across the elbow, weight being held while flexing would affect it. He testified that the use of spatula work and knife work would be sufficient. (PX1).

On cross examination, Dr. Li testified that Petitioner did not demonstrate or relate to him his technique for cutting various foods. He testified that it was the flexion of the elbow that was significant to him. He testified that as to carpal tunnel syndrome, the key points were any activity where there was significant force, repetitive flexion or extension of the wrist, and cold temperature. He testified that it had to be repetition with force and could not be only repetition. He testified that his opinion was based on both the hypothetical presented at the deposition and the information that Petitioner related to him when he saw him. (PX1).

On cross examination, Dr. Li testified that he did not have any indication that Petitioner was not complying with recommended treatment or follow-ups with his care. He testified that it was relatively uncommon for pus to be found in a wound and that some people may carry more bacteria than others. He testified that there was no indication that Petitioner was not properly caring for his wounds or incisions. He agreed that certain activities could make a condition more symptomatic without physically aggravating it further. He testified that he thought that Petitioner's work activities caused his condition to be permanently worse. (PX1).

On cross examination, Dr. Li testified that he did not recall Petitioner having any hobbies or home activities. He testified that he did not know what activities Petitioner engaged in. (PX1).

On redirect, Dr. Li testified that Dr. Won Jhee found no abnormalities in the motor conduction of the median nerve and that in April of 2013, the test showed that there was involvement only of the sensory fibers. He testified that in August of 2014, the sensory fibers were worse on the EMG and the motor fibers were also abnormal in both wrists. He testified that the job duties as described in the hypothetical could have caused the change. He testified that even if Petitioner were obese, his job duties could still have been a causative factor in his cubital and carpal tunnel. He testified that assuming Petitioner was a smoker, his job duties could still have been a causative factor in the cubital and carpal tunnel. (PX1).

On redirect, Dr. Li testified that when Petitioner worked at the grill and was flipping hamburgers and chicken, this involved turning, twisting and some flexion and extension of the wrist and was the type of job duty that could contribute to carpal tunnel. He testified that as far as keeping his elbow in a flexed position while he cut, even if there was not a lot of force but Petitioner kept his elbow in a flexed position then this was the type of activity that could bring about cubital tunnel. He testified that if Petitioner was using tongs in a squeezing or pinching motion, this would be the type of activity that could bring about carpal tunnel. (PX1).

The Operative Report dated August 26, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that on that date Petitioner underwent (1) left cubital tunnel release; (2) anterior transposition of ulnar nerve; (3) left carpal tunnel release by Dr. Li for a diagnosis of (1) left cubital tunnel syndrome; (2) left carpal tunnel syndrome. (PX2).

The Operative Report dated October 7, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that on that date Petitioner underwent (1) right cubital tunnel release and anterior transposition of ulnar nerve; (2) right carpal tunnel release by Dr. Li for a diagnosis of (1) right cubital tunnel syndrome; (2) right carpal tunnel syndrome. (PX3).

The medical records of OSF Occupational Health/Dr. Mary Yee Chow were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on April 18, 2014, at which time it was noted that Petitioner was complaining of pain in both elbows and had complaints of numbness and tingling in both hands, 3rd, 4th and 5th fingers, for three days. It was noted that the pain radiated down both arms to the fingers, that Petitioner's job required repetitive motion in the kitchen, that Petitioner stated no specific action caused this and that Petitioner also stated that he had sporadic elbow pain for 11 months. It was noted that Petitioner stated that his pain started in April of 2013, that he had a change in work with less chopping/dicing afterwards, that his elbows worsened with a shift change to 2nd shift in February of 2014 and that the numbness and tingling in both hands had been present since April of 2013. The assessment was noted to be that of bilateral elbow tendonitis, bilateral hand parethesias and bilateral wrist/forearm strain. Petitioner was given a prescription for Prednisone. A work slip was issued on that date, allowing him to return to work on April 18, 2014 with restrictions of lifting limited to no more than 20 pounds and no repetitive movements or awkward positions of the right and left wrists and elbows. Petitioner was also instructed to wear an elbow brace for support and comfort. (PX4).

The records of OSF Occupational Health/Dr. Mary Yee Chow reflect that Petitioner was seen on April 25, 2014, at which time it was noted that he was seen for a recheck of his bilateral arms. It was noted that Petitioner was using Ace wraps and was unable to find large splints, that he had taken the Prednisone for three days only because of stomach problems and that he had not been working due to his restrictions. It was noted that Petitioner's elbows were feeling better but that he had a crampy stomach from the Prednisone. A work slip was issued on that date allowing Petitioner to return to work on April 25, 2014 with restrictions of lifting limited to no more than 20 pounds and no repetitive movements or awkward positions of the right and left wrists and elbows. At the time of the May 2, 2014 visit, it was noted that Petitioner was seen for a recheck of the bilateral forearms, elbows and hands. It was noted that Petitioner stated that the numbness and tingling in his hands was minimal, that he had increased pain in the right wrist, that he wore wrist splints all the time and that he had constant pain in both elbows. It was noted that Petitioner stated that his elbows started hurting worse when he went to 2nd shift (*i.e.*, 2:30-10:30 p.m.) and that he stated he was on split shift August through February. It was noted that Petitioner stated that the wrist pain started three days ago, that he had less numbness and tingling in his hands, that he noticed weakness with gripping and that he was unsure of the cause. The assessment was noted to be that of bilateral elbow tendonitis/paresthesias/wrist and forearm strain. A work slip was issued on that date allowing Petitioner to return to work on May 2, 2014 with restrictions of lifting limited to no more than 20 pounds, no repetitive movements or awkward positions of the right and left wrists and elbows and to use splints for support. (PX4).

The medical records of Dr. Lawrence Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 11, 2014, at which time it was noted that his chief complaint was that of bilateral elbow and hand numbness and tingling since April 2013. It was noted that Petitioner started working as a prep cook for ISU in early 2013 and then in April started having bilateral elbow pain and numbness and tingling in the hands. It was noted that Petitioner had an EMG/NCV that showed carpal tunnel syndrome, that he had time off during the summer, that his symptoms improved and that in the fall he was working a lighter shift but that his symptoms returned when he returned to 2nd shift. It was noted that Petitioner had pain in both elbows and numbness and tingling in both hands in both the median nerve distribution and ulnar nerve distribution. It was noted that Petitioner's pain was aggravated by work activities and got progressively worse throughout the work shift, that the pain woke him up at night and affected his sleep and that it negatively affected his activities of daily living. The diagnosis was noted to be that of bilateral cubital tunnel syndrome, carpal tunnel syndrome and lateral epicondylitis. Petitioner was recommended to undergo an EMG/NCV and follow-up. (PX5).

The records of Dr. Li reflect that Petitioner was seen on August 11, 2014, at which time it was noted that he was seen in follow-up on his EMG results. It was noted that Petitioner's symptoms were the same and that he continued to have numbness and tingling. The diagnosis was noted to be that of bilateral cubital tunnel syndrome and carpal tunnel syndrome, left worse. Petitioner was recommended to undergo surgery, which was performed on August 26, 2014. At the time of the September 4, 2014 visit, it was noted that Petitioner stated that the numbness and tingling improved and that compression therapy was helping to reduce swelling and pain. Petitioner was recommended to continue vasopneumatic compression therapy and to undergo occupational therapy. At the time of the September 15, 2014 visit, it was noted that Petitioner wanted his left-hand incision checked. It was noted that Petitioner had dry skin that split, but that it was healed deep. Petitioner was instructed to continue occupational therapy. (PX5).

The records of Dr. Li reflect that Petitioner was seen on October 2, 2014, at which time it was noted that he stated that the numbness and tingling had improved and that he was progressing as expected with therapy. It was noted that Petitioner had some numbness at the elbow incision and that vasopneumatic compression therapy was helping reduce swelling and pain. Petitioner was recommended to undergo surgery on the right side, which was performed on October 7, 2014. At the time of the October 15, 2014 visit, it was noted that Petitioner stated that he had typical post-operative pain, that the numbness and tingling had improved and that the vasopneumatic compression therapy was helping reduce swelling and pain. Petitioner was instructed to continue occupational therapy and compression therapy. Petitioner was also dispensed pain medication. At the time of the October 23, 2014 visit, it was noted that Petitioner stated that he noticed some swelling, pain and redness to the elbow incision and that he reported that during scar massage, he had seen a small amount of "pus" come out. Petitioner was instructed to observe the incision and was given Keflex. (PX5).

The records of Dr. Li reflect that Petitioner was seen on November 11, 2014, at which time it was noted that he stated that the numbness and tingling had improved, that he was progressing as expected with therapy and that he still had some thumb pain. Petitioner was given medications and was assessed at intermediate risk for a gastrointestinal event with the medication. Petitioner was also instructed to continue occupational therapy. At the time of the December 9, 2014 visit, it was noted that Petitioner stated that he had some pain with gripping in his right hand and that his numbness and tingling had improved from his pre-operative state. Petitioner was instructed to continue his home exercise program, was cleared for return to work and was instructed to advance activities as tolerated. At the time of the April 21, 2015 visit, it was noted that the left elbow was most bothersome to him, that he had a numbness and tingling sensation when his medial elbow was touched, that he stated that at times he had some numbness in his fingers but was better than before surgery and that he reported some persistent weakness. It was noted that Dr. Li explained to Petitioner that this would gradually decrease but that he may always have increased sensitivity in the

medial elbow area and that he may also have residual weakness in his hand due to his chronic cubital and carpal tunnel syndrome. (PX8).

The records of Dr. Li reflect that Petitioner was seen on February 5, 2016 visit, at which time it was noted that he was seen for follow-up on both elbows. It was noted that Petitioner reported numbness of the incision around the left elbow, that on the right there was mild numbness and that there was still pain that shot down his forearms with increased activity. Petitioner was given Dendracin and was instructed to call if the problem did not resolve. (PX5).

The medical records of Dr. Trudeau were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Dr. Trudeau authored a letter to Petitioner's attorney, Steve Williams, on August 11, 2014, which noted that Petitioner had had work-related difficulties involving the upper extremities, that he had worked as a prep cook, that he did repetitive motion work and that he had documentation of carpal tunnel the year prior but that it had gotten progressively worse to the point that the elbows, wrists and hands were numb, tingly and painful. It was noted that Petitioner described an abnormal feeling in the ventral surface of either forearm, but especially the left greater than right, and that he was right-handed. It was noted that Petitioner's symptoms were worse on the left side. It was noted that Petitioner's chief complaint was tenderness in the elbows, pain, numbness and tingling in the pinky and ring finger and partially the middle fingers of both arms and pain with certain movements. It was noted that this occurred in April of last year related to his repetitive usage and that he was very descriptive of doing the repetitive motion work activities with both upper extremities and that it was felt to be work-related. The interpretation was noted to be that of (1) bilateral median neuropathies at the wrists (bilateral carpal tunnel syndrome), moderately severe on either side, left greater than right in electroneurophysiologic testing quantification; (2) bilateral ulnar neuropathies at the elbows (bilateral cubital tunnel syndrome), left greater than right in electroneurophysiologic testing terms, mild and neurapraxic on either side in electroneurophysiologic testing characterizations; (3) no current evidence of proximal median neuropathy (pronator syndrome); (4) no current evidence of distal ulnar neuropathy (canal of Guyon syndrome); (5) no evidence of other entrapment neuropathy; (6) no current evidence of cervical radiculopathy; (7) no current evidence of brachial plexopathy. (PX6).

The physical therapy records of Dr. Lawrence Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. At the time of the Initial Evaluation on September 4, 2014, it was noted that Petitioner had had bilateral elbow and hand numbness and tingling since April of 2013, that he started working as a prep cook for ISU in early 2013 and then in April started having bilateral elbow pain and numbness and tingling in the hands. It was noted that Petitioner had an EMG/NCV study that showed carpal tunnel syndrome, that he went through a conservative course of occupational therapy at OSF with mild, temporary relief of symptoms, that he had time off during the summer, that his symptoms improved and that in the fall he was working a lighter shift. It was noted that Petitioner's symptoms returned when he returned to 2nd shift, that he stated that his 2nd shift work involved more lifting, pushing/pulling, squeezing, slicing and dicing tasks and that his symptoms progressively worsened. It was noted that Petitioner presented with increased edema, pain, decreased range of motion and weakness, and that these limitations significantly impaired his ability to use his left hand/upper extremity functionally. The Discharge note dated December 8, 2014 noted that Petitioner continued with pain at 3-4/10 at the right volar wrist and occasional tingling/soreness/discomfort at the right elbow. It was noted that Petitioner stated that his left arm felt "pretty good." It was noted that Petitioner had progressed with decreased edema, increased range of motion and increased strength bilaterally, but that his grip strength had somewhat plateaued during the past 3-4 weeks. It was noted that Petitioner's left incisional pain and sensitivity were nearly resolved, that his right incisional pain and thenar eminence pain were improving and that he continued with significant pain with resistance of the palmaris longus muscle/tendon wrist flexor on the right. It was noted that Petitioner frequently rubbed his right wrist and reported right volar wrist and palmar soreness. (PX7).

The Fee Schedule Charges for Dr. Lawrence Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The Fee Schedule Charges for Ireland Grove Center for Surgery were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 10.

The Notice of Injury Forms were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Incident Investigation Report was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Resignation-Related Forms were entered into evidence at the time of arbitration as Respondent's Exhibit 3. Various Timesheets were entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The IME Report of Dr. James Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The report reflects that Petitioner was seen for an IME on February 11, 2015, at which time he complained of numbness on the left elbow on the inside, weakness in the right and left wrists, dropping things with both hands, moreso with the left than the right, waking at night, and rare numbness and tingling. It was noted that Petitioner also complained of left and small finger intermittent numbness and tingling, improved as compared to before. It was noted that Dr. Williams opined that Petitioner was status post right as well as left carpal tunnel release and cubital tunnel release, that he was doing well as identified by his decrease in subjective complaints and good findings on exam, that he had reached maximum medical improvement and that he did not need any further care and had been released by Dr. Li to full duty work but had not worked since April of 2014. (RX5).

The report reflects that Dr. Williams indicated that it would be helpful to know "exactly how long" and that it sounded like from the job tasks that he was doing 5-6 different tasks and at most was doing one tasks 2½ hours at a time. It was noted that if that was true, based on the many different duties Petitioner performed and if he only sliced with the right hand, Dr. Williams did not see why he would have developed it on the right and left sides. It was noted that no other duties that Petitioner performed involved any repetitive forceful gripping and/or pinching and that Dr. Williams felt that moreso than his work duties the problem could be either idiopathic, related to his increased body mass index and/or his tobacco history more than it would be his work duties. (RX5).

The transcript of the deposition of Dr. James Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 6. Dr. Williams testified that he is board-certified in orthopedic surgery. (RX6).

Dr. Williams testified that he saw Petitioner for an IME of the upper extremities and that at the time of the IME, Petitioner stated that he had symptoms of tingling in the hands and all the fingers, first to start on the right side and then the left side started. He testified that Petitioner had pain with the elbow bent with picking stuff up, twisting and waking at night, that he stated that he got stiff, dropped things, had weakness, numbness and tingling in all of the fingers, intermittent at first, then it went to the small and ring fingers all the time on the right and left sides. He testified that Petitioner stated that the left started getting worse than the right. He testified that Petitioner indicated at the time of the IME that he had numbness and tingling on the left elbow in the inside, that on the right and left wrists he had weakness, that he dropped things with both hands, moreso with the left than the right, and that he had waking at night. He testified that Petitioner indicated that the numbness and tingling was rare and that his complaints of left small finger intermitting numbness and tingling were better than it was before surgery. He testified that he saw Petitioner on February 11, 2015 and that Petitioner stated that the symptoms began in March of 2013. (RX6).

Dr. Williams testified that the work activities that Petitioner discussed essentially involved slicing fruit, dicing fruit, cutting meat on an electric slicer and sometimes manually doing it with his right hand, cooking on the grill and monitoring the fryer. He testified that Petitioner indicated that he sliced fruit, sweet potatoes, tomatoes and onions on a slicer and that he stated 60% of slicing was his job using his right hand

with a knife and 40% was cooking. He testified that Petitioner indicated that some nights he cooked the entire time and did no slicing and that he cut grapes and sliced watermelon, cantaloupe, honeydew and pineapple. He testified that Petitioner indicated that he pulled stuff in and out of the ovens and that he stated there were no electric knives and there was no cleaning. He testified that Petitioner indicated that he did hand mixing with the right hand using a wire whisk for pancake batter, sauces, salad dressing and potatoes and that he said he would have to cut the potatoes with a knife with his right hand. He agreed that the activities involved manual grasping or gross manipulation with his right hand. He testified that pretty much everything Petitioner stated he did manually with his right hand. (RX6).

Dr. Williams testified that as to cooking, Petitioner stirred, whisked and cut. When asked whether he had formed an opinion of what the average weight or force Petitioner might be using with his right hand when slicing, Dr. Williams responded that it was something he did with cooking and that it was something sometimes he did with an electric slicer. He testified that it was not something that Petitioner always did with a knife, that it was done intermittently and that he stated some nights he did no slicing at all. He testified that his understanding was that the electric slicer was a machine that items were slid across and then were cut, similar to that at a deli. He testified that the machine would not qualify as using a vibratory tool such that it could be a causal factor in the development of carpal tunnel or cubital tunnel. (RX6).

Dr. Williams testified that Petitioner indicated to him that he had no hobbies and that he did not discuss any prior work history with him. He testified that Petitioner did not say that he had any symptoms before March of 2013. He testified that at the time of the IME, Petitioner was still having related symptomatology in that he was still having complaints of numbness and tingling. He testified that it was better than before, but that he still had symptoms. When asked if this was typical post-operatively, Dr. Williams responded that it was not and stated that if it was something due to carpal tunnel syndrome and no other issues or cubital tunnel syndrome, it usually resolved. He testified that one would think that Petitioner, whose nerve studies did not indicate that he had severe compression, would have had a better result if it simply had been due to compression and not some other factor. (RX6).

Dr. Williams testified that as to the physical examination performed, Petitioner had a BMI of 50.6 which was obese class 3, which put him at a significant increased risk for peripheral neuropathies. He testified that Petitioner had no evidence of lateral or medial epicondylitis on either side, that he had full range of motion of both elbows and wrists, that his elbow flexion and elbow extension strength was 4+/5 on the right and left, that his wrist flexion and wrist extension strength was 4/5 on the right and left and that his digital flexion and digital extension strength was 4+/5 bilaterally. He testified that Petitioner demonstrated a good effort as he demonstrated a bell-shaped curve on grip strength testing on both sides with a negative rapid exchange. He testified that Petitioner's sensation was completely normal from the right thumb to the right small finger and from the left thumb to the left small finger. He testified that Petitioner had a negative Tinel's, Phalen's and median nerve compression tests at the carpal tunnel bilaterally and that he had a negative Tinel's, negative elbow flexion test with no evidence of ulnar nerve subluxation bilaterally at the cubital tunnels and that he had good 5/5 APB and first dorsal interosseous strength bilaterally. (RX6).

Dr. Williams testified that even discounting environmental factors of forced flexion and extension, there would already be increased pressure within the cubital and carpal tunnel given Petitioner's BMI. He testified that it was possible that one could develop carpal or cubital tunnel independent of environmental factors based solely on BMI and that it was possible in this case. He testified that he thought that there was something else still going on that was leading to Petitioner having symptoms considering he had a very capable surgeon who performed what appeared to be well-done surgery and yet Petitioner still, five months following one side and seven months following the other, complained of symptoms. He testified that Petitioner's tobacco history of one pack of smoking per 1½ days for the last 10-12 years was another possible etiology for his problems. (RX6).

Dr. Williams testified that he would not give the diagnosis of lateral epicondylitis based on tenderness alone. He testified that Petitioner had some weakness in wrist flexion and extension on both sides. He testified that more commonly that not you would expect to have abnormal sensation if one had carpal tunnel syndrome and cubital tunnel syndrome. He testified that the negative Tinel's, Phalen's and median arc nerve compression tests showed that Petitioner had no hypersensitivity of the nerve noted on objective exam, yet he still had complaints of symptoms. (RX6).

Dr. Williams testified that he felt that Petitioner's carpal tunnel syndrome and cubital tunnel syndrome could either be idiopathic in nature or it could be related to his increased body mass index and/or his smoking history. He testified that he did not feel that it was related to his work activities, that Petitioner's work did not seem to meet the definition of repetitive and that it was work that he did where he was changing tasks, sometimes using his hands, sometimes using a device, and that he did not do the same repetitive tasks over and over. He testified that it was not something that required forceful gripping and pinching, that it was also an activity of which he only did for approximately one year and five months, and that he did not find that to be a significant period of time to develop the problems which he developed. He testified that Petitioner cut all the time with his right hand and wondered why his symptoms in the left hand would be just as bad as his right if, indeed, he did his activities all the time with his right hand for any of the cutting. (RX6).

Dr. Williams testified that at the time that he saw Petitioner, he did not have any recommendations for further treatment. He testified that it was his belief that all medical treatment performed was reasonable and necessary. He testified that he found Petitioner to be honest and forthcoming. (RX6).

On cross examination, Dr. Williams agreed that he thought that a pinched grip type of motion would be the type of motion that could cause carpal tunnel syndrome if it was forceful repetitive gripping and/or pinching that was sustained. When asked if he was given information that Petitioner as part of his job duties would have to use tongs and whether that could alter his opinion regarding causation for carpal tunnel syndrome, Dr. Williams responded that it would be important to know if the activity using the tongs was repetitive, meaning that it was done with a cycle time of less than 30 seconds for greater than 50% of the shift per NIOSH and that it was sustained, meaning that it was continued throughout the shift. He testified that it was not simply the simple activity of doing one activity. (RX6).

On cross examination, Dr. Williams agreed that Petitioner told him that he was a food service worker at ISU, that he told him that he started in January of 2013 and that his last day of work was in May of 2014. When asked if Petitioner's job duties were sufficiently hand and arm intensive and whether he worked there long enough to develop the carpal tunnel syndrome and cubital tunnel syndrome condition, Dr. Williams responded that it would be very dependent on the activities at which he performed and that they needed to be sustained, repetitive and forceful. He agreed that if those things were true, it was possible that Petitioner would have worked there long enough to develop carpal and cubital tunnel as a result of his job duties. He further agreed that if Petitioner was working 8-hour shifts, this would be a sufficient amount of time per day to develop those conditions if the other factors as he described were present. (RX6).

On cross examination, Dr. Williams agreed that Petitioner told him that his symptoms started in March of 2013 but went away in April of 2013, that he did physical therapy that seemed to help and that he did not work from May to August. He testified that he did not consider the electric slicer to be significantly vibratory and that he had run one himself. He testified that vibratory tools had a causal association with carpal tunnel syndrome if they were used in a sustained repetitive basis and that Petitioner's was intermittent. (RX6).

On cross examination, Dr. Williams agreed that Petitioner mentioned to him that he was slicing fruit, dicing fruit and cutting meat and that the meat was either done with a slicer or sometimes manually with the right hand. When asked if he would agree that that would involve some bending and twisting of

the wrist, Dr. Williams responded that he did not know about significantly twisting when one was cutting things and that it involved some bending of the wrist but not significant amounts, because in order to generate any force the wrist had to be held in a fixed position. He testified that there would be some mild force on the wrist which was intermittent. When asked if he would agree that meat cutting was the type of profession that was commonly associated with carpal tunnel, Dr. Williams responded that it was for butchers who cut meat for 8 hours per day. (RX6).

On cross examination when asked if the activities that Petitioner described were hand-intensive in nature, Dr. Williams responded that he did not think so and that he did not think that the activity of cooking was really hand intensive, which Petitioner stated he did for up to 40% of his shift. He agreed that stirring involved the use of the hands. He agreed that he never saw Petitioner perform the job. He testified that Petitioner did not tell him how much time he spent standing and watching the fryer and that Petitioner told him inclusive of cooking was 40% of the time. When asked what other activities Petitioner told him involved cooking, Dr. Williams responded that Petitioner indicated that it was involving cooking of potatoes for making mashed potatoes, making pancakes and making sauces and salad dressings. (RX6).

On cross examination when asked if Petitioner was using tongs for 2-2½ hours per day whether that could contribute to carpal tunnel, Dr. Williams responded that he did not believe so because he did not believe it was an activity that was done repetitively without changing to any other activity and that he did not believe it was forceful to use tongs to pick up items out of a fryer. Dr. Williams testified that job duties, depending on the positioning of the arm that were forceful and sustained, were possible for causing cubital tunnel. When asked if the position required prolonged flexion of the arm and whether that was the type of activity that could bring about cubital tunnel, Dr. Williams responded that it was possible. (RX6).

On cross examination, Dr. Williams testified that he did not see that twisting had ever been shown to bring about any evidence of carpal or cubital tunnel syndrome. He testified that the cooking of burgers, steak and bacon could involve some twisting of the wrist when the items were flipped. When asked whether that would involve repetitive flexion of the wrist, Dr. Williams responded that it seemed to him more like an extension. He testified that no activities were done with the wrist flexed because every time you go to make a fist, the wrist goes into extension physiologically because that was where the power grip came from. (RX6).

On cross examination when asked whether cooking at a grill, depending on the height of the grill, could involve some prolonged flexion at the elbow, Dr. Williams responded that he did not think it would. He agreed that he had not seen Petitioner do his job. He agreed that slicing up fruit and sweet potatoes would involve some handling, fingering and gripping of a knife. He testified that it was possible that, depending on the positioning of the arm while doing this, it could involve some prolonged flexion at the elbow. He agreed that carpal tunnel involved compression of the median nerve and testified that sustained flexion of the wrist might create pressure on the nerve. He testified that every time one flexed and extended the wrist the pressure was relieved and that unless that was sustained for a period of time, the pressure was never built up. (RX6).

On cross examination, Dr. Williams agreed that it was possible that motion of the fingers could create swelling in the tendons and that it was also possible that the swelling of the tendons could create compression on the median nerve. When asked whether cutting would involve use and motion of the fingers, Dr. Williams responded that he thought the fingers would be fixed during that activity. He agreed that the gripping involved in holding a knife would involve use of the tendons of the hands. He agreed that the meat cutting activity would involve use of tendons of the hand. He testified that slicing and dicing of fruit would involve tendons of the right hand and that Petitioner would have been holding the item with his left hand. When asked if holding the item would involve use of the tendons of the fingers in the left hand, Dr. Williams responded that it would to a limited extent. (RX6).

On cross examination, Dr. Williams testified that Petitioner had no history of diabetes, hypertension or thyroid problems up until this time. He agreed that he did not see any symptom magnification. He testified that he did not sense any type of malingering. He agreed that Petitioner had bilateral carpal tunnel syndrome and that the surgery was warranted, reasonable and necessary. He further agreed that the post-operative treatment was warranted, reasonable and necessary. He agreed with the diagnosis of bilateral cubital tunnel syndrome and that the surgeries performed were reasonable and necessary. He further agreed that the post-operative treatment was reasonable and necessary. (RX6).

On cross examination, Dr. Williams agreed that when he saw Petitioner he had weakness in his right and left wrist and that it was possible that it could be from carpal tunnel. He agreed that it was possible that Petitioner's dropping things more with the left than the right could be from carpal tunnel and that the waking at night could be from carpal tunnel as well. He testified that Petitioner had pain on both sides and that it was possible that it could be a residual from the carpal tunnel. He agreed that at the elbow, Petitioner described having some numbness in his left or small fingers and that it could be from the cubital tunnel. (RX6).

On cross examination, Dr. Williams agreed that he noted that obesity could be a contributing factor to Petitioner's neuropathy and his carpal and cubital tunnel syndrome. He agreed that in general terms, there could be one or more causes of carpal and cubital tunnel and that each factor could be a contributing factor to the development of that condition. (RX6).

On redirect, Dr. Williams testified that many times that he was a treating physician in a worker's compensation case and that it was 20-30% of his practice. He testified that medical science did not support twisting actions of the wrist as a causative factor in the development of carpal or cubital tunnel, nor did twisting actions in the elbow. He testified that he cooks in his free time quite a bit and that he has cut potatoes and tomatoes. When asked if manipulating the potato or tomato in his left hand constituted sufficient use of the fingers to cause swelling of the tendons near the median nerve, Dr. Williams responded that it did not. He agreed that the movement of the fingers in that situation would be less than average when typing. He testified that the same was true of the hand that was holding the knife. (RX6).

On redirect, Dr. Williams testified that he worked at Dominick's from age 16-18 and did not find the meat slicer to be an activity that was significantly vibratory nor gave any symptoms of carpal tunnel. He agreed that he had cut meat before and had at a deli as well, and that he did not find intermittent meat cutting to be sufficient to cause those types of symptoms. When asked whether Petitioner described anything abnormal about the meat cutting he was involved in, Dr. Williams responded that he did not and that he did not describe the machine as being overly vibratory or anything else. He testified that all that a butcher did was cut meat, that sometimes they used saws to cut the bones and that this was sufficient repetitive, forceful gripping on a sustained basis. (RX6).

On redirect, Dr. Williams agreed that when he said intensive, he was not just referring to using the hands all the time but also the degree of work involved. When asked to define intensive, he responded that he would use the definition that was set by NIOSH where they defined an activity as repetitive as being activity done with a cycle time of less than 30 seconds, meaning that activity was done every 30 seconds and that single activity was done for greater than 50% of the shift. He testified that by the job analysis that was done at Petitioner's work, he did not complete one task for more than 2½ hours. (RX6).

On redirect, Dr. Williams testified that he did not feel that there was sufficient force using tongs based on what Petitioner told him about his tong usage. He testified that he had never worked a fryer before and that his assumptions based on Petitioner's fryer usage were that he would spend most of his time watching the frying. He agreed that his assumption of Petitioner's fryer activities involved putting the items in the fryer, waiting until it was cooked and then removing it. He testified that Petitioner indicated that he put chicken, fish and fries in the fryer. He testified that Petitioner indicated that it was chicken pieces. He

testified that Petitioner indicated that it was a basket, but that he did not describe the size of the basket. (RX6).

On redirect, Dr. Williams agreed that his focus was on the upper extremity surgery and this constituted approximately 99% of his work. He testified that he thought that there was a differential diagnosis of Petitioner having some other cause which was why he still had symptoms despite having a well-trained surgeon and still having significant symptoms. When asked whether the medical records supported one diagnosis over the other as to what was causing his symptomatology, Dr. Williams responded that he believed that it indicated that the etiology was something other than compression of the median or ulnar nerve at the carpal tunnel and pointed to more of a systemic-type etiology for his problems which may be an underlying neuropathy from undiagnosed diabetes, due to his obesity or being idiopathic in general. (RX6).

On further cross examination, Dr. Williams agreed that carpal tunnel was or could be the result of compression of the median nerve and that compression could be brought about by swelling. He agreed that it was possible that the swelling could be from the tendons that controlled the fingers in the hand and that if one held the elbow in a flexed position for a sufficient amount of time, it could at least aggravate the symptoms of cubital tunnel. (RX6).

On further redirect, Dr. Williams testified that he did not note that Petitioner held his elbow in a fixed position for any period of time as deemed intensive or sufficient. (RX6).

Various Facebook Photos were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F) as it pertains to 14 WC 37195, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on April 15, 2014 and that his current condition of ill-being is causally related to his work activities for Respondent.

In so concluding that Petitioner's carpal tunnel and cubital tunnel syndromes in his bilateral hands and arms is related to his work activities, the Arbitrator finds the opinions of Dr. Li to be more persuasive than those proffered by Dr. Williams in this matter. The Arbitrator finds that the job duties as testified to by Petitioner at the time of arbitration were consistent with those as proffered to Dr. Li in the hypothetical posed by Petitioner's attorney at the time of the deposition. (PX1). Furthermore, the Arbitrator notes Dr. Williams in the IME report noted that no other duties that Petitioner performed involved any repetitive forceful gripping and/or pinching and that he felt that moreso than his work duties the problem could be either idiopathic, related to Petitioner's increased body mass index and/or his tobacco history more than it would be his work duties. (RX5). The Arbitrator infers this particular indication by Dr. Williams to be suggestive of an admission that Petitioner's work duties could, in fact, have been contributing to his condition of ill-being, but rather just not to the same extent of the other issues which were that Petitioner's condition was idiopathic, related to his increased body mass index and/or his tobacco history.

The Arbitrator finds that Petitioner's job duties are sufficiently repetitive or cumulative to support a finding of causation and/or aggravation of both the carpal and cubital tunnel syndrome conditions. Petitioner's testimony demonstrated that his job duties were forceful and required frequent gripping and

that he regularly held his elbows in a flexed position while performing his job duties. As a result thereof, the Arbitrator finds that the job duties as described by Petitioner at the time of arbitration -- which involved the gripping and grasping of knives and spatulas as well as the chopping and cutting of a multitude of food items -- were sufficient to cause or aggravate both the carpal tunnel syndrome and cubital tunnel syndrome conditions in both of his upper extremities.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on April 15, 2014, and that his current condition of ill-being is causally related to his work activities.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment to his bilateral hands and arms was reasonable, necessary and causally related to his work accident of April 15, 2014. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from August 11, 2014 through December 9, 2014. (AX1). Related thereto, the Arbitrator notes that Dr. Li testified that Petitioner's work status as of August 11, 2014 was that he was unable to work and that as of the December 9, 2014 visit, Petitioner was cleared to return to work. (PX1). Therefore, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 17 1/7 weeks, addressing the timeframe of August 11, 2014 through December 9, 2014, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his last occupation was a kitchen manager at the jail, which was a similar to the occupation that he previously held for Respondent. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 35 years old on his date of accident. Given the age of Petitioner and the fact that his treating physicians have placed him under no restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner resigned from Respondent and testified that his last occupation was a kitchen manager at the jail, a job from which he was terminated for sleeping through his assigned shifts. (RX3). As there was no definitive evidence of reduced earning capacity contained in the record beyond Petitioner's

assertions that he did not feel that he could continue cooking because his wrists hurt, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his right hand and arm are not as strong as they were before, that it still hurts in his wrist and that he has numbness at the elbow. As to the left wrist and arm, Petitioner testified that he still has pain in the hand and that his whole elbow is completely numb. At the time of the February 5, 2016 visit with Dr. Li, it was noted that Petitioner was seen for follow-up on both elbows. It was noted that Petitioner reported numbness of the incision around the left elbow, that on the right there was mild numbness and that there was still pain that shot down his forearms with increased activity. Petitioner was given Dendracin and was instructed to call if the problem did not resolve. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records at the conclusion of his treatment with Dr. Li. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. The Arbitrator further notes that the evidence presented at the consolidated hearing in these matters was insufficient to "delineate and apportion the nature and extent of permanency attributable to each accident." *See City of Chicago v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 258, 265 (1st App. Ct. Dist. 2011). As such, the permanency award in this case encompasses and compensates Petitioner for his injuries alleged in both of the above-captioned claims and no separate award is being made. *See Baumgardner v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 274, 279-80 (1st App. Ct. Dist. 2011) ("From a procedural and practical standpoint, where a claimant has sustained to separate and distinct injuries to the same body part in the claims are consolidated for hearing and decision, it is proper for the commission to consider all of the evidence presented to determine the nature and extent of his permanent disability as of the date of the hearing."). Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent **12.5% loss of use of the left hand, 12.5% loss of use of the right hand, 12.5% loss of use of the left arm and 12.5% loss of use of the right arm** as provided in Section 8(e) of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF MCLEAN	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Stanford,
Petitioner,

vs.

NO: 14WC 39395

State of Illinois/Illinois State University,
Respondent.

19IWCC0152

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 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.

No bond or summons required for State of Illinois cases.

DATED: MAR 7 - 2019
O011419
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STANFORD, CHRIS
Employee/Petitioner

Case# **14WC039395**

14WC037195

19IWCC0152

SOI/ILLINOIS STATE UNIVERSITY
Employer/Respondent

On 3/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

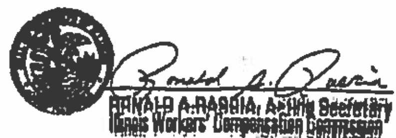
0988 ASSISTANT ATTORNEY GENERAL
JORDAN A HOMER
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

MAR 2 - 2018



STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Stanford
Employee/Petitioner

Case # 14 WC 39395

v.

Consolidated cases: 14 WC 37195

State of Illinois/Illinois State University
Employer/Respondent

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 4, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$15,806.82**; the average weekly wage was **$303.98**.

On the date of accident, Petitioner was **35** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

With regard to the nature and extent of Petitioner's injury, the Petitioner has already been compensated as explained more fully in the decision of Petitioner's consolidated Case No. 14 WC 37195. In that case, Petitioner was compensated for permanent partial disability stemming from his injuries on April 15, 2014 as a result of a consolidated full trial on the merits of both cases. Thus, the Arbitrator denies any additional award for further compensation as a result of Petitioner's injury.

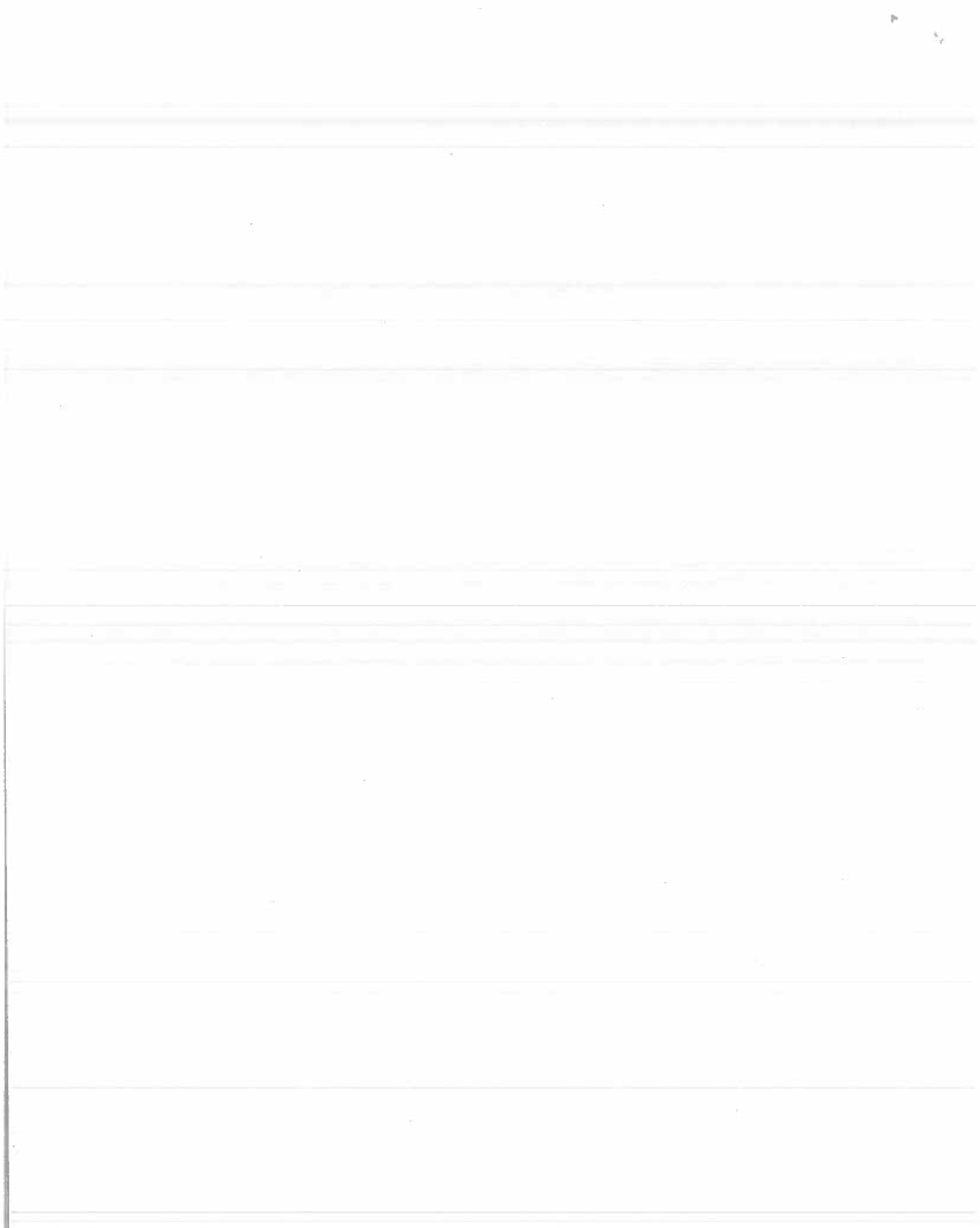
RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

3/1/18
Date

MAR 2 - 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER BAHR,

Petitioner,

vs. NO: 16 WC 2780

ARLINGTON HEIGHTS S.D. 25, **19IWCC0153**

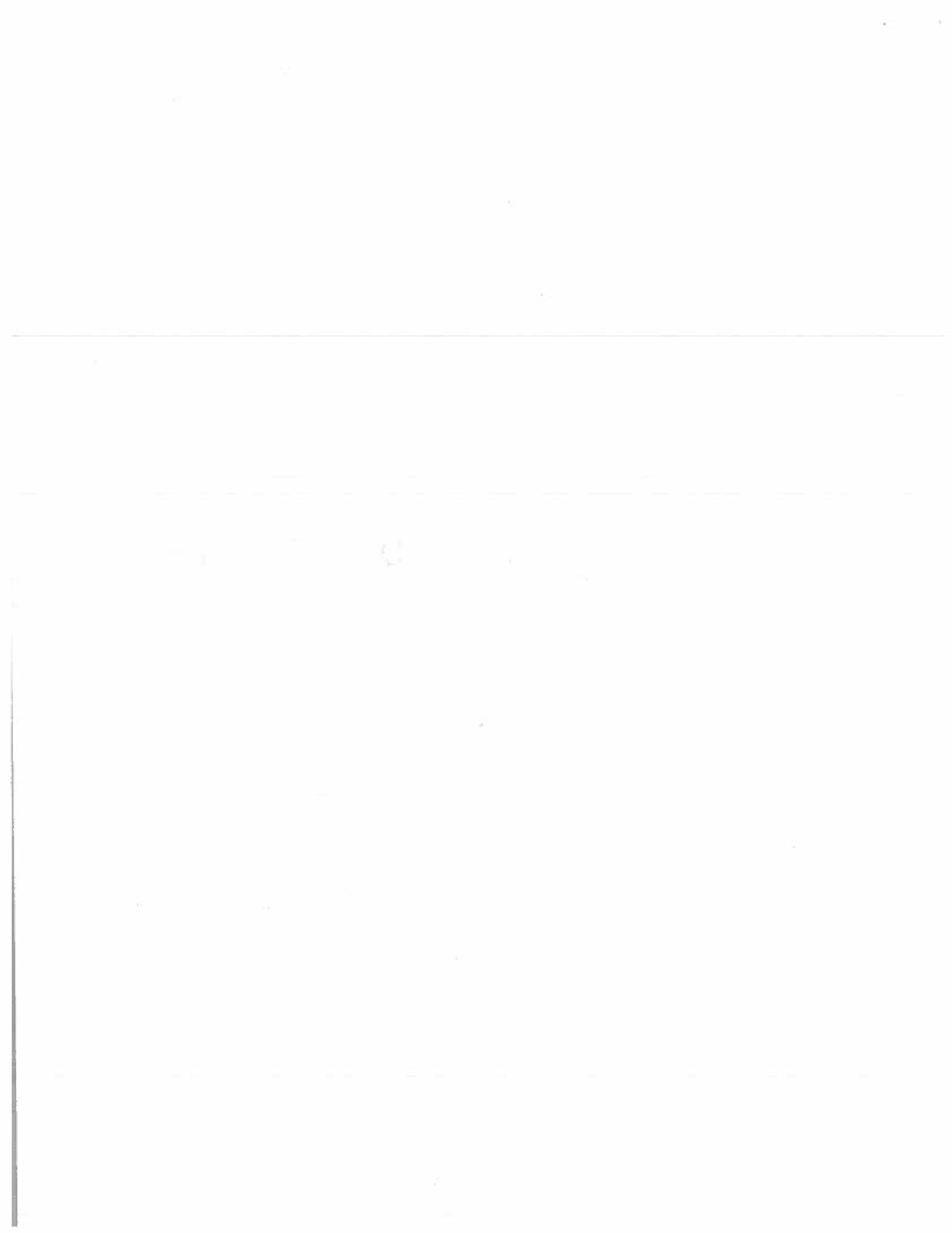
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses, penalties, and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

We affirm the Arbitrator's decision regarding causal connection with Petitioner's right hamstring tear and right superior labral tear but reverse the decision regarding the "partial tear on the left." Petitioner's medical records clearly show that her work injury caused symptoms and pain complaints on the right side.

She underwent an MRI of the right hip on May 1, 2015, which revealed a complete avulsion of the right hamstring tendon origin with small avulsed bony fragment and mild right gluteus medius tendinosis. On May 19, 2015, Petitioner underwent an open repair of the right proximal hamstring tendon with Dr. Moss. On September 25, 2015, Dr. Moss noted Petitioner was having sciatic symptoms in the *left* leg because of postural and gait adjustments from her surgery. Petitioner underwent another MRI on January 8, 2016, which showed: 1) Recurrent right hamstring



tendon tear involving the biceps femoris/semitendinosus common origin with distal retraction by 2.7 cm; 2) Mild right proximal semimembranosus tendinopathy without a tear; 3) Superior right acetabular labral tear.; 4) Partial tear of the left hamstring tendon with mild underlying tendinopathy, worse compared to May 1, 2015. The radiologist noted regarding the left hip findings: "This is incompletely evolved on this right hip MRI."

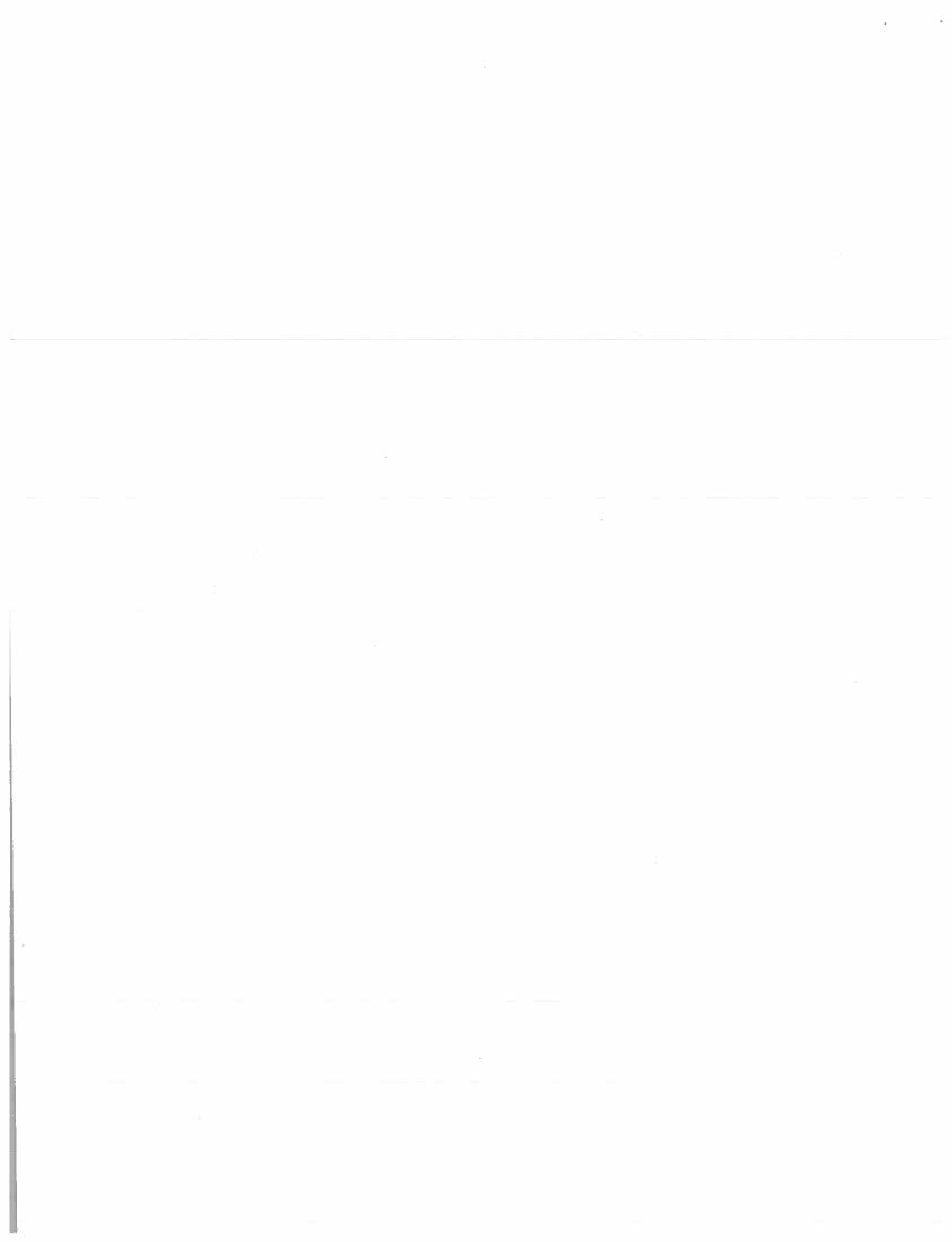
On January 14, 2016, Dr. Moss wrote that he was only minimally concerned about either of her hamstrings. Petitioner demonstrated good motion and strength in the operative leg. He did not feel that any of her left leg posterior shooting pain was coming from a partial hamstring tear. Instead, he opined she was having sciatica since Petitioner was describing a shoot/burning type of pain radiating to the ankle. Dr. Moss noted that even if she had a recurrent tear in the operative hamstring, she still had one tendon attached and with less than 3 cm of retraction she should heal without further surgery. Dr. Moss stated that her labral tear does help explain some of her groin pain which she has been complaining of for months. He recommended an intra-articular injection for this. Dr. Moss did not feel she would be ready to go through another surgery at that point but recommended she get a second opinion from Dr. Domb or another hip arthroscopy specialist.

On January 28, 2016, Dr. Domb reviewed the MRI and examined Petitioner. He diagnosed a work-related injury, which caused: 1) right hip labral tear; 2) right hamstring partial thickness re-tear after operative intervention in April 2015; 3) full thickness tear of the left hamstring tendon; and 4) sciatica left side possible secondary to hamstring tear or from lumbar etiology. Dr. Domb opined that Petitioner's hamstring repair "did not hold up and has retorn." He discussed surgical options with Petitioner. On July 21, 2016, Dr. Domb recommended surgery including a right arthroscopy with labral treatment, femoroplasty, and possible capsulotomy.

Although Dr. Domb causally related Petitioner's left-sided conditions to her work accident, we find this unpersuasive in light of Petitioner's initial post-accident complaints and the opinion of Dr. Moss. Petitioner testified upon falling she heard a pop in her right leg. Moreover, when questioned regarding the source of her pain, Petitioner testified her injury caused symptoms to her right leg only.

We agree with the arbitrator that the opinion of Dr. Nho is unpersuasive regarding the causal relationship between her current condition of ill-being and her work injury and also the need for prospective surgery. We affirm the award of prospective surgery with Dr. Domb as it relates to the *right side.*

Next, we vacate the Arbitrator's award of penalties under §19(k) and attorney's fees under §16 of the Act. However, we affirm Petitioner's entitlement to §19(l) penalties but modify the reasoning and the amount. Petitioner was scheduled for a §12 examination with Respondent's Dr. Nho at 7 a.m. on February 8, 2016. Petitioner's uncontradicted testimony is that on Friday, February 5, 2016, she called Dr. Nho's office and attempted to reschedule the appointment to later in the day on February 8th because she had to drive her son to school that morning, but was told by the scheduler that this could not be accommodated and they would send Petitioner a letter for a different appointment. *T.43-45, 69-70.* We find that Respondent's termination of temporary total disability benefits (TTD) after she did not attend the scheduled §12 examination with Dr. Nho was "without good and just cause" under §19(l) but does not rise to unreasonable and vexatious conduct under §19(k). Petitioner testified that the last TTD check she received covered the period through



February 22, 2016. *T.48*. We find that Petitioner is entitled to §19(l) penalties for Respondent's failure to pay benefits from February 23, 2016 through April 18, 2016, when Petitioner attended the rescheduled examination with Dr. Nho. Respondent's subsequent decision to deny TTD in reliance on Dr. Nho's opinion was not unreasonable but, based on the above, Petitioner is entitled to §19(l) penalties of $30 per day for 287 days, from February 23, 2016, when Respondent terminated TTD "without good and just cause" through the date of hearing on December 5, 2016. The total amount of §19(l) penalties is $8,610.00.

Finally, we correct several clerical errors in Section M on pages 11 and 12 of the Arbitrator's decision, which refers, in multiple places, to a scheduled §12 examination with Dr. Nho on April 8, 2016 and states that Petitioner telephoned Dr. Nho's office on "April 5" to reschedule. The Commission finds, and hereby corrects the decision to reflect, that the examination being referred to is the one that was scheduled for February 8, 2016 and that Petitioner called Dr. Nho's office on February 5th. Petitioner actually did attend the rescheduled §12 examination with Dr. Nho on April 18, 2016.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $466.25 per week for a period of 71-6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $238.16 per week for 11-6/7 weeks for temporary partial disability benefits under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses contained in Petitioner's Exhibits under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for the prospective right-sided surgery recommended by Dr. Domb, along with all reasonable and necessary post-operative care, 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 pay to Petitioner additional compensation of $8,610.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of penalties under §19(k) of the Act and attorney's fees under §16 of the Act are hereby vacated.

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

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 $30,800.00. 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: MAR 12 2019

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 1/16/09
49

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

BAHR, JENNIFER
Employee/Petitioner

Case# **16WC002780**

ARLINGTON HEIGHTS SCHOOL DISTRICT #25
Employer/Respondent

19IWCC0153

On 5/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.02% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3091 DOUGLAS C DORN PC
500 N MICHIGAN AVE
SUITE 600
CHICAGO, IL 60611

0507 RUSIN & MACIOROWSKI LTD
MICHAEL E RUSIN
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

19IWCC0153

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)

Jennifer Bahr
Employee/Petitioner

v.

Arlington Heights School District #25
Employer/Respondent

Case # **16** WC **002780**

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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **December 5, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

C. [ ] 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 [x] TTD

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

ICArbDec19(b) 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 the date of accident, **April 29, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,367.24**; the average weekly wage was $**699.37**.

On the date of accident, Petitioner was **43** 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 $**14,844.77** for TTD, $**3,402.27** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**18,247.04**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$466.25/week** for **71 & 6/7** weeks, commencing **April 30, 2015** through **October 23, 2015**, and from **January 15, 2016** through **December 5, 2016**, as provided in §8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$238.16/week** for **11 & 6/7** weeks, commencing **October 24, 2015** through **January 14, 2016**, as provided in §8(a) of the Act.

Respondent shall authorize and pay for the surgery recommended by Dr. Benjamin Domb, and all reasonable and necessary post-operative care, pursuant to §8(a) of the Act and adjusted in accord with the Medical Fee Schedule as provided in §8.2 of the Act.

Respondent shall be given a credit of for all medical benefits that have been paid by group health insurance provided to Petitioner by Respondent, and Respondent shall hold Petitioner harmless from any claims for reimbursement brought by Petitioner's group health carrier, as provided in Section 8(j) of the Act.

Respondent shall pay to Petitioner penalties of **$3,728.12**, as provided in §16 of the Act; **$3,363.53**, as provided in §19(k) of the Act; and **$8,550.00**, as provided in §19(l) of the Act.

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

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

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

Signature of Arbitrator

May 17, 2017
Date

ICArbDec19(b)

MAY 17 2017

Jennifer Bahr v. Arlington Heights School District #25
16 WC 2780

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care and services?; ***L:*** What temporary benefits are in dispute? TTD TPD; ***M:*** Should penalties be imposed upon Respondent?

FINDINGS OF FACT

Petitioner Jennifer Bahr testified that she was employed as a custodian by Respondent, working the second shift, 2:45 p.m. to 10:45 p.m. Her job as a custodian required her to be on her feet most of the workday, sweeping, mopping, cleaning, vacuuming, and buffing floors. She testified that she had no physical problems before the work accident of April 29, 2015. She testified that on April 29, 2015 she slipped and fell on water while performing her job. She immediately felt a pop and pain in her right buttock and hamstring area.

Petitioner was taken by Arlington Heights Fire Department ambulance to Northwest Community Hospital (Northwest) April 29 (PX #4). She reported that she had fallen on a puddle of water and felt a pop in the hamstring/buttock region. She described 10/10 pain. Petitioner was seen at the Northwest emergency department complaining of pain in the right hip/buttock and leg area as a result of slipping and falling on water (PX #1). She fell with her right leg extended landing on her left knee. She also hurt left wrist. X-rays were negative for fracture. She was diagnosed with left wrist pain, right hip pain, and muscle strain. She was taken off work, prescribed pain medication, crutches, a wrist splint, and instructed to follow up with orthopedics.

On May 1, 2015 Petitioner followed up with Dr. Thomas Kim, M.D., at Orthopedic Associates (PX #2), complaining of pain in the low back and the right hip/buttock and leg as a result of slipping on water and falling. Examination of the hip was limited due to Petitioner's guarding. She was unable lie flat due to pain. There was pain in the right hip on motion. Dr. Kim diagnosed with right hip sprain and strain, lumbar sprain and strain, and left wrist sprain and strain. She was continued off work and referred for an MRI of her right hip and hamstring.

The May 1, 2015 MRI revealed a complete avulsion of the right hamstring tendon origin with an avulsed fragment and mild gluteus medius tendinosis (PX #2).

Petitioner returned to Dr. Kim May 4, 2015 for follow up and review of the MRI. Dr. Kim noted the MRI revealed a complete avulsion of the right hamstring tendon with a small bony fragment. Petitioner was restricted from working and instructed to follow up with Dr. Brian Moss, D.O. Dr. Kim also ordered a venous Doppler test to rule out a DVT. Petitioner saw Dr. Moss on May 6, 2015 (PX #2). He confirmed the avulsion of the hamstring and noted a 3 cm. displacement. Dr. Moss diagnosed a right proximal hamstring tendon avulsion. Dr. Moss discussed treatment options from conservative to surgery. He explained that the avulsion may heal without surgery. By May 13, 2015, Petitioner's symptoms had persisted. She complained that she could not sit without pain. Dr. Moss and Petitioner then agreed on surgery (PX #2).

On May 19, 2015 Dr. Moss performed an open surgical repair of the right proximal hamstring tendon at Northwest Community Hospital (PX #1 & PX #2). Petitioner followed with Dr. Moss approximately once per month following surgery. She used crutches until October 2015. She started physical therapy in July 2015. Petitioner was restricted from working through October 23, 2015. Throughout this time, Petitioner continued to complain of pain and limitations in the buttock and hamstring area (PX #2).

Petitioner testified she was released to work light duty with restrictions which started on November 2, 2015. She then worked 20 hours per week.

On November 19, 2015 Petitioner followed up with Dr. Moss (PX #2). He noted Petitioner's complaints of continued to have posterior thigh pain radiating to groin. Dr. Moss noted Petitioner was making slow progress with but still with significant pain. He recommended she continue physical therapy for strengthening and motion. He prescribed a home TENS unit. He recommended part time work and restrictions because extended time in a chair will aggravate her ischial bursitis further. He noted that if her inflamed sciatic nerve does not calm down in one month he would recommend referral to pain management for possible ischial bursa steroid injection.

On December 17, 2015, Petitioner returned to Dr. Moss complaining of groin pain which radiates to hamstring and down the back of her leg, complains of sciatic pain in both legs (PX #2). Dr. Moss recommended continued physical therapy for strengthening, a referral to Dr. Marsiglia for pain management recommendations on oral medicine for sciatic nerve type pain, and recommended an MRI of her hip to evaluate a reason for her groin pain and to look at hamstring repair.

On January 8, 2016, Petitioner had another MRI at Northwest Community Hospital (PX #1 & PX #2). The MRI revealed a recurrent tear of the biceps femoris/semitendinosus common origin with distal retraction by 2.7 cm., mild right proximal semimembranosus tendinopathy without a tear, a partial tear of the left hamstring tendon with mild underlying tendinopathy worse compared to May 1, 2015, and a superior right acetabular labral tear.

On January 14, 2016 Petitioner returned to Dr. Moss (PX #2). Petitioner complained of pain down both legs which radiated below the knee to the ankle and groin pain on the right. Dr. Moss explained that he was minimally interested in her hamstrings but noted the MRI finding of a recurrent right hamstring tear and labral tear. He believed the labral tear explained some of her groin pain which she had been complaining of for months. Dr. Moss noted that he believed Petitioner's hamstring tear would heal without surgery but still recommended she get a second opinion from Dr. Benjamin Domb, M.D. Petitioner testified on cross-examination that Dr. Moss did not recommend surgery and said he did not do that type of surgery. He restricted Petitioner from working and held her physical therapy because it aggravated symptoms.

On January 28, 2016, Petitioner saw Dr. Domb at Hinsdale Orthopedics (PX #3). She gave a history of her fall onto her right hip at work. She reported her history of care with Dr. Moss and his diagnosis of hamstring tear with surgery. Petitioner continued to have groin pain since her surgery. On examination Dr. Domb noted an antalgic gait. Right hip motion was limited by pain. There was a positive anterior impingement sign, a positive Faber sign, a negative iliopsoas snapping, and reduced strength in the right hip.

After examination and review of the MRI, Dr. Domb diagnosed a right hip labral tear with FAI (femoral acetabular impingement), a right hamstring partial thickness re-tear, and a full thickness tear of the left hamstring tendon. He opined that these problems were caused by the work injury in April 2015. He recommended a diagnostic arthroscopic labral repair vs debridement vs reconstruction, a femoroplasty with possible acetabuloplasty, iliopsoas release, microfracture, and capsular release vs plication.

On February 12, March 16, May 20 and July 15, 2016, Petitioner saw Dr. Moss (PX #2, PX #5, & PX #7). On each visit, Dr. Moss noted no improvement in Petitioner's condition and she was to remain off work pending surgery recommended by Dr. Domb.

Petitioner testified that she was notified that she was to attend a §12 IME at Respondent's request on February 8, 2016 at 7:00 a.m. with Dr. Shane Nho of Midwest orthopedics at RUSH in Westchester. She testified that on February 5, 2016 she called

the scheduler to inform them that she was unable to attend the exam at 7:00 a.m. as she had to take her son to school in Palatine early for special help. She asked if the exam could be scheduled later the same date. The scheduler advised her that they couldn't reschedule it for the same date but they would send her a letter with a new date.

Petitioner was extensively cross-examined on the circumstances of her requesting rescheduling the IME. She was asked about what alternative transportation was available for her son such as a cab or asking someone else to driver her son. She testified that at that time there was no alternative transportation available.

Petitioner had not received a new letter for the rescheduled IME by February 16, 2016, Petitioner's attorney left a voicemail message and sent correspondence to Respondent requesting the IME be rescheduled (PX #6). Respondent terminated Petitioner's benefits effective February 8, 2016.

On March 30, 2016, Respondent rescheduled Petitioner for an IME on April 18, 2016 (PX #6). Petitioner attended that exam with Dr. Nho. Dr. Nho faxed a "quick report" to Respondent on that same day opining that Petitioner was not able to work, that Petitioner's diagnosis and treatment was causally related to her accident, and that Petitioner was not at MMI (PX #6 & RX#1).

On July 25, 2016 Petitioner returned to Dr. Domb (PX #3). Dr. Domb examined Petitioner and reviewed the MRI. He also reviewed Dr. Nho's IME report. He noted that Dr. Nho opined that Petitioner's hamstring tear had healed and that Petitioner was at MMI. Petitioner complained of persistent bilateral buttock pain and shooting pain down to the calf. She also complained of low back pain on the right and right groin pain.

On examination Dr. Domb noted snapping of left and right iliopsoas. He noted antalgic gait. Left hip motion and strength, except for hamstrings, were normal. Right hip motion and strength were limited by pain. There was still positive anterior impingement and positive log roll on the right. Dr. Domb noted there was a recurrent right hamstring tear, a right superior labral tear, and a partial tear on the left. He noted Petitioner would benefit from a right hip arthroscopy, labral treatment, femoroplasty, possible capsulotomy, iliopsoas fractional lengthening, capsular plication, and microfracture. He noted that Petitioner was unable to return to work.

Petitioner testified that she continues to experience pain in her buttocks and groin and the pain has been ongoing since she slipped and fell while working on April 29, 2015. Petitioner testified that she would like to have surgery as recommended by Dr. Domb.

Dr. Nho testified at evidence deposition on August 8, 2016. He refreshed his memory from the IME report he wrote April 18, 2016 and the addendum dated June 3, 2016. Petitioner objected to Respondent's offer of admission in evidence of the two reports. Petitioner's hearsay objection was sustained and the reports were not admitted or considered by the Arbitrator.

Dr. Nho testified to the history Petitioner gave as well as his review of her medical care following her work accident. Dr. Nho agreed with the initial diagnosis of right hamstring avulsion tear and that it was related to the work accident. He also agreed that the surgical repair of the torn hamstring was medically necessary.

On examination Dr. Nho Petitioner's hip range of motion was reduced. He also found tenderness and reduced strength in the hip musculature. He did not find signs of joint instability or impingement. He diagnosed right proximal hamstring syndrome. At the time of the April 18 exam he did not have the MRI images to review, and so did not opine whether Petitioner required further medical intervention.

Dr. Nho wrote his June 3 addendum after reviewing the January 1, 2016 MRI. He then opined that Petitioner had a fully healed right hamstring. He further opined That Petitioner was at MMI and did not require further treatment. He also opined that Petitioner could return to work without restriction. Dr. Nho explained that the findings on the January MRI were degenerative and not unusual for someone Petitioner's age.

Dr. Nho's cross-examination was at times contentious. He argued with Petitioner's counsel from time to time. Dr. Nho conceded that Petitioner's tenderness at the time of his exam was over that same area of the hamstring tear. He noted that his interpretation of the January MRI was contrary to the radiologist's interpretation, who he assumed was board certified. He stated that nothing on the MRI supports a need for surgery. Dr. Nho also testified that he did not believe the tendinosis apparent on the MRI could come from incomplete healing of the original hamstring tear, emphasizing that the hamstring was totally healed. He did not agree that Petitioner has proximal tendinosis of the right hamstring. He further stated that tendinosis is not a real diagnosis or even painful.

CONCLUSIONS OF LAW

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

There is no dispute that Petitioner sustained a torn right hamstring and other hip injuries when she fell at work on April 29, 2015. There is no dispute that her injuries required surgery and post-operative physical therapy. What is disputed is whether

Petitioner fully recovered from her injury and whether her current condition of ill-being is due to a recurrence of her original injury. The Arbitrator finds that Petitioner proved that her current condition of ill-being is causally related to her original work injury on April 29, 2015.

The Arbitrator reviewed the testimony and medical evidence including records of Dr. Moss, Dr. Domb, and Dr. Nho. The Arbitrator after weighing all the testimony and evidence adopts the opinions of Dr. Domb. Dr. Domb's opinions are based on his clinical exams of Petitioner as well as the January 8, 2016. Based on that evidence he opined that Petitioner has a recurrent tear of the right hamstring which requires surgery. To the contrary, Dr. Nho opined that, despite objective evidence of a recurrent tear of the right hamstring with 2.7 cm. of retraction from the January 8 MRI, that the hamstring is totally healed. Dr. Nho turned a blind eye to objective evidence on the MRI. Two competent physicians, Dr. Domb and radiologist Dr. David Dubois, found a recurrent tear of the right hamstring on the January 8 MRI. In particular, Dr. Dubois' interpretation was based on comparison with the May 1, 2015 MRI.

In addition, the Arbitrator finds that Dr. Nho was not otherwise persuasive. He tended to testify in dogmatic absolutes, which is not typical of an academically based expert. In addition, he displayed an arrogant and dismissive demeanor and frequently argued with counsel during cross-examination.

It is the Arbitrator's conclusion that Petitioner proved that her current condition of ill-being as described by Dr. Domb is causally connected to her work injury of April 29, 2015. The arbitrator finds that the recurrent right hamstring tear, a right superior labral tear and a partial tear on the left are causally connected to the work injury.

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

In light of the Arbitrator's findings above that Petitioner current condition of ill-being is causally related to her work injury the Arbitrator finds that petitioner is entitled to the medical care necessary to cure or relieve the effects of her injuries. Therefore, Respondent shall pay reasonable and necessary medical services, as indicated in Exhibits 4, 7, 8, 9 and 10, pursuant to §8(a) of the Act to the extent that charges for those services are unpaid and in accord with the Medical Fee Schedule provided in §8.2 of the Act.

Respondent shall be given a credit of for all medical benefits that have been paid by group health insurance provided to Petitioner by Respondent, and Respondent shall

hold petitioner harmless from any claims for reimbursement brought by Petitioner's group health carrier, as provided in §8(j) of the Act.

K: Is Petitioner entitled to prospective medical care and services?

The Arbitrator previously found that Petitioner proved that her current condition of ill-being is causally related to her work accident. That finding was based on the Arbitrator finding that the opinions of Petitioner's treating physician, Dr. Domb, was more persuasive that the opinions of Respondent's §12 expert. For the reason stated above the Arbitrator also finds that the opinion of Dr. Domb that Petitioner requires additional surgery to be more persuasive that the opinion of Dr. Nho to the contrary.

The Arbitrator did not afford Dr. Moss' opinion regarding future surgery inasmuchas he referred Petitioner to Dr. Domb specifically for a second opinion.

Therefore, the Arbitrator orders Respondent to authorize and pay for surgery recommended by Dr. Domb, which includes a right hip arthroscopy, labral treatment, femoroplasty, possible capsulotomy, iliopsoas fractional lengthening, capsular placation and microfracture. Respondent shall also authorize and pay for reasonable and necessary post-operative care.

L: What temporary benefits are in dispute? TTD/TPD

Petitioner was restricted from working by her treating physicians starting April 30, 2015 through October 23, 2015. Petitioner was released to work part time, 20 hours per week which started on November 2, 2015 and continued through January 14, 2016. From January 15, 2016 through December 5, 2016, petitioner has been restricted from working by Drs. Moss and Domb. Respondent shall pay Petitioner temporary total disability benefits of $466.25/week for 71 & 6/7 weeks, commencing April 30, 2015 through October 23, 2015, and from January 15, 2016 through December 5, 2016, as provided in §8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $238.16/week for 11 & 6/7 weeks, commencing October 24, 2015 through January 14, 2016, as provided in section 8(a) of the Act.

M: Should penalties be imposed upon Respondent?

Petitioner was scheduled for a §12 IME with Dr. Shane Nho at his Westchester office at 7:00 AM on Monday, April 8, 2016. Petitioner credibly testified that on the afternoon of Friday, April 5 she telephoned Dr. Nho's office requesting a rescheduling of

the IME. She testified that rescheduling was necessary because all she had to drive her son to school early on the morning of April 8 for special academic help. Petitioner testified credibly that Dr. Nho's scheduler agreed to reschedule and contact her later regarding a new date for the IME. Respondent offered no evidence to rebut Petitioner's credible testimony that she requested rescheduling of the IME. Respondent terminated Petitioners benefits when she did not appear for her IME before Dr. Nho on April 8, 2016.

It is undisputed that both Dr. Moss and Dr. Domb had restricted Petitioner from working at that time of the schedule IME.

The Arbitrator notes that Petitioner resided in Palatine, Illinois at the time of the scheduled IME. The Arbitrator further knows Dr. Nho's office at Midwest Orthopedics at RUSH in Westchester, Illinois is approximately 27 miles from Petitioner's residence in Palatine. The Arbitrator also notes that the estimated travel time from Palatine to Westchester is approximately 35 minutes, without accounting for rush-hour traffic. Petitioner's IME was scheduled for 7:00 a.m., which would have required Petitioner to leave her home no later than 6:00 a.m., not accounting for normal daily personal preparation.

The Arbitrator finds that scheduling an IME at the time and place scheduled here did not comply with the provisions of §12 of the Act requiring an examination to be conducted "at a time and place reasonably convenient for the employee." The Arbitrator may have been persuaded otherwise with the showing Dr. Nho routinely consulted with his own patients beginning office hours at 7:00 AM. The Arbitrator also finds that Petitioner made a good faith effort to comply with Respondent's request for a §12 IME when she requested rescheduling the business day before the IME. Accordingly, the Arbitrator finds that Respondent violated the provisions of §19(k) and §19(l) of the Act for unreasonable and vexatious termination of Petitioner's benefits for her purported refusal to attend a §12 IME on April 8, 2016.

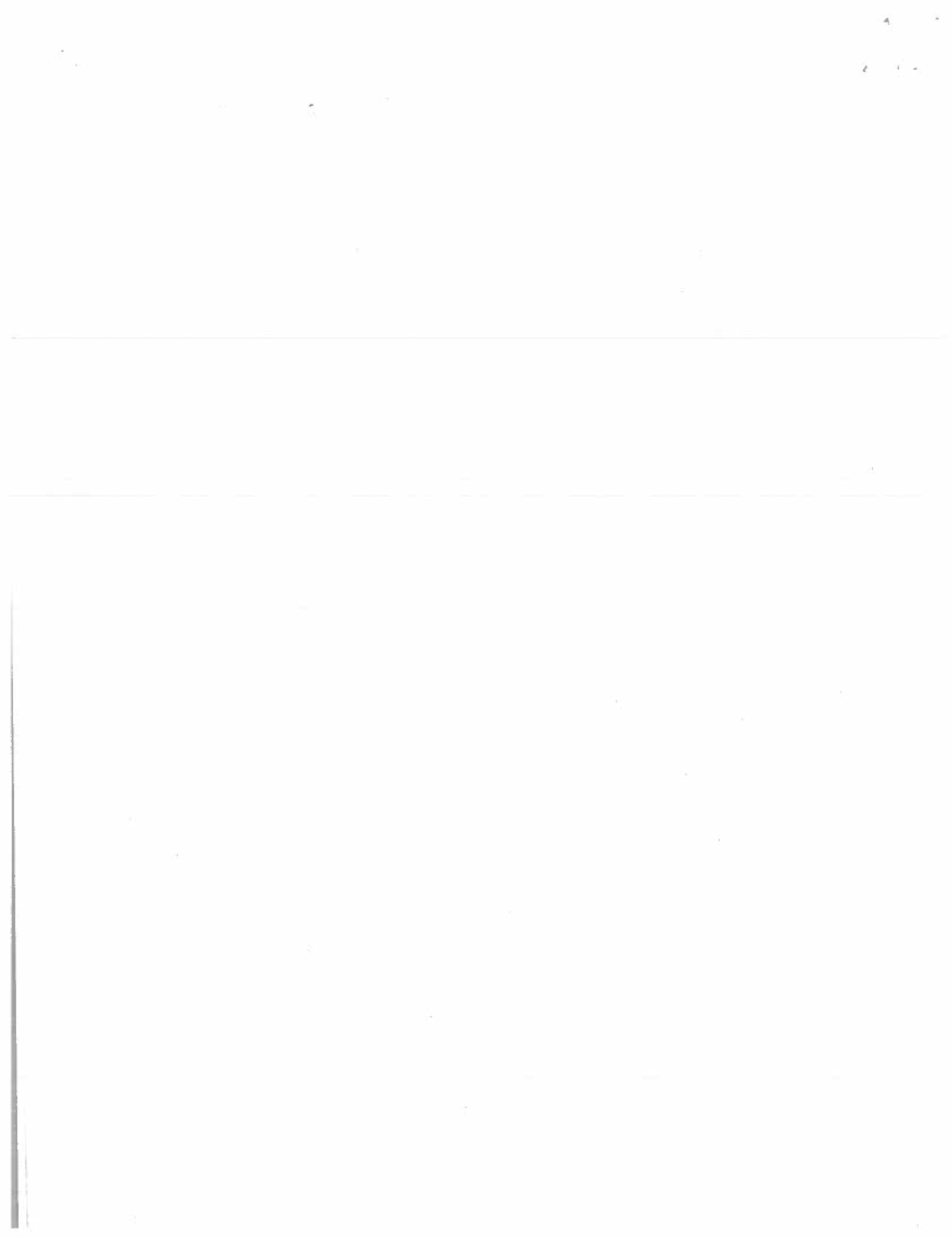
The Arbitrator finds that Respondent's refusal to pay Petitioner temporary total disability from February 23, 2016 through June 3, 2016, 14 & 3/7 weeks was unreasonable and frivolous pursuant to §19(k) of the Act. 14 & 3/7 weeks of TTD is $6,727.06. 50% is $3,363.53.

The Arbitrator finds that Respondent's refusal to pay Petitioner temporary total disability from February 23, 2016 through June 3, 2016 was without good cause pursuant to §19(l) of the Act. Respondent failed to pay TTD owed to Petitioner for 285 days, which multiplied by $30.00 per day amounts to $8,550.00.

The Arbitrator finds that Petitioner is entitled to attorney's fees pursuant to §16 of the Act totaling $3,728.12. The current award includes TTD of $6,727.06 plus §19(k) penalties $3,363.53 plus §19(l) penalties $8,550.00 equaling balance due of $18,640.59. 20% of this award equals $3,728.12 for Respondent's reasonable denial of benefits owed to Petitioner.

Steven J. Fruth, Arbitrator

May 17, 2017



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

ROBERT BROCK,

Petitioner,

vs. NO: 10 WC 00629

CENTURION INDUSTRIES, INC.,
a/k/a A-LERT,

19IWCC0154

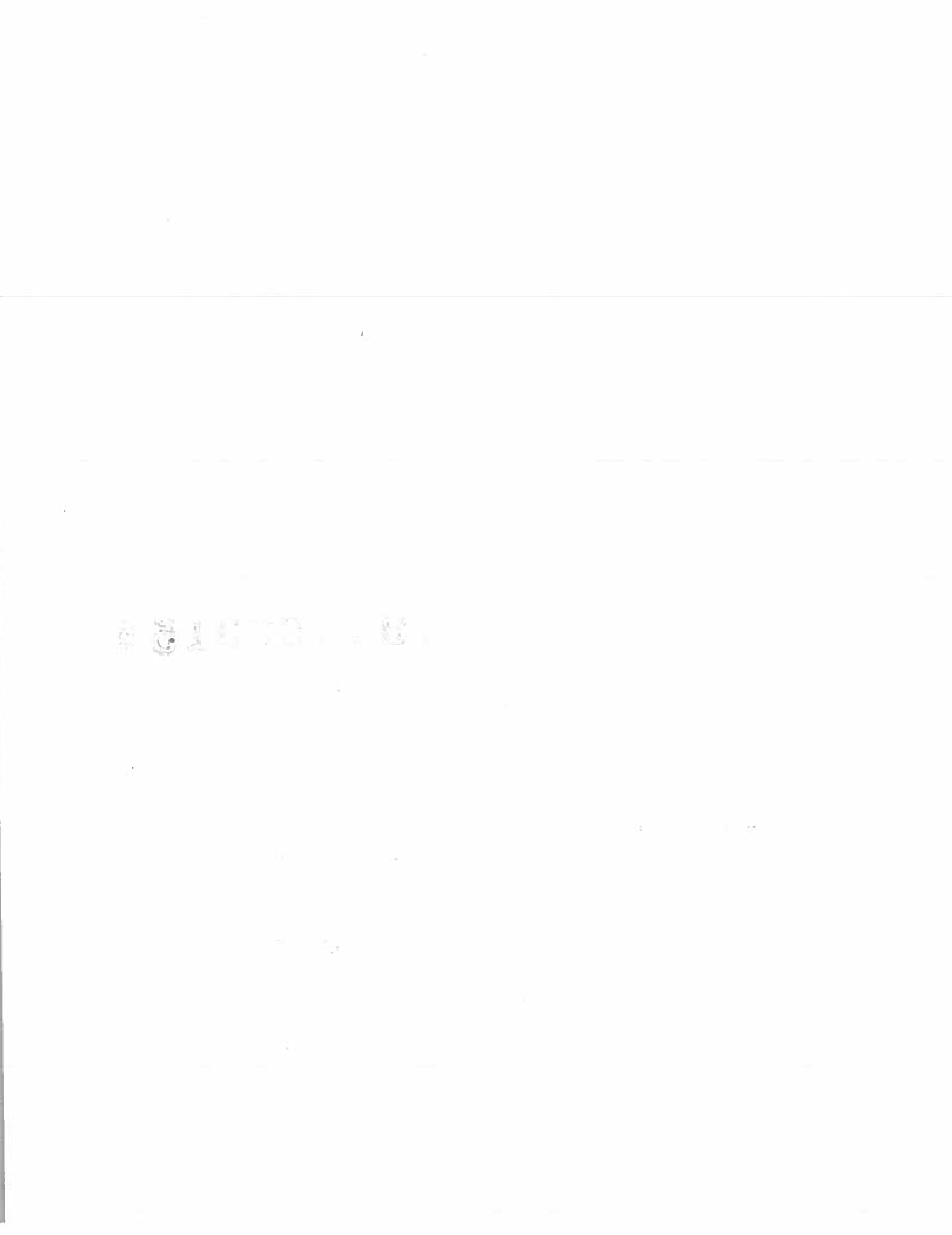
Respondent.

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 wage differential, permanent partial disability (PPD) benefits, and the objections contained therein, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator filed with the Commission on May 9, 2018, which is attached hereto and made a part hereof.

After the hearing of oral arguments on January 14, 2019, the Commission received a Motion from the Respondent on January 17, 2019, requesting leave to file a Supplemental Brief *Instanter* regarding the vocational rehabilitation process and its application to the facts of the case. Respondent has alleged that it was ambushed by the argument of Petitioner's counsel and the questions posed by the Commissioners then sitting.

Effectively, Respondent's counsel believes he should be granted such leave due to his perceived ineffectiveness at oral argument. The filing of a supplemental pleading will not, however, change the Commission's collective mind regarding the outcome of this case.



Respondent's Motion is hereby denied for the following reasons: Firstly, it is not timely. The Commission Rules do not provide for the taking of additional briefs and argument based upon a poor performance at oral arguments. Secondly, the issues raised were neither new nor novel. Thirdly, the vocational rehabilitation of the Petitioner was at issue at the time of the Commission's first Decision on Review. Finally, the issue of vocational rehabilitation and Petitioner's position regarding same were raised both by the Respondent in its initial brief and by Petitioner in his Response Brief.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 9, 2018 is hereby affirmed and adopted;

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to File Supplemental Brief *Instanter* is hereby denied;

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion to Strike is hereby deemed moot;

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 the Circuit Court.

DATED: MAR 1 2 2019

KWL/mv
O: 1/14/19
042

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROCK, ROBERT H
Employee/Petitioner

Case# **10WC000629**

CENTURION INDUSTRIES INC A/K/A A-LERT
Employer/Respondent

19IWCC0154

On 5/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

2986 PAUL A COGHLAN & ASSOC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

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

Robert H. Brock
Employee/Petitioner

v.

Centurion Industries, Inc., a/k/a A-Lert
Employer/Respondent

Case # 10 WC 00629

Consolidated cases: n/a

19IWCC0154

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 12, 2018. By stipulation, the parties agree:

On the date of accident, December 18, 2009, 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 $n/a; the average weekly wage was $1,163.58.

At the time of injury, Petitioner was 32 years of age, single, with 0 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, commencing August 20, 2017, of $482.39 per week for the duration of the disability weeks because the injury 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.

William R. Gallagher, Arbitrator

May 5, 2018
Date

MAY 9 - 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on December 18, 2009. The Application alleged Petitioner sustained an injury to the left upper extremity and man as a whole as a result of the accident of December 18, 2009 (Arbitrator's Exhibit 2).

This case was previously tried in a 19(b) proceeding on February 10, and April 26, 2010. At that time, Respondent disputed liability on the basis of accident and causality. The Arbitrator ruled in favor of Petitioner and awarded temporary total disability benefits, medical, penalties and attorneys' fees as well as prospective medical treatment. The prospective medical treatment awarded was left shoulder surgery (Petitioner's Exhibit 1).

Respondent filed a review of the Arbitrator's Decision to the Workers' Compensation Commission. The Commission affirmed the Arbitrator's Decision and Opinion on Review on March 18, 2011. Respondent then filed an appeal of the Commission's Decision and Opinion on Review to the Circuit Court of Perry County. On September 8, 2011, the Circuit Court of Perry County affirmed the Commission's Decision and Opinion on Review. Respondent then filed an appeal to the Fifth District Appellate Court. On September 26, 2012, the Appellate Court vacated the Commission's Decision and Opinion on Review in regard to penalties and attorneys' fees, but affirmed the remainder of the Commission's Decision and Opinion on Review (Petitioner's Exhibit 1).

On October 15, 2015, the case was again tried. At that time, Petitioner sought an order for payment of temporary total disability benefits, maintenance, medical, penalties and a determination of permanent disability. On September 6, 2016, the Arbitrator awarded Petitioner temporary total disability benefits, maintenance and medical expenses. In regard of permanent disability, the Arbitrator awarded Petitioner wage differential benefits pursuant to Section 8(d)1 of $583.22 per week commencing February 18, 2015 (Arbitrator's Exhibit 3).

Respondent filed a review of the Arbitrator's Decision of the case tried on October 15, 2015, to the Workers' Compensation Commission. On May 10, 2017, the Commission modified the Arbitrator's Decision and vacated the award of wage differential benefits. The case was remanded to the Arbitrator and Respondent was ordered to provide vocational rehabilitation services to Petitioner with the objective being to retrain Petitioner to work as a welder (Arbitrator's Exhibit 3).

When this case was tried on April 12, 2018, the only disputed issue was the nature and extent of disability. Counsel for Petitioner alleged that Petitioner was entitled to a wage differential award pursuant to Section 8(d)1 of the Act. Counsel for Respondent alleged Petitioner was entitled to a person as a whole award pursuant to Section 8(d)2 of the Act (Arbitrator's Exhibit 1).

As was noted in the prior Decisions, Petitioner sustained an injury to his left shoulder on December 18, 2009, while working for Respondent as a welder. Petitioner was eventually treated by Dr. George Paletta, an orthopedic surgeon. Dr. Paletta performed left shoulder surgery on May 26, 2011, which consisted of a type II labral repair, subacromial decompression and bursectomy (Petitioner's Exhibit 1).

Both Dr. Paletta and Dr. James Strickland (Respondent's Section 12 examiner) agreed that Petitioner had permanent restrictions of no overhead welding and no lifting in excess of 25 pounds at chest level (Arbitrator's Exhibit 3). There was no dispute that, because of the restrictions, Petitioner could not return to work to the job he had at the time he sustained the accident.

Both counsel for Petitioner and Respondent had Petitioner evaluated by vocational experts. Petitioner's counsel had him evaluated by June Blaine. Respondent's counsel had Petitioner evaluated by Joseph Belmonte.

Blaine saw Petitioner for the first time on October 30, 2013, and opined Petitioner could not return to work to his previous job as a welder. In a report dated March 27, 2015, Blaine opined Petitioner could not return to work as an industrial welder, but without further training, Petitioner could earn $10.00 to $11.00 per hour in his local area (Petitioner's Exhibit 1; Petitioner's Exhibit 9; Deposition Exhibit 3).

Belmonte evaluated Petitioner on February 18, 2014. Belmonte noted that Petitioner had a lifting restriction above the shoulder level, but could not determine if Petitioner had lost access to his customary employment as a welder (Petitioner's Exhibit 1; Respondent's Exhibit 3).

Blaine was deposed on June 4, 2015, and her deposition testimony was received into evidence when this case was previously tried on October 15, 2015. Blaine testified that Petitioner's industrial welding job (the job he had at the time of the accident) was in the heavy demand category because it required 50 pounds of force occasionally and 25 to 50 pounds of force frequently. Given his restrictions, Blaine testified Petitioner could not return to work as an industrial welder. Blaine stated Petitioner could perform shop welding, but at a pay of $11.00 to $13.00 per hour versus $29.00 to $30.00 per hour as an industrial welder (Petitioner's Exhibit 1; Petitioner's Exhibit 9; pp 16-20, 24-25).

Belmonte was deposed on July 22, 2015, and his deposition testimony was received into evidence when this case was previously tried on October 15, 2015. Belmonte testified Petitioner was determined to have lost access to his usual and customary job as a welder. He stated Petitioner could return to work as a welder at the heavy demand level so long as the job did not require Petitioner to lift 25 pounds above chest level (Petitioner's Exhibit 1; Respondent's Exhibit 9; pp 9-13).

Subsequent to the Commission's Decision and Opinion on Review of May 10, 2017, Petitioner again met with Blaine on June 13, 2017. At that time, Blaine assisted Petitioner with job seeking skills to help him prepare for a job search in Southern Illinois (Petitioner's Exhibit 2; Deposition Exhibit 2).

On June 15, 2017, Petitioner interviewed with a potential employer in DuQuoin, Illinois. While the potential employer was impressed with Petitioner's welding skills, he needed a mechanic who could also do welding (Petitioner's Exhibit 2; Deposition Exhibit 2).

Petitioner subsequently saw Blaine on July 6, and July 20, 2017. Petitioner had continued to follow up with potential employers for welding jobs. He was informed that his inability to read blueprints prevented him from being considered. The pay for those jobs was $10.00 to $11.00 per hour. When Blaine was informed of the preceding, she determined that there was a blueprint reading class available at a community college that would cost approximately $360.00 and ran from August 21, to December 15, 2017 (Petitioner's Exhibit 3; Deposition Exhibit 2).

On August 7, 2017, Petitioner's counsel sent Respondent's counsel an e-mail attaching a copy of Blaine's most recent report and asked if Respondent would approve Petitioner's enrollment in the blueprint reading class at a community college (Petitioner's Exhibit 3). At trial, Petitioner testified he never received either an approval or denial from Respondent regarding enrollment in the blueprint reading class.

At trial, Petitioner testified that his house had burned down in August, 2017. At that time, he met with a representative of Ed Gund Construction about rebuilding his house. Ed Gund Construction was a company that builds homes, steel buildings and other non-industrial structures. In the course of his discussions with Ed Gund Construction, he advised them of his prior work as a welder.

On August 20, 2017, Petitioner began working for Ed Gund Construction as a welder at the rate of $11.00 per hour. Petitioner testified in detail about the welding jobs he performed for Ed Gund Construction and how it was different from the welding jobs he had performed for Respondent at the time he sustained the accident. The welding tasks Petitioner performs for Ed Gund Construction included such things as working on trailer hitches and forklifts. Petitioner remains seated and the items he welds are set before him. In additional to welding, Petitioner also operates heavy equipment for Ed Gund Construction. All of the work Petitioner has performed for Ed Gund Construction has been consistent with his work restrictions. When Petitioner worked as a welder for Respondent, he had to do a great deal of overhead work, get in various awkward positions, lift 50 to 60 pounds, etc.

On August 30, 2017, Petitioner again met with Blaine and informed her of his job with Ed Gund Construction. At that time, Petitioner informed Blaine he was working full time, 40 hours per week at $11.00 per hour. Petitioner thought that the job would be a long-term position for him because Ed Gund Construction has been in business for over 20 years (Petitioner's Exhibit 2; Deposition Exhibit 2).

At the direction of Respondent's counsel, Belmonte reviewed various documents which included the reports prepared by Blaine, Petitioner's job search records, payroll information from Ed Gund Construction and the prior Decision and Opinion on Review of the Commission. Belmonte noted Petitioner had returned to work as a welder and could continue to work in that capacity (Respondent's Exhibit 1; Deposition Exhibit 2).

Blaine was deposed on January 16, 2018, and her deposition testimony was received into evidence at trial. Blaine's testimony was consistent with her narrative reports and she reaffirmed the opinions contained therein. Specifically, Blaine testified that because of Petitioner's left shoulder condition and restrictions that he could not return to work as an industrial welder. She noted that Petitioner's job duties as a welder for Ed Gund Construction were substantially different than those that he performed while an industrial welder because he no longer had to climb or work overhead. She stated Petitioner's $11.00 per hour wage rate was consistent with similar positions in Southern Illinois for welders (Petitioner's Exhibit 1; pp 17-21).

Belmonte was deposed on April 4, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Belmonte reaffirmed his opinion Petitioner could return to work as a welder (Respondent's Exhibit 1; pp 8-9).

On cross-examination, Belmonte could not state whether some welding jobs required lifting of 25 pounds overhead. He could not recall if Petitioner had informed him that his job for Respondent required him to lift 25 pounds overhead (Respondent's Exhibit 1; pp 15-19).

Conclusion of Law

The Arbitrator concludes Petitioner has sustained an injury which caused a permanent loss of earnings pursuant to Section 8(d)1 of the Act and that he is entitled to permanent partial disability benefits of $482.39 per week for the duration of the disability commencing August 20, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner could not return to work to the job of an industrial welder that he had at the time he sustained the injury. Both Petitioner's treating physician, Dr. Paletta, and Respondent's Section 12 examiner, Dr. Strickland, imposed permanent restrictions which prevented Petitioner from returning to work as an industrial welder.

The Arbitrator is persuaded by the opinion of Petitioner's vocational expert, June Blaine, that Petitioner's current job as a welder for Ed Gund Construction at $11.00 per hour was consistent with similar positions in Southern Illinois.

Respondent's vocational expert, Joseph Belmonte, agreed that Petitioner could return to work as a welder, but was not aware of the fact that the duties of an industrial welder were more physically demanding than the welding currently performed by Petitioner for Ed Gund Construction.

If not for the shoulder injury and the restrictions imposed as a result thereof, Petitioner would have an average weekly wage of $1,163.58. Petitioner presently has an average weekly wage of $440.00 (40 hours at $11.00 per hour). The difference is $723.58 ($1,163.58 - $440.00). The wage differential pursuant to Section 8(d)1 is $482.39 (2/3 of $723.58).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marisela Flores,

Petitioner,

vs. NO. 14WC 27777

Chick-Fil-A,

19IWCC0155

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical 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 April 19, 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.

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: MAR 12 2019
SJM/sj
o-2/21/2019
44

Stephen J. Mathis

David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator, issued pursuant to Section 19(b), in which she found that Petitioner proved a compensable accident on November 28, 2014, which caused a condition of ill-being of her right wrist. The Arbitrator awarded Petitioner 188&2/7 weeks of temporary total disability benefits (to the date of arbitration), current medical expenses submitted by Petitioner, and ordered Respondent to authorize and pay for prospective treatment recommended by Dr. Fernandez. I would have found that Petitioner did not sustain her burden of proving her current condition of ill-being was causally related to her alleged work accident and denied compensation.

Petitioner testified that on February 26, 2014 she was carrying items on a tray when she slipped and fell and landed on her right hand. However, on cross examination, she testified that she slipped but did not fall but rather she reached forward to place the tray on a counter and in the process the tray struck her wrist. The medical records also note other inconsistent histories of accident. Petitioner also testified that she had pain around the "plate" in her wrist but did not know where the plate was.

Petitioner did not seek medical care until March 13, 2014 when she went to a hospital emergency department. She was referred to Dr. Elstrom, who noted the x-rays were normal. He

diagnosed wrist sprain, recommended therapy, and took Petitioner off work for two weeks. Later, she had an injection and was released to work without restrictions on June 23, 2014.

Despite her release, Petitioner continued treatment, including treatment with a chiropractor. She saw Dr. Fernandez for a Section 12 examination on November 20, 2014. He recommended an MRI with contrast. Petitioner had an MRI on August 6, 2015 which showed Kienbock's disease, in which ulnar bone tissue becomes necrotic because of lack of blood supply. Dr. Fernandez was provided additional medical records, including the MRI, and an EMG showing evidence of carpal tunnel syndrome. On November 24, 2015, Dr. Fernandez issued an addendum report in which he opined that Petitioner's falling on her outstretched hand at a minimum aggravated her condition and caused her current complaints related to Kienbock's disease and carpal tunnel syndrome. Later in his deposition, Dr. Fernandez opined that her "fall" "could have" aggravated her underlying condition. Petitioner returned to Dr. Fernandez, now as her treating doctor. On April 18, 2016, Dr. Fernandez performed right-wrist arthroscopy with partial synovectomy, carpal tunnel release, and radius shortening osteotomy.

Petitioner was seen by Dr. Vender for two Section 12 examinations. It was his understanding that Petitioner suffered an injury when a metal box she was carrying fell on her hand. At his deposition, Dr. Vender explained that Kienbock's disease is idiopathic in nature and the cause is unknown. He did not believe that a single traumatic event could cause Kienbock's disease. He also noted that Petitioner exhibited various non-physiologic behaviors during his examinations.

I find the causation opinion of Dr. Vender more persuasive than Dr. Fernandez. In my opinion, Dr. Fernandez had an inaccurate impression of the mechanism of injury. In addition, his causation opinion was equivocal in nature, while Dr. Vender's was not. Finally, because of the internal inconsistencies in Petitioner's testimony, inconsistent histories of injury in the medical records, and her display of non-physiologic behaviors, I find Petitioner not to be a credible witness. Therefore, I would have found that Petitioner did not sustain her burden of proving she sustained a work-related condition of ill-being and denied compensation. Therefore, I respectfully dissent from the majority opinion.

Deborah L. Simpson

Deborah L. Simpson

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

FLORES, MARISELA
Employee/Petitioner

Case# **14WC027777**

CHICK-FIL-A
Employer/Respondent

19IWCC0155

On 4/19/2018, 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 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1609 BOTTO GILBERT LANCASTER PC
FRANCISCO J BOTTO
970 McHENRY AVE
CRYSTAL LAKE, IL 60014

0507 RUSIN & MACIOROWSKI LTD
EVAN KLUG
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

19IWCC0155

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- xxxNone of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(A)

Marisela Flores
Employee/Petitioner

Case # 14 WC 27777

v.

Consolidated cases: ______

Chik-Fil-A
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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Woodstock**, on **March 8, 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] Is Petitioner entitled to any prospective medical care?

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **February 26, 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 **$21,299.23**; the average weekly wage was **$409.60**.

On the date of accident, Petitioner was **36** years of age, *single* with **2** dependent children.

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

Respondent shall be given a credit of **$36,357.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$36,357.20**. ARB EX 1.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. ARB EX 1.

ORDER

Respondent shall pay Petitioner the reasonable and necessary medical services incurred in connection with the care and treatment of her causally related conditions pursuant to Sections 8(a) and 8.2 of the Act and as indicated on Petitioner's exhibit 9. Respondent shall authorize and pay for prospective medical care as recommended by Dr. Fernandez pursuant to Sections 8 and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 188-2/7 weeks, commencing July 31, 2014 through March 8, 2018, 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.

Carolyn M. Doherty
Signature of Arbitrator

4/18/18
Date

APR 19 2018

FINDINGS OF FACT

Petitioner testified via interpreter at trial. At trial, the issues in dispute were accident, causal connection, ttd, medical expenses, fees and penalties, and Petitioner's request for prospective medical treatment under Section 8(a) of the Act. ARB EX 1.

Petitioner testified that on 2/26/14, she worked for Respondent Chik-Fil-A as a fast food worker. On that day, her job duties required her to carry a heavy aluminum tray with both hands. Petitioner testified that as she carried the tray she slipped. As she slipped, she tried unsuccessfully to put the tray on a counter but testified that the bottom of the tray struck her right wrist. Petitioner testified that the tray hit her right wrist "hard." Petitioner testified that she reported the incident to her manager and notice is not at issue. ARB EX 1.

Petitioner testified that she continued to work for the next few weeks. Petitioner testified that on March 13, 2014, she went to the ER due to the pain in her right wrist for the previous 2 weeks. Thereafter, Petitioner waited for approval to see an orthopedic physician. She received approval and saw Dr. Elstrom on April 24, 2014. Petitioner complained of right wrist pain. Dr. Elstrom recommended physical therapy which was not approved. Dr. Elstrom again recommended PT at the next visits of May 8 and 19th and again on June 8, 2014. He administered a cortisone injection on June 2, 2014.

Petitioner began PT on June 18, 2014 but returned to Dr. Elstrom on July 31, 2014 reporting no improvement. Dr. Elstrom administered a second cortisone injection and took Petitioner off work. Petitioner returned to Dr. Elstrom again in August 2014 who continued Petitioner off work.

Petitioner testified that she next saw Nellie Christ a chiropractor at Rehab Dynamix on August 15, 2014 where she treated 3 times per week through December 29, 2014. Part of his treatment included an MRI and an EMG to her right wrist. The 9/12/14 MRI showed "non-specific edema lunate, possibly due to bony contusion or evolving lunatomalacia/osteonecrosis." PX 2. The EMG of 9/24/14 showed electrodiagnostic evidence of a severe right median nerve mononeuropathy suggestive of carpal tunnel syndrome. ... There is no electrodiagnostic evidence of a distal right ulnar nerve injury at this time. Also, there is no electrodiagnostic evidence of a distal radial sensory nerve injury at this time." PX 2.

On November 20, 2014, Petitioner attended a Section 12 exam at Respondent's request with Dr. Fernandez. He reviewed the MRI and the EMG ordered by the chiropractor and began Petitioner's treating physician thereafter. Dr. Fernandez recommended a repeat MRI which was completed on 11/22/14. However, Petitioner did not see Dr. Fernandez again until 2/2/16, almost 2 years later, in that Dr. Fernandez would not see her without authorization.

In the interim, Petitioner testified that on September 10, 2015 she saw Dr. Elstrom who recommended a splint and discussed surgery. Petitioner was kept off work. On October 19, 2015, Dr. Elstrom prescribed pain medication. PX 7.

Petitioner received approval to see Dr Fernandez and on 2/2/16, he reviewed the MRI from 2014. Petitioner continued to complain of pain in her right wrist and fingers. On 4/18/16, Dr. Fernandez performed surgery on her right wrist including a radial shortening osteotomy with locking plate and a carpal tunnel release. Petitioner went to PT and OT thereafter. Petitioner initially wore a hard cast for 2 weeks and then a splint. She testified that PT helped initially for about 2 months and then she started having right thumb complaints which she reported to Dr. Fernandez on 7/19/16. Dr. Fernandez recommended an injection to her right thumb for trigger

finger and through September 2016 administered 3 injections to the right thumb. Petitioner testified the injections helped temporarily but the pain returned.

As of 9/20/16, Petitioner reported the same problems with her right thumb with pain now in her entire right hand. Dr. Fernandez recommended the use of a splint at night. Dr. Fernandez recommended trigger finger release surgery on the right thumb. Petitioner wants the surgery but it has not been approved. In January 2017, Petitioner made the same complaints to Dr. Fernandez and reported that her right hand, wrist, and thumb pain was worsening. Dr. Fernandez recommended removal of the plate in her wrist and trigger finger release to the right thumb. He kept Petitioner off work. Dr. Fernandez will no longer treat Petitioner as she does not have authorization for the recommended surgeries. Petitioner testified that she currently she has significant pain in her right wrist, thumb and in her right hand due to the plate in her hand. She testified that the pain radiates to her right elbow.

Petitioner testified that the last day she worked for Respondent was on 7/31/14. Respondent continued to pay Petitioner TTD from 7/31/14 through 12/18/16. Petitioner testified that from 2014 through 2015 she brought her off work notes to her supervisor but that eventually he told her not to bring the notes but only a return to work note. Petitioner testified that the store owner then sold the store in April 2015 and advised Petitioner he could no longer hold her job for her. She testified that she was clearly told she was fired but that her TTD payments would continue. Respondent in fact continued to pay TTD through the date of her exam with Dr. Vender in December 2016. Respondent also paid Petitioner's medical benefits, including her surgery with Dr. Fernandez, through December 2016.

Petitioner testified that after the store owner sold the store she had no further contact with Respondent and never spoke to anyone in the corporate office. Specifically, she testified that after her surgery in April 2016 Dr. Fernandez released her for light duty with no use of her right hand. However, she did not present this one hand work release to Respondent as she testified that she was "very clearly fired" by the store owner. Respondent RX c and d include correspondence showing that Petitioner's counsel was advised by respondent in September and December 2016 that Petitioner could apply for a new job with the new store owner. The correspondence does not offer accommodated work. Petitioner's counsel replied that Petitioner was off work per Dr. Fernandez.

Dr. Fernandez testified via evidence deposition on July 21, 2017. PX 10. He testified that when he first saw Petitioner for an IME on 11/20/14, she gave a consistent history of accident when she slipped and injured her right wrist. Petitioner had no prior complaints or problems regarding her right wrist or hand. Petitioner complained of pain and swelling of the wrist with associated weakness and numbness and tingling in her fingers. He reviewed her MRI of 9/12/14 and her EMG of 9/14. The EMG revealed right carpal tunnel. The MRI revealed evidence of Kienbock's disease in her right wrist. He testified that there was no evidence that Petitioner was previously diagnosed with or treated for Kienbock's disease prior to 2/26/14. PX 10, p. 9. He testified that Kienbock's disease is "the medical name that we give the condition of avascular necrosis of the lunate. The lunate bone is one of eight bones inside of the wrist, the bones are supplied by blood vessels that keep the bones alive, bringing them oxygen and nutrition and bringing away waste products. If the blood supply is cut off to a bone, the bone literally dies and that's what we call avascular necrosis. So when the blood supply dies to the lunate bone, we refer to that as Kienbock's disease." PX 10, p. 10.

He testified that the disease can develop after a traumatic event, randomly, idiopathically or in association with other medical conditions or systemic diseases. Based on his review of Petitioner's medical history, the history of accident, her physical complaints and the diagnostic testing, he opined that Petitioner's Kienbock's disease

was caused or aggravated by "the fall" at work. PX 10. p. 11. He further opined that Petitioner's carpal tunnel was also causally related to her fall in that it can arise in association with diseases like Kienbock's due to the swelling that's generated and or traumatic factors like Petitioner's fall at work. PX 10, p. 12-13.

Dr. Fernandez ordered a second MRI to determine involvement of scapholunate ligament which was ultimately determined not to be involved. He recommended surgery for the carpal tunnel and/or the Kienbock's disease. He issued work restrictions of 5 pound restriction with the right hand and a mandatory use of a splint.

Dr. Fernandez saw Petitioner again almost 2 years later as a treating physician. His opinions and recommendations did not change as Petitioner's complaints remained the same as in November 2014. PX 10, p. 15. On April 18, 2016, he performed carpal tunnel release and a radial shortening osteotomy designed to relieve or redistribute the pressure along the lunate bone fixing it with a 2.7 millimeter stainless steel plate to hold the bone so it could heal. Petitioner was off work and subsequently placed in cast. PX 10, p. 17. Her work capacity as of May 2016 with no use of the affected hand.

As of June 14, 2016, Petitioner complained of pain involving the right thumb with flexion and residual complaints of pain and stiffness at the wrist. Her numbness and tingling had resolved. Petitioner complained of thumb pain in July 2016 and was diagnosed with trigger thumb and given an injection. At the visit on August 16, 2016, Petitioner's complaints remained the same regarding her thumb and a second injection was performed. Surgery was discussed with regard to her thumb if she did not improve and she was given the work restrictions of no use of the right arm. She was given pain medication and told to return on 9/20/16. P. 20. On 9/20/16, Petitioner was still having pain along the thumb and pain and swelling along the wrist. They discussed the use of a night splint along with trigger finger surgery for the right thumb. Petitioner was again given a restriction of no use of the right arm and follow up was set for the date of surgery. P. 22.

Dr. Fernandez opined that the right thumb A-1 trigger thumb was caused or aggravated by the surgery that was performed for the Kienbock's disease and/or postoperative recovery for the Kienbock's disease surgery. He further opined that the splint use during recovery was at the base of the thumb and that it's common for patients with a wrist condition to develop trigger thumb. The other cause was the surgery itself as it directly involved the tendon involved with trigger thumb. He testified that it is common for patients with wrist fractures or plate or a wrist osteotomy to develop swelling or thickening along the tendon which causes or contributes to trigger thumb. P. 23-24.

Dr. Fernandez saw Petitioner on two additional occasions with the last visit on 1/17/17. At that time, he noted Petitioner's continued complaints of pain and locking of the thumb and that Petitioner developed increasing pain and swelling along the hardware/plate itself. His recommendation was to release the thumb pulley and remove the hardware from Petitioner's hand as it was now symptomatic. Dr. Fernandez continues to recommend both procedures and opines that the need for both procedures is causally related to Petitioner's injury. He disagrees with Dr. Vender's opinion that the trigger thumb is not related to the work injury. Dr. Fernandez clarified that Petitioner's Kienbock's disease is still radiographically present and that as such her post surgical prognosis is guarded. P. 29.

On cross, Dr. Fernandez acknowledged that Petitioner's ongoing Kienbock's symptoms include pain, swelling, stiffness and weakness in her wrist. The thumb pain is separate and distinct to the base of the thumb area. P. 30. He further testified that he understood from Petitioner that the mechanism of injury was "a fall when she slipped and it was an extension injury across the wrist." He defined extension injury as "the patient landed with the hand folded back with the wrist in extension, meaning you're pulling the wrist backwards." P. 33. He was

asked, "so your understanding is that she slipped and fell onto the ground, landed on her hand and it was a flexed posture and it was pressed backwards, is that correct." He responded, "correct." P. 33.

At the last visit in January 2017, Dr. Fernandez recommended no work for Petitioner due to continued pain and swelling increase. P. 41.

Dr. Vender testified via evidence deposition on 9/15/17. RX A. He examined Petitioner at Respondent's request on 10/24/16 with an interpreter present. P. 8,11. Petitioner had previously undergone her surgery on April 18, 2016. Petitioner reported an injury to her right upper extremity in February 2014. Petitioner advised she was carrying a metal box which fell on top of her hand. P. 10. He noted she was diagnosed later with Kienbock's disease and had surgery in April 2016 including right carpal tunnel release, right wrist arthroscopy, and right radial shortening osteotomy. Petitioner was in therapy and using a splint and that "after the splint" she developed pain in her right thumb. At the time of her exam, Petitioner complained of continued numbness and tingling in her fingers, stiffness, pain in the thumb at both the metacarpal phalangeal joint and the interphalangeal joint and pain in the wrist. P. 11. Exam revealed a range of motion at the wrist of 70 degrees of extension, 65 degrees of flexion vs. 80 on the opposite side, a mild decrease in range of motion. A-1 pulley was tender to palpation and there was pain with passive extension of the thumb. P. 12. X-rays revealed findings consistent with residuals of Kienbock's, a change in radio density of the lunate.

Dr. Vender defined Kienbock's as "an idiopathic condition where the blood supply to the lunate bone is lost... and the bone eventually dies. Sometimes it remains asymptomatic and sometimes it becomes symptomatic." P. 13. He testified "we don't know why people get Kienbock's disease." P. 13. He diagnosed Petitioner with status post right radial shortening osteotomy performed for the Kienbock's disease and with right thumb flexor stenosing tenosynovitis. P. 15. In his opinion, Petitioner's Kienbock's disease was not related to the injury described because "we have no idea how, why, and where people get Kienbock's" other than from steroid use which is known to cause avascular necrosis. P. 17. He described Kienbock's as "completely random" with "no known cause." P. 17. He further testified that the condition can remain asymptomatic.

Dr. Vender described Petitioner's Kienbock's presentation as "unusual" in that Petitioner had "basically normal range of motion" in her wrist even after surgery. He testified that Kienbock's usually presents with a significant amount of motion loss and that the surgery "usually is not going to improve your motion." He suspected that Petitioner had very little motion loss before the surgery, although he opined this "without looking at the records... ." p. 18-19.

With regard to Petitioner's tenosynovitis, Dr. Vender opined that it was not related to her Kienbock's disease or from her reported injury. He testified, "...there's no reason to suspect that a splint is going to cause flexor stenosing tenosynovitis." P. 20. He felt Petitioner could perform her normal job with nothing preventing her from performing normal work activities.

Dr. Vender reexamined Petitioner on August 17, 2017 and she complained of "new complaints" including forearm pain and swelling and that the implant bothered her and caused pain in the palm side of her forearm. Petitioner reported significant symptoms including pins and needles sensation in her wrist bones, pain and stiffness in all fingers, and decreased strength. P. 23. He noted that Petitioner pointed to her entire forearm when indicating pain and that the Kienbock's pain would be localized to the wrist. P. 25. He found no objective basis for Petitioner's complaints at the exam and that her described complaints "made no sense." P. 25. His exam of Petitioner's wrist and forearm was normal with no sign of swelling. He did confirm continued tenderness at the A-1 pulley location indicating trigger thumb. Lastly, with regard to the plate placed during

surgery, he testified that it was placed away from the wrist and away from the flexor tendons. He further testified that "there should be no problem associated with that type of plate." P. 28. Dr. Vender reiterated his agreement that Petitioner had trigger thumb and needed surgery but that there was no need to remove the plate. P. 29-30. He agreed the tendons could not be seen on the x-rays he performed.

On cross, Dr. Vender agreed with Dr. Fernandez' diagnosis of Kienbock's disease, carpal tunnel syndrome, and trigger thumb. P. 33-34. He further agreed that the treatment for all three conditions had been reasonable and necessary. He also agreed Petitioner would benefit from trigger thumb surgery. He also agreed there was no indication in any medical records that Petitioner was ever treated for Kienbock's disease prior to the "fall" of 2/26/14 nor was there a history of pain or weakness to her right wrist. P. 35. The "fall" was then clarified as a box falling on Petitioner's hand by way of the history she provided. P. 35.

Dr. Vender further testified that although he does not believe trauma can cause Kienbock's disease, he does agree that trauma can aggravate Kienbock's disease and can lead to increased symptoms from a preexisting condition. P. 36-37. He is unable to opine whether Petitioner's accident accelerated or aggravated her Kienbock's disease because he "wasn't there to examine her so... I don't even know if all of her symptoms were really Kienbock's disease, an aggravation of a Kienbock's disease, or simply the results of a contusion that could resolve with time. P. 37-38. Dr. Vender agreed that Petitioner's carpal tunnel could be caused by either the accident or by inflammation related to Kienbock's. P. 42. Lastly, he does not agree with Dr. Fernandez' opinion that the trigger thumb was caused or aggravated by the Kienbock's disease surgery or the post op recovery. P. 44. He further agreed that a poorly fitted or made splint could cause trigger thumb. P. 47.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

In support of the Arbitrator's decision relating to (C) and (F), whether an accident occurred that arose out of and in the course of Petitioner's employment and whether Petitioner's present condition of ill-being is causally related to the employment, and (K), whether the Petitioner is entitled to any prospective medical care, the Arbitrator concludes:

Based on a preponderance of the credible evidence at trial, the Arbitrator finds that Petitioner sustained accidental injury arising out of and in the course of her employment for Respondent on 2/26/14, that her conditions of Kienbock's disease, carpal tunnel, right trigger thumb and the need for hardware removal are causally related to the accident, and that Petitioner shall receive the surgeries as recommended by treating physician, Dr. Fernandez. In so finding, the Arbitrator notes that Petitioner's medical evidence did not present a history of symptom or problem with Petitioner's right wrist prior to 2/26/14. At trial, Petitioner testified in detail that she was at work for Respondent on 2/16/14, carrying a metal tray, when she slipped causing the heavy metal tray to strike her right wrist. On the issue of accident, the Arbitrator notes but is not dissuaded by the references to Petitioner having a "fall" at work as contained in the record. Petitioner testified that her symptoms of pain began immediately and that she sought treatment 2 weeks later. Petitioner has treated consistently thereafter other than during the period of time during which she waited for treatment authorization for Dr. Fernandez, Respondent's first Section 12 physician turned treating physician. The chain of events and supporting medical records buttress the finding of accident arising out of and in the course of her employment on 2/26/14.

The Arbitrator further finds causal connection for Petitioner's conditions of Kienbock's disease, carpal tunnel, right trigger thumb and the need for hardware removal. In so finding, the Arbitrator places greater weight on the opinion of Dr. Fernandez over that of Dr. Vender when those opinions differ in this matter. The Arbitrator finds it persuasive that both doctors agree to Petitioner's diagnosis of Kienbock's disease. Dr. Fernandez opined that trauma can cause Kienbock's disease. Although Dr. Vender disagreed that trauma could cause the disease, he opined that trauma could aggravate the pre-existing disease. The Arbitrator finds it significant that neither doctor specified a type of trauma or mechanism of injury necessary to cause or aggravate the condition. Therefore, the Arbitrator is not dissuaded by any discrepancy in the mechanism of injury as noted by Dr. Fernandez. While Dr. Fernandez believes Petitioner fell and sustained an extension injury to her wrist, it is not clear that his causal opinion was solely premised on this mechanism of injury as the necessary type of trauma to cause Kienbock's disease. Lastly, the Arbitrator notes that both physicians agreed that Petitioner's carpal tunnel could be caused by either the accident or by inflammation related to Kienbock's.

With regard to the trigger thumb, Dr. Fernandez opined that the right thumb A-1 trigger thumb was caused or aggravated by the surgery that was performed for the Kienbock's disease and/or postoperative recovery for the Kienbock's disease surgery. He further opined that the splint use during recovery was at the base of the thumb and that it's common for patients with a wrist condition to develop trigger thumb. The other cause was the surgery itself as it directly involved the tendon involved with trigger thumb. He testified that it is common for patients with wrist fractures or plate or a wrist osteotomy to develop swelling or thickening along the tendon which causes or contributes to trigger thumb. P. 23-24. The Arbitrator places greater weight on these opinions than on those offered by Dr. Vender in this matter.

Lastly, the Arbitrator finds causal connection for Petitioner's current complaints of pain and symptomology stemming from the hardware in her right wrist. Petitioner credibly complained of this developing pain following her April 2016 surgery through her last visit with Dr. Fernandez in January 2017. Again, in finding causal connection for her continued hand, wrist and arm complaints, and the need for hardware removal, the Arbitrator places greater weight on the opinion of Dr. Fernandez as buttressed by the chain of events and the logical development of the symptoms post right wrist surgery versus Dr. Vender's opinion that "there should be no problem associated with that type of plate."

Finally, based on the Arbitrator's findings on the issues of accident and causal connection, as well as the agreed opinions on the propriety of the recommended trigger thumb release, the Arbitrator finds that Respondent shall authorize and pay for the trigger release surgery and plate removal recommended by Dr. Fernandez, and the attendant care, pursuant to Sections 8 and 8.2 of the Act.

In support of the Arbitrator's decision relating to (J), whether the medical services provided to Petitioner were reasonable and necessary, whether respondent has paid all appropriate charges for all reasonable and necessary medical care, the Arbitrator concludes:

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of his causally related injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any. PX 9. However, to the extent Petitioner sought and received chiropractic care for her right wrist complaints between August and December 2014, the Arbitrator specifically finds that such care was not reasonable or necessary and excludes those incurred medical expenses from this award. Dr. Fernandez explicitly testified that chiropractic care would have no appreciable scientific benefit for petitioner's condition, and that he would not consider a patient compliant with a treatment recommendation for

occupational therapy if that patient instead elected care with a chiropractor. (Px10, pp. 44-45) The Arbitrator therefore finds that Petitioner has failed to demonstrate the reasonableness or medical necessity of subsequent treatment at Rehab Dynamix and denies those medical expenses.

In support of the Arbitrator's decision relating to (L), what amount of compensation is due for temporary total disability, maintenance, and vocational rehabilitation, the Arbitrator concludes:

The evidence submitted at trial showed that Petitioner was placed on light duty without accommodation or was taken off work from July 31, 2014 through the date of trial on March 8, 2018. Petitioner testified that Respondent was unable to provide work for her within her restrictions which she provided to the store owner until April 2015 when she was advised that the store was being sold and her job could not be held any longer. Thereafter in February 2016, Dr. Fernandez took Petitioner off work when she resumed treatment and received surgery. Petitioner remained off work at the time of trial pending the requested surgery. Accordingly, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits of $286.00 per week for the period of 188-2/7 weeks commencing July 31, 2014 through March 8, 2018. Respondent shall receive credit for amounts paid. ARB EX 1.

M. Is Petitioner entitled to penalties and fees?

To the extent that penalties and fees are raised on the stip sheet Arb Ex 1, the Arbitrator finds that Respondent's conduct was neither so unreasonable nor vexatious so as to justify the imposition of penalties and fees under the Act. Petitioner's request for penalties and attorneys fees is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrea Bullock,

Petitioner,

19IWCC0156

vs.

No. 10 WC 26098

Organick, and
Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

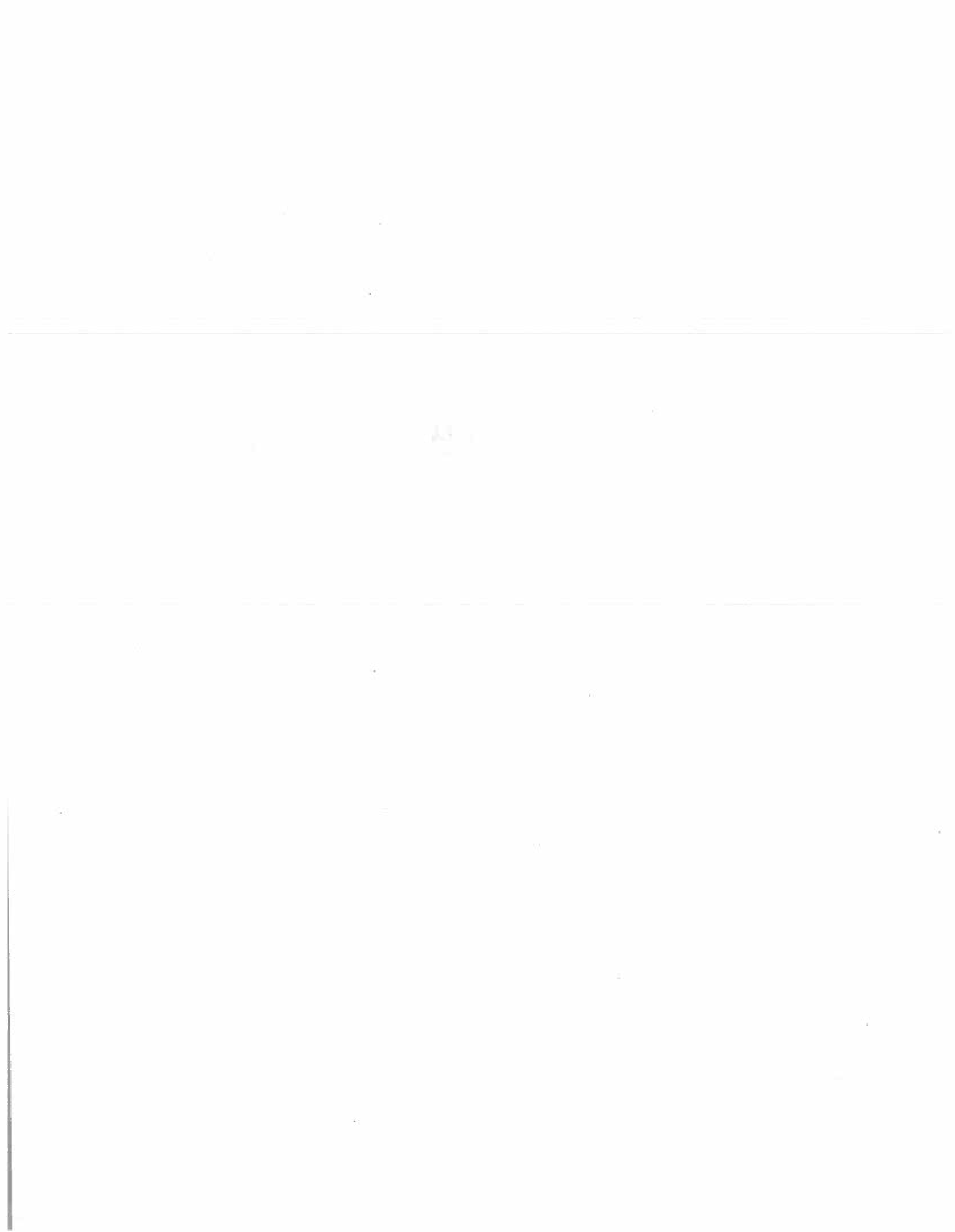
Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund (the Fund) and proper notice given to Petitioner, the Commission, after considering the issues of jurisdiction, notice to Respondent Organick, accident, causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

On July 9, 2010, Petitioner filed an application for adjustment of claim against Respondent Organick alleging that on June 4, 2010, she injured her right shoulder during the course of her employment. Petitioner subsequently amended the application for adjustment of claim to add the Fund as co-Respondent. On February 16, 2018, the matter proceeded to an *ex-parte* arbitration hearing, with only Petitioner and the Fund appearing.

Petitioner testified Organick was a small restaurant that opened approximately two weeks before her accident and remained in business for approximately two years. Petitioner was hired by a man she thought was named Nick. Petitioner described the events of June 4, 2010, as follows:



"It was the first day that we were open. It was just [two] of us that were there. We were both listed as assistant managers. We had our first transaction of the day. *** We had made everything for [the customer], and the system went down, the POS system, the sales system, and neither one of us could figure out how to turn it back on. We wound up giving her meal to her for free. And for about an hour we tried getting in touch with other managers and other assistant managers to get a key to the office to open up the office where everything was located, the computers, all of our personal information. Everything that pertained to the business was in this office. And we just waited for about an hour. We couldn't take any more customers because nothing was working.

So I suggested that I try to get into the office some way, and I noticed—it was a newly constructed building, so it was pretty cheaply made. So there was drywall that separated all these offices and this like particle board for the ceiling. There was about this much of a gap in-between the stop of the wall to the ceiling (indicating). And I said, well, why don't I just try to go over *** the wall and see if I can get in there.

So I pulled a ladder up to the wall, and I made it over very clear, but hanging there, quite a drop *** before I used the ladder, this time it was just going to be basically falling. So I hung on for as long as I could and kind of turned to my right and turned to my left. There was nothing obstructing *** my jump down. And when I turned to my left, I felt something really sharp, and that's when I dropped down. And then I lost my footing and rammed up into the wall on my right shoulder."

Petitioner clarified she felt something sharp in her left shoulder, which made her "let go." She then fell "[a]ll the way to the right of the wall and banged it pretty bad," indicating the right shoulder near the socket. The pain on the right side felt like "a pinched nerve," or like a torn muscle or tendon, or like a sprain. Although the pain was severe, Petitioner continued to work and finished her shift. The first time she mentioned the injury to someone at work was "[p]robably about [two] weeks later," when she told Patel, "[o]ne of the managers there." Petitioner told Patel "the whole story," and he fired her. Petitioner stated she sought medical treatment "[a]bout [two] weeks after the accident."

On cross-examination, Petitioner testified she was hired by Nick, whose last name she believed was Patel. Nick was also the person to whom she reported her injury. The following exchange took place regarding the circumstances leading up to the incident:

"Q. So on the opening day of Organick you couldn't get in contact with the manager?

A. *** [N]obody had keys. Me and the other person that was working with did not have keys. Everybody else seemed to have keys except us. And any of the assistants or the managers we were trying to get anyway we could, and nobody was answering.

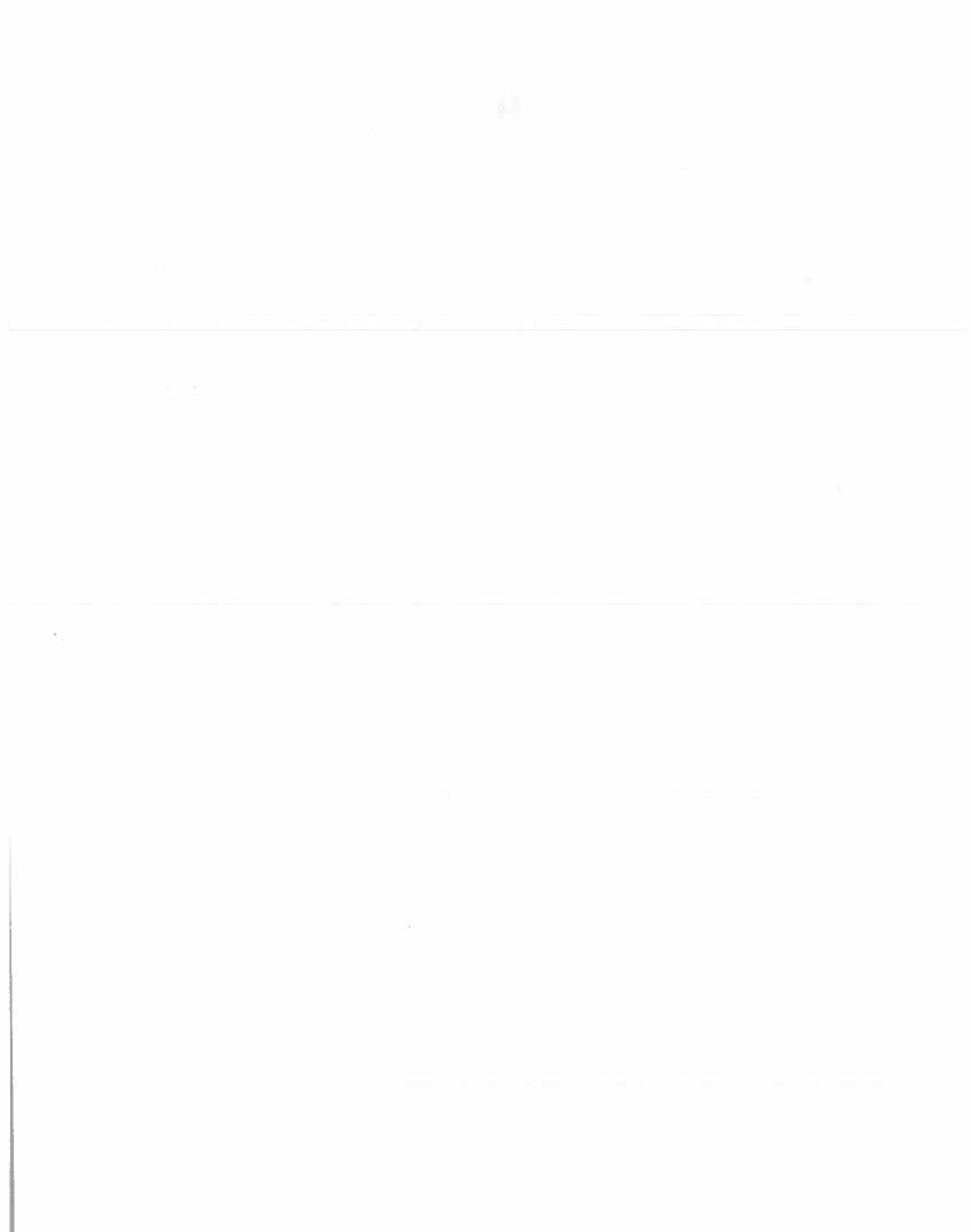
Q. So to be clear on that, the opening day of his restaurant you couldn't get in contact with Nick Patel?

A. No, believe it or not, no."

Petitioner's coworker that day was her subordinate, so Petitioner had to make the decision whether to climb over the wall. When asked about any occurrence witnesses, Petitioner responded she knew the people by their first names only and would not know how to contact them. Petitioner agreed she sought emergency treatment on June 6, 2010.

The medical records from Evanston Hospital show that on June 6, 2010, two days after the alleged accident, the emergency room triage nurse noted the following history and complaints: "Pt presents to ED c/o right shoulder pain x 2 wks and pain at base of neck for 2 wks. Pt states feels discomfort on alternating sides of neck. Pt denies trauma, injury or fever. Denies any hx of neck problems." Petitioner also complained of numbness and tingling in the right arm for two weeks. The resident physician noted the following history and complaints: "[The patient complains] of right sided neck and back pain that has been present for two weeks. *** No trauma, illness, change in exercise routine. No old injuries." Petitioner also complained of vague tingling in the right hand. Petitioner's drug use was noted as follows: "Meth addict x 12 years, last usage in 2004; snorted cocaine use 4x/every other year, last use 1/2008; Vicodin." The attending physician noted a complaint of right trapezius pain, "[g]etting worse over last [two] weeks with radiation down r arm." The attending physician further noted Petitioner worked in "food service industry." Physical examination was significant for tenderness and spasm in the right trapezius. The attending physician: diagnosed a strain/spasm; prescribed hydrocodone, cyclobenzaprine and ibuprofen; and imposed restrictions.

On June 16, 2010, Petitioner returned to the emergency room with complaints of pain and spasms in the right and/or left shoulder. She also complained of numbness and tingling in the left hand for three days. The triage nurse noted: "She had an accident in 2007 without any diagnosis." The resident physician noted: "[The patient] presents with right shoulder pain. She had tried vicodin and flexeril without relief. She gets relief only from keeping her right arm above her head. She has trouble lifting. The feeling is an 'ache' accompanied by left hand numbness. The pain is located around the right trapezius area, 7/10 in intensity. Started about 2.5 weeks ago while working, and has been worsening since. Left hand numbness has been present for the last few days. She pushes heavy stuff at her job. She had an MVA in 2007 where she injured her shoulder and fears she might never recover. It hurts her to move her right arm." The resident suspected a muscle/ligament strain/sprain "causing frozen shoulder." The attending physician noted a markedly decreased range of motion, significant guarding, and tenderness in



the anterior right humeral joint. X-rays of the shoulder were negative. The attending physician stated: "I believe her problem is most likely due to chronic right shoulder strain and now a frozen shoulder," and prescribed physical therapy.

On June 28, 2010, Petitioner returned to the emergency room. The triage nurse noted: "[The patient] c/o right shoulder pain, states hurt shoulder at work." Petitioner complained of increased pain in the right shoulder and numbness in the left hand. Petitioner was seen by an advanced practical nurse, who noted: "[The patient presents] with complaint of right shoulder pain and intermittent numbness and tingling to left hand. *** Injuries sustained a few weeks ago after jumping over a fence at work. Also has not improved right shoulder trapezius pain. Wearing sling since injury." After discussing the case with the attending physician, the nurse practitioner noted: "Will not refill narcotics and muscle relaxers." The attending physician noted: "[The patient presents] with persisting shoulder pain after injury fall from fence 3 weeks ago seen in ER twice has not yet followed with ortho in clinic, req more pain meds." The attending physician stressed the need for physical therapy and orthopedic follow-up.

An initial physical therapy note dated July 13, 2010, states the date of onset of June 4, 2010, and the following mechanism of injury: "Injury at work – Hanging thru arms from ceiling conduit and turned head and then felt a burning in the R shoulder; then fell onto L shoulder."

Thereafter, Petitioner intermittently treated with different providers through mid-2011.

The Arbitrator found the claim compensable and awarded benefits. The Commission disagrees that Petitioner proved accident arising out of and in the course of her employment with Organick. Petitioner's testimony regarding accident is incredible and inconsistent with the early medical records. The medical records themselves note inconsistent histories, a history of drug abuse, and preexisting problems with the right shoulder. The Commission finds it particularly significant that during the emergency room visit on June 6, 2010, two days after the alleged accident, Petitioner complained of right shoulder/trapezius/neck pain for two weeks and denied any injury or trauma. Accordingly, the Commission denies the claim.

All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 23, 2018, is hereby reversed and Petitioner's claim is denied.

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

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

DATED: MAR 12 2019
o-02/21/2019
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BULLOCK, ANDREA
Employee/Petitioner

Case# **10WC026098**

ORGANICK & STATE OF ILLINOIS
Employer/Respondent

19IWCC0156

On 4/23/2018, 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 1.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
CHARLES R CULERTSON
225 W WASHINGTON ST SUITE 1600
CHICAGO, IL 60606

0000 ORGANICK
1228 CHICAGO AVE
EVANSTON, IL 60201

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
19IWCC0156
)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

ANDREA BULLOCK
Employee Petitioner

Case # 10 WC 26098

v.

Consolidated cases:

ORGANICK & STATE OF ILLINOIS
Employer Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **2/16/2018**. 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. ☒ 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 **06/04/2010**, 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 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 **$736.00**; the average weekly wage was **$300.00**.

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

Petitioner has received all reasonable and necessary medical services. Whether Respondent has paid all appropriate charges for all reasonable and necessary medical services was not placed in dispute at trial. Petitioner alleged there was no unpaid 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. Whether Respondent is entitled to a credit under Section 8(j) of the Act was not placed in dispute at trial.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$213.33/week** for **34-3/7th** weeks, commencing **6/5/10** through **1/31/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **6/5/10** through **1/31/11**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of **$213.33/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the **man as a whole**, as provided in Section 8(d)2 of the Act.

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

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

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

Signature of Arbitrator

4-23-18
Date

APR 2 3 2018

FINDINGS OF FACT

Background

Andrea Bullock ("Petitioner") alleged injuries to the right shoulder arising out of and in the course of her alleged employment with Organick ("Respondent") occurring on 6/4/10. Ax1. Petitioner further alleged that on the date of accident, Respondent carried no workers' compensation insurance and amended her application for adjustment of claim to add the Injured Workers' Benefit Fund ("IWBF"). Ax1, Px3. On 6/16/18, by agreement between Petitioner and IWBF, along with notice to Respondent, this matter proceeded to hearing on all issues. Ax1. The IWBF challenged all issues, including whether notice of the trial date ws proper and whether Respondent lacked insurance. The following is a recitation of the facts adduced at trial.

Testimonial and Other Evidence

Petitioner testified that she worked for Respondent and was hired by its owner, Nick Patel, as an assistant manager. She said Patel held interviews at the nearby L.A. Tan, which he apparently also owned.

Her job duties included training on all machines in the front part of the restaurant, customer sales and making product. She said she was paid $12.25/hour and worked up to about 30 hours per week. She said she was paid bi-weekly by check and taxes were withheld. She said she trained for 3 to 4 weeks before the store first opened up.

Petitioner testified that on the first day the business opened, she and another assistant manager worked. At the first transaction of the day, the point of service/sale system went down, and neither could figure out how to turn it back on. She gave the customer the meal for free. For one hour, Petitioner attempted to get in touch with the owner about the system being down and she attempted to gain access to the office where the computers were located. She testified there was a wall that separated the restaurant from the office but that the top was open between the wall and the ceiling.

Using a ladder, she climbed up and over the wall but remained hanging once on the other side. She hung on for as long as she could, dropped down, lost her footing and rammed up against something. She said she fell and banged her right shoulder. She felt a pinched nerve, hot searing pain. She finished her shift then went home. She applied ice and heat. Petitioner testified that she reported her injury two weeks later to Nick Patel and was fired. She admitted she was not told to climb over the wall.

Regarding treatment on 6/6/10, Petitioner presented to Evanston Hospital. Px6. The history noted right shoulder pain for two weeks prior to that visit and denied trauma. She also disclosed an MVA accident and Petitioner testified she had no reason to question the accuracy of these records. She testified that the MVA accident resulted in no shoulder injury or treatment. Petitioner testified she does not know where they got the word fence as she never said fence. She was diagnosed with spasm of the muscle and trapezius strain. She was given medications, light duty work and advised to follow up.

On 6/16/10, Petitioner returned to Northshore and was diagnosed with frozen shoulder/adhesive capsulitis. Px6. Doctors noted her right shoulder pain began approximately 2 weeks prior while working. She was noted to be working in the food service industry. She disclosed she pushed heavy stuff at her job. Dr. Jeffrey Graff suspected that Petitioner's condition was likely due to "chronic right shoulder strain and now a frozen shoulder." Physical therapy was recommended.

On 6/28/10, Petitioner returned to Northshore for the right shoulder. Px6. Notes indicated she hurt it at work and that she was told it was a tear but that a strain was written down instead. She was advised to avoid wearing a sling and to work on range of motion. An MRI of the cervical spine showed degenerative changes. MRI of the right shoulder showed mild tendinosis of the supraspinatus and infraspinatus, isolated teres minor edema raising the question of quadrilateral space syndrome and mild degenerative changes.

On 12/29/10, Petitioner presented to Dr. Alleva at Northshore for pain in the right shoulder. Px2. She was referred by Dr. Moshe Sweet, DO. She complained of neck pain that radiated diffusely to the right arm and hand with numbness and tingling. It had been going on for several months and she felt it was related to a work injury. She had no prior history of same. EMG/NCV revealed no evidence of radiculopathy, neuropathy, plexopathy or myopathy.

On 1/26/11, Petitioner attended physical therapy. Px6. Therapists compared progress from 1/12/10, 1/26/10 and 12/15/10. On 1/27/11, Petitioner followed up with Northshore for the right shoulder. Px6. Petitioner complained of increased pain following physical therapy. Diagnosis was chronic shoulder pain. The plan was for Petitioner to follow up with her primary doctor, an orthopedic specialist, rest and ice. Petitioner was discharged.

On 1/31/11, Petitioner saw Dr. Benson for the right shoulder. Px1. The history noted that she was seen in the ER for having more shoulder pain. She had been recommended to therapy which had helped but that recently her shoulder pain had worsened. He recommended an injection to the shoulder and more therapy.

On 3/26/11, Petitioner underwent a second MRI of the right shoulder, which was essentially unchanged from prior imaging. Px6. On 4/17/11, Petitioner presented to Northshore for acute bronchitis. On 7/15/11, Petitioner returned to Northshore for physical therapy evaluation, complaining of pain in the right shoulder. Px6. The onset date was 6/10/11. The mechanism noted that Petitioner was hanging onto a conduit with the right hand. She then landed back on the ground and fell into a wall on 6/4/10.

Regarding losing time from work, Petitioner testified that she tried calling in sick after she had reported her work accident and was told she no longer had a job to come back to.

Today, Petitioner testified her shoulder still feels "crappy" especially when its cold outside, with extreme temperature changes, that it feels like someone stabbed her. Since that job, she has bartended and now she walks dogs. Petitioner testified she had no prior or subsequent right shoulder injuries before the alleged date of accident.

Arbitrator's Findings as Adequacy of Notice

No one purporting to be the representative Respondent Employer, Organick, was present at the hearing. Petitioner provided three exhibits to support its contention that notice to Respondent Employer was proper. The record shows that on 1/8/18, Petitioner provided notice of a 2/16/18 trial date to Respondent's addresses, purportedly located at both or either 1228 Chicago Avenue and 1223 Chicago Avenue. Px4. This letter states that it was sent via regular and certified mail. The bottom of the letter gives certified mail article numbers. The article number for the letter sent to 1228 Chicago Ave. is listed as "9314 7699 0430 0042 1094 78." The article number for the letter sent to 1223 Chicago Ave is listed as "9314 7699 0430 1094 92." The second page of Px4 is a copy of an envelope addressed to Organick at 1228 Chicago Ave., Evanston, IL 60202. The envelope is stamped as "Return to Sender Attempted – Not Known Unable to Forward." The stamp is dated "1/20/18."

The letter sent to Respondent at 1223 Chicago Avenue was returned, indicating there was no such number. Px7. The letter sent to Respondent at 1228 Chicago Avenue, was returned indicating no such number. Px8. At trial, the IWBF objected to notice. Having considered the evidence, the Arbitrator has considered the evidence presented, along with Petitioner's testimony, and finds that notice of the hearing was sufficient. Despite USPS indicating that no such number exists, it is unclear what that means or could have meant. The Arbitrator finds that Petitioner giving two addresses is credible insofar as it demonstrates her attempts to be thorough and notify Respondent of the notice of hearing.

Arbitrator's Findings as to Lack of Workers' Compensation Insurance

Regarding lack of insurance the Arbitrator finds that sufficient evidence was presented that Respondent did not carry workers' compensation insurance on the alleged date of accident using either address. Px3.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator finds Petitioner to be truthful, candid and forthright regarding what she could recall surrounding the circumstances of her employment, the injury, her treatment and her current condition as it related to her right shoulder.

ISSUE (A) Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
ISSUE (B) Was there an employee-employer relationship?

The Arbitrator finds that on 6/4/10, Respondent-Employer Organick was operating under and subject to the Illinois Workers' Compensation Act. Such evidence includes, but is not limited to, the unrebutted testimony of Petitioner that Respondent-Employer Organick employed Petitioner to perform assistant manager duties, which included the sale of food, preparation of food and serving of such food to the public at Respondent's restaurant, which was located in Evanston, Illinois. Such actions result in Respondent being subject to the Act pursuant to Section 3(14).

Further, pursuant to the Act, Illinois may acquire jurisdiction over a claim (1) if the contract for hire was made in Illinois, (2) if the accident occurred in Illinois, or (3) if the claimant's employment was principally located in Illinois. 820 ILCS 305/1(b)(2). Petitioner's un-contradicted testimony shows that she was hired by Nick Patel, owner of Organick, whose job site was located in Illinois. Petitioner credibly testified she was hired in Illinois.

Based upon the above, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act on 6/4/10. The Arbitrator finds that Petitioner presented sufficient, credible evidence that on 6/4/10 an Employee-Employer Relationship existed. Such evidence includes, but is not limited to, the unrebutted testimony of Petitioner that she was hired by Respondent-Employer Organick and its owner, Nick Patel, that she was paid $12.25/hour, that she worked up to about 30 hours per week, that she was paid bi-weekly by check and taxes were withheld and that she trained for 3 to 4 weeks before the store first opened up. Such evidence demonstrates that Respondent exercised control over Petitioner's method and manner of work, that Respondent controlled the method of payment, that Respondent exercised the right to hire and therefore likely controlled the right to discharge Petitioner and that Respondent provided the tools, materials and/or equipment in Petitioner completing the work for which she was ultimately hired to do.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (D) What was the date of the accident?
ISSUE (E) Was timely notice of the accident given to Respondent?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner alleges that she injured herself while working for a restaurant named Organick on June 4, 2010. She testified that Petitioner testified that she could not find the manager or the keys to the manager's office on opening day of Organick Restaurant. Her injury occurred when she climbed over a wall into the manager's office. No one instructed her to climb over the wall, but she felt she had to do it to do her job. Petitioner testified that she successfully climbed over the wall into the office but injured her right shoulder when she was hanging down from the wall in the office.

Based on the foregoing, the Arbitrator finds that Petitioner was in the course of her employment as she was on the clock working for Respondent. In addition, the Arbitrator finds that Petitioner's right shoulder injury arises out of her employment with Respondent as she was performing duties incidental to her employment, namely, that of attempting to fix the computer point of sale system, which apparently had shut down. Such actions could reasonably be expected to be performed in furtherance of that employment with Respondent. While it may appear that perhaps the method in which she undertook that incidental duty was questionable, the Arbitrator notes that Respondent benefited from this action and no other evidence was presented to show that Petitioner's conduct was unreasonable.

Regarding the history noted in Petitioner's treatment records, Petitioner stated she did not have any reason to doubt the accuracy of the emergency room records from Evanston hospital and that she typically gives a full history of her pain and/or injuries to doctors so that they can treat her as best they can. It is Petitioner's understanding that the doctors and nurses who treat her will give accurate descriptions of her pain and problems in their notes. Initial records suggest that her right shoulder pain began two weeks prior to arrival. Still, other records note Petitioner fell from a fence and another noted said she fell from a conduit. The medical records appear replete with typographical errors, including dates of service, dates of onset and mechanism of injury such that the history noted must also be questioned. For example, one note indicated Petitioner returned in July 2011 but there is no billing or prescription for physical therapy for that time period. Other notes indicated Petitioner's onset attended therapy in January 2010, six months before the accident but also noted that her pain began June 2010 and June 2011. The Arbitrator resolves the discrepancy in favor of Petitioner, who credibly testified that she told providers she injured her shoulder at work. In addition, contrary to the IWBF's assertion, Petitioner's medical records do not state that she injured her right shoulder in an MVA in 2007 – rather the record states that she had an accident in 2007 without any diagnosis. There is no mention of any shoulder and other medical records indicate that Petitioner had no prior history of shoulder pain.

The Arbitrator also concludes that Petitioner provided notice to Respondent when she testified that she notified Nick Patel, owner of the place of business, of her work accident. her testimony was unrebutted in this regard.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator finds that Petitioner's current condition of ill-being as it relates to the right shoulder is causally related to her work accident.

Petitioner explained that she had no prior history of right shoulder injury or pain before the work accident. She credibly stated that she did not injure her right shoulder in any prior motor vehicle accident but that she had been involved in one. Petitioner's explanations at trial are corroborated by her treatment records. Petitioner also stated that she had no subsequent injuries to the right shoulder after the accident. Treatment records indicated an increased in shoulder pain but that it came after starting physical therapy. The Arbitrator finds that insufficient to break any causal connection. Petitioner was diagnosed with adhesive capsulitis and was released from treatment in January 2011. Based on the foregoing, the Arbitrator finds Petitioner's current condition of ill-being casually related to her work accident.

ISSUE (G) What were Petitioner's earnings?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner earned $300.00 per week at the time of her injury. Petitioner's testimony is instrumental in this regard. Petitioner testified she made around $300.00 a week while working for Organick. This arrangement was made when Petitioner was hired. Because the date of the accident was a number of years ago, Petitioner testified that she did not have any pay stubs from Organick. No exhibits or evidence was introduced to dispute Petitioner's testimony. Therefore, the Arbitrator adopts Petitioner's testimony in this regard and concludes Petitioner earned $300.00 per week.

ISSUE (H) What was Petitioner's age at the time of the accident?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner was 41 years old at the time of the accident. In so finding, the Arbitrator relies on Petitioner's undisputed testimony and on her medical records, which corroborate same.

ISSUE (I) What was Petitioner's marital status at the time of the accident?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner was single at the time of her accident. In so finding, the Arbitrator relies on Petitioner's undisputed testimony and on her medical records, which corroborate same. Petitioner alleged no dependents and the Arbitrator finds in favor of Petitioner for same.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner is entitled to TTD from 6/5/10 through 1/31/11, representing the day after she worked and injured herself thru the date she last treated for her right shoulder or 34-3/7th weeks. Medical records indicate Petitioner was given light duty. Regarding losing time from work, Petitioner testified that she tried calling in sick after she had reported her work accident and was told she no longer had a job to come back to. Those restrictions were in place through-out her treatment. Therefore, the Arbitrator concludes that Respondent shall pay Petitioner temporary total disability benefits of **$213.33/week** for **34-3/7th** weeks, commencing **6/5/10** through **1/31/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **6/5/10** through **1/31/11**, and shall pay the remainder of the award, if any, in weekly payments.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner has proven she is entitled to permanency for her right shoulder injury. Petitioner's work accident resulted in a chronic shoulder sprain/strain and an eventual frozen shoulder. She underwent conservative care, including medications, light duty work restrictions, one injection and physical therapy. MRIs were essentially unremarkable and her EMG/NCV was negative. Petitioner last treated for her work injury in January 2011 and she has not treated since. Accordingly, her claim for any PPD is ripe for adjudication.

The Arbitrator finds that the nature and extent of the injury to be 3.5% man as a whole. The medical records and testimony of Ms. Bullock are instrumental in this regard. Petitioner testified to immediate pain in her right shoulder at the time of the accident. The medical records from Evanston Hospital and her numerous visits there indicate that she did have an injury to that shoulder that caused her a loss of motion and pain. She had a course of physical therapy which helped her condition and an injection that also helped her condition. Respondent shall pay Petitioner permanent partial disability benefits of **$213.33/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the **man as a whole**, as provided in Section 8(d)2 of the Act.

Signature of Arbitrator

4-23-18
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSIE NEWSON,
Petitioner,

vs. NO: 15 WC 18908

CHICAGO LIGHTHOUSE FOR
PEOPLE WHO ARE BLIND OR
VISUALLY IMPAIRED,
Respondent,

19IWCC0157

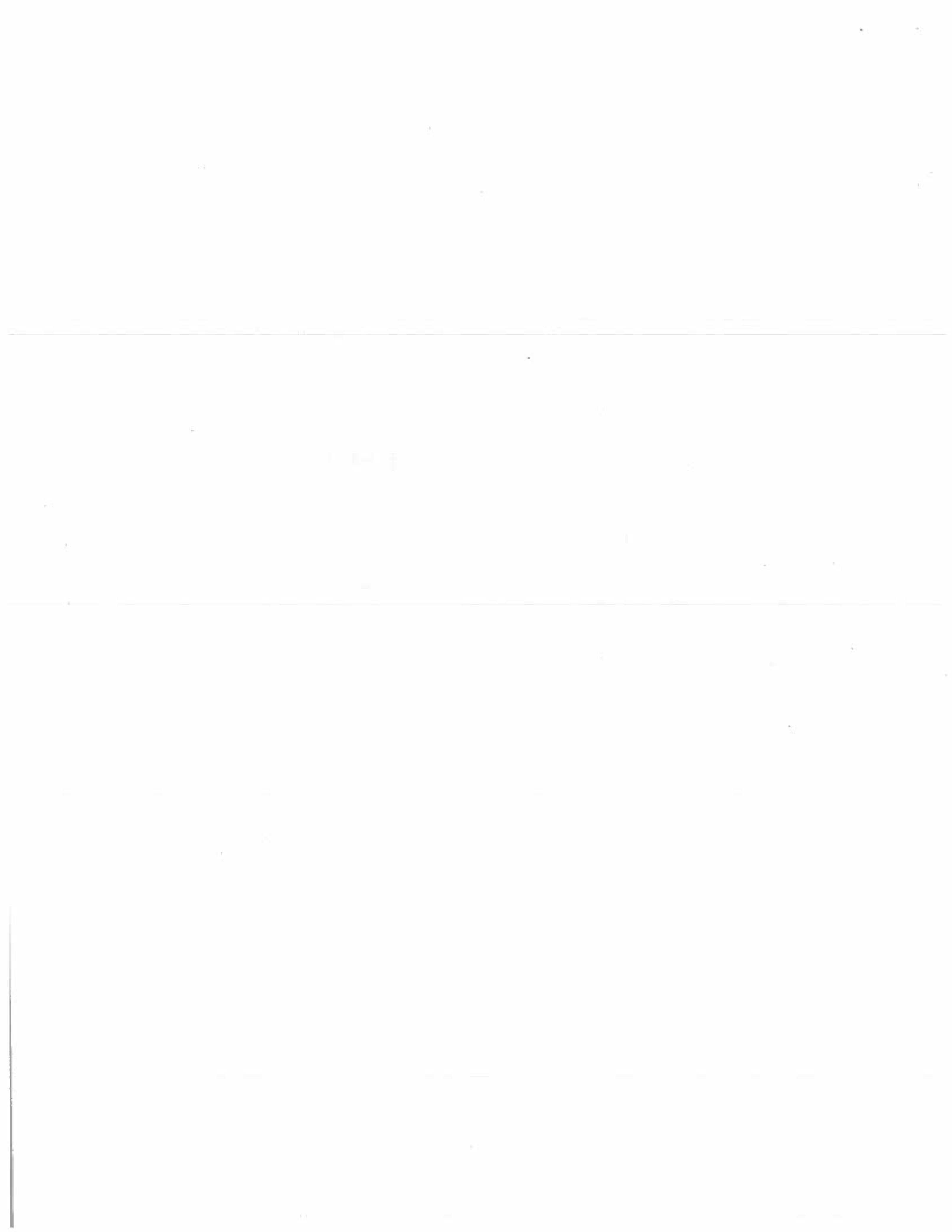
DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident and nature and extent, and being advised of the facts and law, affirms and adopts the statement of facts contained in the Arbitrator's decision but reverses the decision of the Arbitrator for the reasons outlined below and finds Petitioner failed to prove her injury was sustained in the course of her employment.

Conclusions of Law

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]. 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). Moreover, as the court noted in *Illinois Bell Tel. Co. v. Industrial Commission*, "when an employee slips and falls, or is otherwise injured, at a point off the employer's premises while traveling to or from work, his injuries are not compensable." 131 Ill. 2d 478, 483-484 (1989) (quoting *Reed v. Industrial Commission*, 63 Ill. 2d 247, 248-49 (1976)). Two exceptions to this general rule exist: 1) when an employee falls in a parking lot maintained or controlled by the employer; or 2) when an employee is required to be at a place in fulfillment of her job duties, and the employee is exposed to a risk to a greater degree than the general public. *Illinois Bell Tel. Co* at 484. Neither exception applies.

While traveling to work, Petitioner slipped in the common area of the University of Illinois-Chicago (UIC) student union which houses Respondent's facility in the basement. As such, the parking lot exception is inapplicable. The second exception is no more applicable. Petitioner testified she slipped on the wet floor immediately adjacent to a door leading to a stairwell in the lobby. T. 29-11/22/16. Petitioner testified Respondent's premises are located in



the basement of the UIC student center. T. 15-11/22/16. Petitioner testified to access the basement area where Respondent's facilities are located, either the stairwell or the elevators are used by Respondent's employees. T. 21- 11/22/16. Petitioner testified both the stairwell and the elevators are also used by the general public in order to access the businesses located in the student center. T. 22- 11/22/16. Petitioner testified there are several doors which allow entry into the student center. T. 21; 61-62; 72- 11/22/16.

Ms. Monique Thurman testified consistent with Petitioner regarding the lay-out of the student center and the general access to the stairs and elevators. Ms. Thurman testified there were two main entrances to the student center, but the center could also be accessed through connecting buildings. T. 96-7- 11/22/16. Ms. Thurman verified there are multiple entrances to the student center as it is a very large building. T. 100- 11/22/16. Ms. Thurman testified Respondent's premises is located in the basement of the student center. T. 95- 11/22/16. Ms. Thurman explained UIC is responsible for the maintenance of the lobby. T. 99- 11/22/16. Ms. Thurman confirmed the stairs and the elevators are used by both Respondent's employees as well as the general public. T. 103- 11/22/16.

Clearly, Petitioner could use whatever entrance she so desired. Petitioner could use either the stairs or the elevators to access Respondent's premises. The stairs and the elevators were without question open to the general public and used by the general public. More importantly, there is no testimony that Respondent required Petitioner to utilize a specific door or a specific route in order to reach Respondent's premises. Petitioner was free to choose which door for entering the building and free to choose either the stairs or the elevators. As the Supreme Court of Illinois noted in *Bommarito v. Industrial Commission*, 82 Ill. 2d 191, 196-7, 412 N.E.2d 548 (1980), "Injuries sustained off the employer's premises have been held compensable when the injuries occurred while the employee was acting under the direction of the employer or for his benefit or accommodation. [Citation omitted]."

In *Bommarito* (a case relied upon by the arbitrator in finding accident), the claimant sustained injury when she fell in a hole while traversing an alley full of debris. It was undisputed that the claimant's employer required her to utilize one entrance which was only accessible through the debris ridden alley. *Bommarito*, 82 Ill. 2d at 196. In awarding compensation, the Court reiterated the well-established principle "when an employee incurs injuries at a place off the employer's premises while traveling to and from work, the injuries are not compensable unless the employee's presence at the place where the accident occurred was required in the performance of his duties. [Citations omitted]." *Id.* at 194. Moreover, the employee must be exposed to the risk to a greater degree than the general public. *Id.* As the employer in *Bommarito* required the claimant to use the rear entrance, this directive naturally exposed the claimant to the debris ridden alley to a greater degree than the general public and satisfied the "in the course of" requirement.

Such facts are not present here. There is no testimony indicating Respondent required Petitioner to use a specific route. On the contrary, Petitioner was not directed by Respondent to use any specific entrance into the student union, and she was free to choose her route while commuting to work. Further, Petitioner could elect to use either the stairwell or elevators, both of which were open to the general public, in order to access Respondent's premises.

Petitioner argues the "in the course of" requirement is met as Petitioner's injury was

sustained while traveling on her usual and customary route to work. Such argument ignores Petitioner's freedom to choose her own route *i.e.* her presence was not required at the place her accident occurred. Even assuming her presence was mandated, Petitioner failed to prove she was exposed to a risk to a greater degree than that of the general public. To that end, the matter of *Illinois Bell Tel. Co v. Industrial Commission*, 131 Ill. 2d 478, 546 N.E.2d 603 (1989), is instructive and on point.

In *Illinois Bell Tel. Co*, the claimant's employer was located in a mall. After completing her work day, the claimant left the employer's premises, and while walking through the mall, fell on a slippery floor. In denying benefits, the Supreme Court of Illinois reiterated the principle that employees who fall or are otherwise injured off the employer's premises while travelling to or from work are not entitled to benefits. The Court noted the two exceptions: 1) parking lots maintained or controlled by the employer; 2) the employee's presence is required in fulfillment of her job duties, and she is exposed to a risk to a greater degree than the general public. *Id.* at 483-4. The Court found the claimant was not required by her employer to use any particular entrance, and as such, she failed to prove she was required to be in the place where she fell. Moreover, the Court found the claimant failed to prove she was exposed to a risk to a greater degree than the general public. The Court specifically stated:

> Claimant argues that she was compelled to cross the common areas for access to reach her place of employment; her risk, therefore, was greater than that of the public. This court has held, however, that "the mere fact that the duties take the employee to the place of the injury and that, but for the employment, [s]he would not have been there, is not, of itself, sufficient to give rise to the right of compensation." [Citations omitted]. *Id.* at 485-6.

Petitioner is exposed to the same risk as any member of the general public who might enter the building. The fact she would be required to walk through the lobby of the student union twice a day, coming to and leaving work, does not establish the requisite increased risk.

Petitioner relies on two other cases in advancing her argument both of which were relied upon by the arbitrator in formulating his decision- *Mores-Harvey v. Industrial Commission*, 345 Ill. App. 3d 1034, 804 N.E.2d 1086 (2004) and *Litchfield Healthcare Center v. Industrial Commission*, 349 Ill. App. 3d 486, 812 N.E.2d 486 (2004). Both cases are distinguishable, and neither are applicable. The Court in *Mores-Harvey* applied the parking lot exception which is irrelevant to the present inquiry. The Court in *Litchfield* found the claimant to be "in the course of" her employment as she was on the employer's premises when her injury occurred. The Court's analysis thusly focused on the "arising out of" component. As Petitioner failed to prove her fall occurred "in the course of" her employment with Respondent, such analysis is inapplicable to the case at hand. The same is true for a more recent case decided by the Court, *Brais v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 120820WC. In *Brais*, the Court again specifically found the claimant proved she was "in the course of" her employment when she fell. Again, the Court confined its analysis to the "arising out of" component in essence finding an increased risk due to the employer's requirement that the claimant utilize a hazardous entrance. Again, such facts are not present in this case.

Falls or injuries which occur off an employer's premises while an employee is commuting to or from work are not compensable as the employer has no interest in where an

employee lives and/or how she commutes to work. Two exceptions exist as the employer in those two circumstances exerts control over the employee's actions. Therefore, the purpose of those exceptions is to hold the employer liable for a risk that it requires its employee to confront by the virtue of the employee's job duties. It is not meant to hold an employer liable for any potential risk an employee may confront. For the reasons state above, the Commission finds Petitioner failed to prove she sustained an injury which occurred in the course of her employment. As such, all other issues are moot.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $64,923.27. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 13 2019

CJD/dmm
O: 11619
49

Joshua D. Luskin

L. Elizabeth Coppoletti

Dissenting Opinion

I must respectfully dissent and would have affirmed and adopted the Arbitrator's decision. Petitioner's fall occurred in an area which was the sole or usual route to the Respondent's premises. The evidence is also clear that Petitioner sustained a broken ankle requiring surgery as a result of her fall.

Petitioner's testimony regarding the location of her fall – at the entrance to the stairs leading to the basement – and the unrefuted cause of the fall – wet flooring – were more credible than the speculative testimony tendered by Monique Thurman on behalf of the Respondent. Additionally, Petitioner credibly testified her supervisor, Kathy Nolan, was present at the time of her fall. Respondent did not tender Ms. Nolan as a witness even though she is still employed by, and arguably under the control of Respondent.

Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to be in the course of the employment. However, the fact that an injury is in the course of the employment is not sufficient to impose liability; to be compensable, the injury must also "arise out of" the employment. For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Sisbro, Inc.

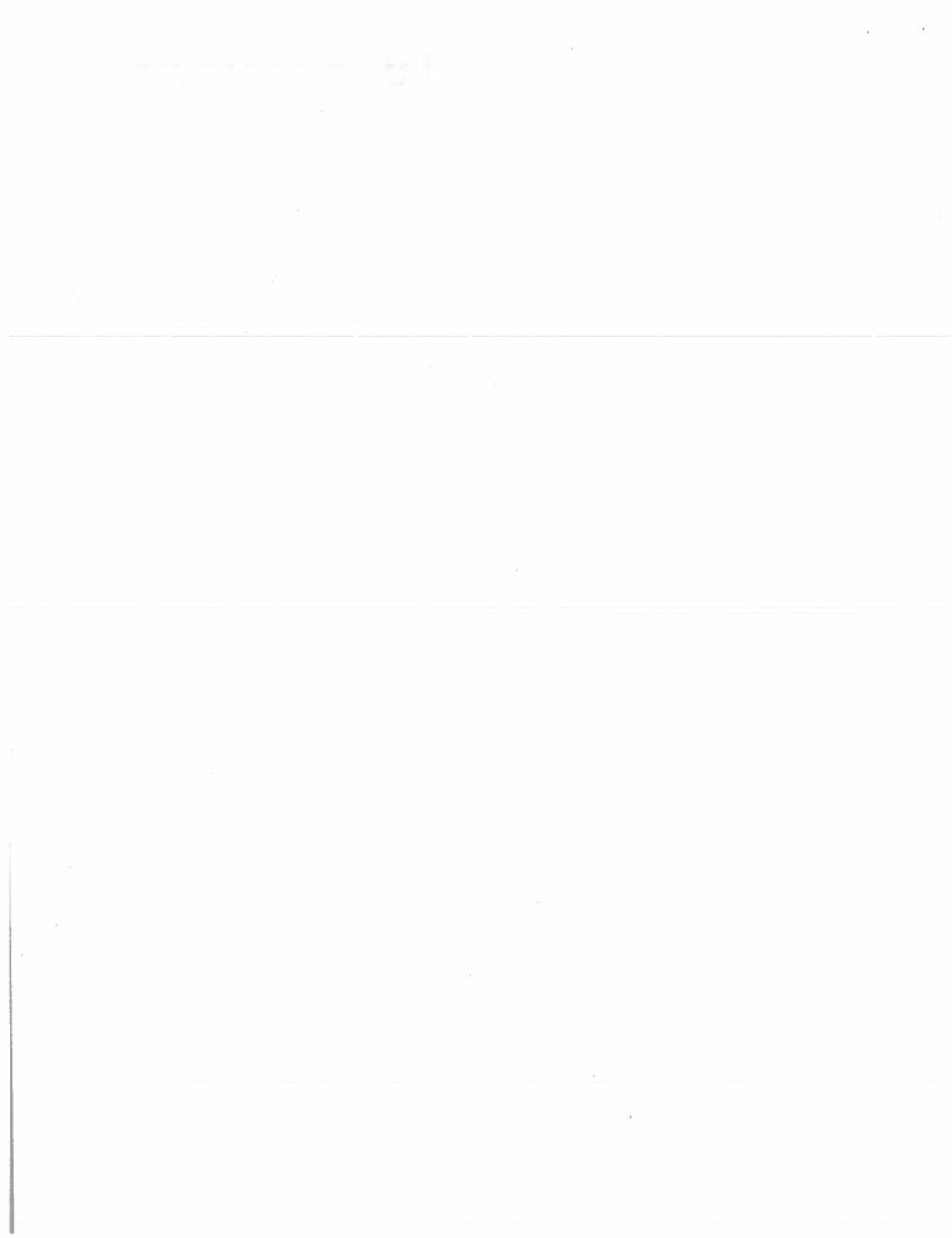
v. Industrial Comm'n, 207 Ill.2d 193, 203 (2003), Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 62 (1989).

The disputed issue here concerns the "arising out of" element of a workers' compensation claim. There are three types of risks to which an employee might be exposed: (1) risks distinctly associated with the employment; (2) risks which are personal to the employee, such as idiopathic falls; and (3) neutral risks which have no particular employment or personal characteristic. Potenzo v. Illinois Workers' Compensation Comm'n, 378 Ill. App.3d 113, 116 (2007). Risks are distinctly associated with employment when, at the time of injury, "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." Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 58 (1989). "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." Id. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of her employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable. Id.

Although Petitioner's accident occurred approximately 45 minutes before her scheduled shift, there was sufficient, credible testimony to support that employees routinely arrived early for their shifts. Additionally, Petitioner was exposed to a greater risk than the general public because she slipped in an area where there was basically exclusive access to her work site. Although members of the general public could use the stairs and/or elevator near that area to go to other areas of the student center, there was no other way to access the basement, where only Petitioner's place of employment was located. Additionally, Petitioner provided credible, unrefuted testimony, that the area where Petitioner fell was wet from rain water. When an injury to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act. See Bomarito v. Industrial Comm'n, 82 Ill.2d 191, 195 (1980); see also Mores-Harvey v. Industrial Comm'n, 345 Ill. App.3d 1034, 1040 (2004).

Petitioner's current condition of ill-being is causally connected to the work-related accident of June 23, 2014. Petitioner credibly testified as to the mechanism of injury, provided supporting photographic evidence of the accident site, as well as her injury (Px8A-C)

The evidence shows that Petitioner immediately felt pain and sought treatment at the UIC Emergency Room the same day of the accident. The records indicate that Petitioner reported that she felt a pain in her right knee, ankle, foot, wrist and hand, as well as her left shoulder. On June 24, 2014, she followed up with chiropractor Paul Levy, DC and then was referred to foot specialist Dr. Tee, with whom she began treatment on June 28, 2014. Petitioner underwent surgery on July 25, 2014, to repair the fracture, as well as underwent additional procedures on October 17, 2014 and October 31, 2014 due to ongoing pain. Respondent did not dispute the injuries resultant from the accident, but disputed that the accident took place "in the course of" Petitioner's employment, and therefore disputed that the injuries were causally related to her work. Petitioner met her burden of proof regarding accident (per above), and the resultant



injuries are causally related to Petitioner's fall on June 23, 2014. Respondent did not put forth any witnesses to dispute causation.

I would affirm the Arbitrator's findings on accident and causation. It is clear to me that Petitioner's injury was resultant from a risk incidental to employment. I would, likewise, affirm the Arbitrator's awards for temporary total disability, medical expenses, and permanent partial disability.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWSON, JOSIE
Employee/Petitioner

Case# **15WC018908**

CHICAGO LIGHTHOUSE FOR PEOPLE WHO ARE BLIND OR VISUALLY IMPAIRED
Employer/Respondent

19IWCC0157

On 3/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
SAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
SURABHI SARASWAT
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

Josie Newson
Employee/Petitioner

v.

Chicago Lighthouse for People Who are Blind or Visually Impaired
Employer/Respondent

Case # **15** WC **0018908**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **11/23/2016 & 12/20/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

C. [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 23, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**14,592.76**; the average weekly wage was $**280.33**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL SERVICES OF $ 59,940.84, AS PROVIDED IN SECTIONS 8(A) AND 8.2 OF THE ACT. SAID PAYMENT IS TO BE MADE TO PETITIONER AND HER ATTORNEY.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $ 220.00 /WEEK FOR 2-1/7 WEEKS, COMMENCING 6/24/2014 THROUGH 7/1/2014 AND 8/1/2014 THROUGH 8/4/2014 AND 10/17/2014 AND 10/31/2017, AS PROVIDED IN SECTION 8(B) OF THE ACT. SAID PAYMENT IS TO BE MADE TO PETITIONER AND HER ATTORNEY.

WITH REGARD TO SUBSECTION (I) OF §8.1B(B), IT IS NOT APPLICABLE HEREIN.
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 CUSTOMER SERVICE REPRESENTATIVE AT THE TIME OF THE ACCIDENT AND THAT SHE IS ABLE TO RETURN TO WORK IN HER PRIOR CAPACITY AS A RESULT OF SAID INJURY. BECAUSE OF THE ABOVE, THE ARBITRATOR THEREFORE GIVES LESSER WEIGHT TO THIS FACTOR.

WITH REGARD TO SUBSECTION (III) OF §8.1B(B), THE ARBITRATOR NOTES THAT PETITIONER WAS 51 YEARS OLD AT THE TIME OF THE ACCIDENT. BECAUSE OF HER SIGNIFICANT FUTURE LIFE AND WORK LIFE EXPECTANCY, 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 THERE IS NO EVIDENCE OF FUTURE WAGE LOSS. BECAUSE OF THE THIS, THE ARBITRATOR THEREFORE GIVES NO WEIGHT TO THIS FACTOR.

WITH REGARD TO SUBSECTION (V) OF §8.1B(B), ARBITRATOR NOTES PETITIONER TESTIFIED SHE CONTINUES TO EXPERIENCE SHARP PAIN IN HER RIGHT ANKLE NUMEROUS TIMES PER WEEK. HER INJURY LIMITS THE DISTANCE SHE CAN AMBULATE WITHOUT AN INCREASE OF PAIN IN HER ANKLE. THESE COMPLAINTS ARE CORROBORATED BY THE TREATING RECORDS WHICH NOTE THAT THE PETITIONER SUSTAINED A RIGHT ANKLE AVULSION FRACTURE. SHE FAILED CONSERVATIVE CARE AND EVENTUALLY REQUIRED ARTHROSCOPIC DEBRIDEMENT. DURING THE ARTHROSCOPY, DR. TEE NOTED TRAUMATIC SYNOVITIS. HYPERTROPHIC SYNOVIUM WAS REMOVED. BECAUSE OF THE ABOVE, THE ARBITRATOR GIVES GREATER WEIGHT TO THIS FACTOR.

BASED ON THE ABOVE FACTORS, AND THE TOTALITY OF EVIDENCE, THE ARBITRATOR FINDS THAT PETITIONER SUSTAINED PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 30% LOSS OF USE OF RIGHT FOOT PURSUANT TO § 8(E)11 OF THE ACT OR 50.1 WEEKS AT APPLICABLE PPD RATE, PAYABLE TO THE PETITIONER AND HER ATTORNEY. ALL PAYMENTS SHALL BE MADE IN REASONABLE TIME.

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

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

_#001 Arbitrator George J. Andros
Signature of Arbitrator

February 28, 2017
Date

MAR 1 - 2017

19TWCC0157

FINDINGS OF FACT: NEUTRAL RISK & EXPLAINED FALL

On June 23, 2014 the petitioner, Josie Newson, was a 51-year-old Customer Service Representative for the respondent, The Chicago Lighthouse for People Who are Blind or Visually Impaired (Lighthouse) at the respondent's facility in the UIC Student Center East (hereinafter "Student Union," 750 S. Halsted St., Chicago, Illinois. (R.5-8)

The respondent was the sole occupant of the lower level of that facility (R.17), where they operated a call center for questions, complaints and payments related to the Illinois Tollway Authority's IPass units. (R.10&16) Petitioner would operate one of the phones at a desk in the facility. (R.9)

The Student Union is accessible by students as well as workers of various businesses located at the address. Petitioner estimates that there are approximately 80 to 100 of her coworkers for the respondent who access that facility on a daily basis for each shift. (R.17) To access the respondent's work area, each employee would enter the Student Union (PX8a). After entering the facility, each employee must access the hallway leading to an elevator bank directly adjacent to a stairway which leads down to the respondent's basement facility. (R.21) Both petitioner and respondent's witness, Monique Thurman, respondent's call center manager, agree that the vast majority of respondent's employees use the stairway because the elevators were extremely slow. (R.21&116)

Petitioner estimates that 99% of her coworkers use the stairwell which can only be accessed by traversing a single hallway leading to that stairwell. (R.26&PX8c) It is uncontroverted that the flooring of that hallway, immediately in front of the stairwell, is comprised of a shiny and slick hard surface. (R.28)

On June 23, 2014 the petitioner was scheduled to begin working at noon, but arrived early as was her customary practice. (R.28) Respondent's witness, Ms. Thurman agreed many workers arrive before their shift to prepare. (R.105)

The petitioner testified that after arriving at the Student Union she headed to the respondent's facility on the lower level. It was still raining outside, and the rain water had been tracked into the Student Union hallway leading to the stairwell vestibule.(R.29) While reaching for the handle of the door to the stairwell, petitioner slipped and fell on the slick wet surface of the flooring, causing her to fall to the ground and causing her right ankle to twist beneath her. (R.29)

Petitioner testified that she immediately felt pain in her right ankle and was unable to get off of the floor. (R.30) UIC security was called. Petitioner's supervisor, Kathy Nolan, came to speak to the petitioner while she was still on the floor. Petitioner informed Ms. Nolan that she could not get up and that she had slipped and fallen on the floor. When Ms. Nolan asked if she was "OK", the petitioner informed her that she was not, and an ambulance was called. (R.33-34)

University of Illinois at Chicago EMS personnel arrived and attended to the petitioner. Those records note that the emergency personnel found the petitioner sitting on the floor. She stated that she had slipped and fallen. The emergency personnel recorded the smell of alcohol on the petitioner, but she denied either eating or drinking anything that day. (PX6)

Petitioner testified, and the EMS records confirm, that at no time from the instant of her fall to the time when the petitioner was placed upon a gurney for transport to the hospital, did she ever leave the position on the floor where she had fallen. (PX6)

Petitioner was immediately taken to the University of Illinois at Chicago Medical Center. (PX1) Those records note that the petitioner suffered a mechanical fall on a slippery marble floor injuring her left shoulder, right wrist, right knee, and right ankle and hitting her head. Those records further note negative drug and alcohol indicators; petitioner was alert and oriented to person, place and time. ER X-rays were read showing a right avulsion fracture of the medial malleolus with widening of the lateral clear space. .

Petitioner was released with a post mold on her right ankle. She was non-weight bearing and on crutches, provided medication and advised to follow-up with her personal physician. Until such time, she was unable to return to work. (R.35-36)

On June 24, 2014 petitioner followed up with Bridgeport Pain Control. (PX3) Again, petitioner gave a consistent history of a slip and fall on a wet floor inside the Student Union, while reaching for a door. Petitioner was treated with therapy and kept off work through July 1, 2014. Petitioner informed the doctor that she was unable to afford any further time off work past that date. (R.36)

On June 26, 2014 new x-rays were taken and the petitioner was advised by the doctor at Bridgeport Pain Control to see Dr. Kim Tee, an Orthopaedic DPM.(R.37)

Petitioner was initially seen by Dr. Kim Tee on June 28, 2014.(PX4) She gave a consistent history of falling at the UIC Student Union on wet flooring which caused her to fall. Dr. Tee opined that the incident caused a traumatic fracture of her right ankle. Her right ankle was casted. Dr. Tee advised following up with Bridgeport Pain Control for therapy. (R.38)

Petitioner returned to Bridgeport for physical therapy on June 30, 2014. Petitioner was released to work sedentary duties as of July 2, 2014. On July 2, 2014 the petitioner returned to Bridgeport Pain Control and those records note that, although she was in considerable pain, she could not afford to remain off of work. Therefore, petitioner did return to work on July 2, 2014. (R.39)

Petitioner testified that she was able to return to the call center in a sedentary capacity. Her supervisor provided her a box to rest upon her casted leg. On July 5, 2014 Dr. Tee continued therapy. Petitioner so continued three times per week. (R.39)

On July 19, 2014 Dr. Tee ordered observation under fluoroscopy plus cast change at the Oak Brook Surgical Center, performed July 25, 2014. A Cam Walker issued plus cane use continued.(R.41) .

Petitioner continued to work sedentary duty while in therapy at Bridgeport Pain Control. From August 1,14 through August 5, 14 she was ordered off work again due to a flare up of pain in her right ankle, neck and back from walking in the Cam Walker. She returned to work on August 6, 2014.

On August 9, 2014 petitioner was seen by Dr. Tee who noted ankle swelling, edema and healing of the fracture. She was kept immobilized in the Cam Walker and continued in a sedentary position. Petitioner continued therapy. On August 23, 14 Dr. Tee removed the Cam Walker. (R.42-43)

Petitioner remained under the care of Dr. Tee and the Bridgeport Pain Control Clinic. On Oct. 17, 14 she underwent an additional fluoroscopy was provided, with diminished right joint space. Due to continued pain, swelling in right ankle with synovitis Dr. Tee ordered arthroscopic debridement. (R.45)

On Oct. 31,14 arthroscopic debridement - right ankle – ensued at Oak Brook Surgical Center. Dr. Tee documented from surgical observation traumatic synovitis. Hypertrophic synovium was removed, while off work the surgical day (R.45) while under care of Dr. Tee and Bridgeport.
RTW: She was released full duty on Dec. 20, 14. No treatment ensued since that date. (R.46)

Petitioner testified that currently she experiences sharp pain in her right ankle three to four times per week. These episodes last approximately five to ten minutes. She describes these episodes as "electric bolts". She continues to experience pain while walking more than a block or a block and a half. It causes her ankle to throb. These problems continue to affect her to the present time. (R.47-48)

Ms. Monique Thurman testified that she is the Director of Human Resources for the respondent. (R.92-93) Ms. Thurman testified she was in the basement , at the Lighthouse call center. She heard employees talking about a coworker falling upstairs. (R.94). Ms. Thurman testified t she went upstairs and found the petitioner, not on the floor, but sitting on benches near the elevators. According to Ms. Thurman, the petitioner advised her that she had fallen in between the front doors to the Student Union building, and not in front of the stairwell leading to the respondent's facilities. (R.106-108)

Ms. Thurman testified that the respondent was the only entity operating out of the basement of the Student Union building. Further, Ms. Thurman confirmed that all of the respondent's employees would have to access the respondent's facilities in the basement by walking across the flooring directly in front of the stairwell doors and or in front of the elevators. (R.116)

Ms. Thurman testified consistently with the petitioner that the elevators were slow and that she, as well as respondent's employees, used the stairwell for their usual and customary access to the basement call center. (R.116) Ms. Thurman testified that she did not create any report.ssss (R.122) She asserts she was in close proximity to Ms. Newson; witness did not testify to the smell of alcohol. (122)

On cross-examination Ms. Thurman testified all of the respondent's employees must access the same area in the proximity of the elevator or the stairwell as the usual and customary method of entering the respondent's call center. The same shiny, slippery flooring covered both areas. (R.120)

As a rebuttal witness the petitioner presented her coworker, Ms. Fulton. Ms. Fulton is, and was on June 23, 2014, a Customer Service Representative in that call center. She knows petitioner from work, but not social friends. Ms. Fulton testified that she too begin her shift at noon that day.

While entering the Student Union on that date, Ms. Fulton saw the petitioner on the floor where she had fallen. Ms. Fulton testified that the petitioner had fallen on the floor immediately in front of the doors leading to the respondent's facilities in the basement. Ms. Fulton, like the petitioner, is unequivocal in her testimony that the petitioner did not fall anywhere near the front door of the Student Union, as testified to by respondent's witness. Ms. Fulton did not see the petitioner get up from the ground and sit on a bench in the proximity of the elevators.

Further, petitioner testified in rebuttal. She reiterated the fall was immediately next to the doors leading to the stairwell leading to the respondent's basement facilities: she did not fall near the front door of the building itself. Petitioner never got up off of the floor prior to being loaded onto a gurney by the emergency personnel. At no time did she get up and sit on benches near the elevator. In fact, petitioner testified the respondent's witness never appeared in the vicinity of her fall from time of incident to the time she was taken away by ambulance.

CONCLUSIONS OF LAW:

C

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

HOLDING: Based upon the totality of the evidence, the Arbitrator finds as a matter of law petitioner sustained an accident as alleged at bar, arising out of and in the course of her employment with the respondent on June 23, 2014.

First, the respondent raised the factual issue as to where the petitioner's fall occurred. Petitioner testified that she fell directly in front of the doors leading to the stairwell that was her and her coworker's usual and customary route to access the respondent's call center. Respondent witness testified that she heard employees discussing the fact that a coworker fell on the first floor then asserts to have gone up to the first floor finding Petitioner sitting on a bench in the vicinity of the elevators. It is Ms. Thurman's testimony that the petitioner indicated that she had fallen directly in between the front entry doors of the Student Union building, and not anywhere in the vicinity of the doors leading to the stairwell to access the respondent's call center. The nonexistence of any report by the supervisor, highly credentialed by articulate testimony, is probative that no visual observation took place, at least seeing a bench event.

Based upon the totality of the evidence and a preponderance thereof, the Arbitrator adopts the petitioner's testimony she fell immediately in front of the stairwell leading to the respondent's facility in the basement. The petitioner is known to have sustained a fractured right ankle resulting from fall. She was unable to stand up from the moment of her fall until the ambulance crew took her away from the scene on a gurney. This is consistent with the records contained in the University of Illinois at Chicago EMS records. (PX6) Those records confirm that the emergency personnel found the petitioner sitting on the floor and remained there until the petitioner was assisted onto a stretcher with straps and rails. The Arbitrator finds at no time was the petitioner sitting on benches near the elevators. Petitioners also testified that the benches are a recent addition, and were not even available on the date of her injury.

Further, the Arbitrator finds the testimony of the petitioner's coworker, Ms. Gernard Fulton, to be most determinative of the factual question as to the site of the fall. She came upon the scene observing petitioner on the floor while immediately in the proximity of the doors leading down to the basement of the Student Union where the respondent's facility was located.

FINDING OF FACT; Accordingly, the Arbitrator finds as material fact the petitioner's testimony as to where she fell plus the mechanics and floor condition thereof on the alleged accident date of June 23, 2014.

Respondent counsel aggressively defends by cross examination and case presentation the petitioner's injury occurred before she entered into the respondent's call center, prior to the moment she punched into work and in an area accessible to the general public. This is noted.

. However, it is well-established that when an employee incurs injuries at a place off the employer's premised while traveling to and from work, the injuries are not compensable unless the employee's presence at the place where the accident occurred was required in the performance of her duties. Bommarito v. Industrial Comm'n, 82 Ill.2d 191, 194-95 (1980) (citations omitted). Further, injuries incurred off the employer's premises are compensable only when the employee "is exposed to a risk common to the general public to a greater degree than other persons." Id. (citations omitted). "Moreover, if the risk or hazard is so increased by the employment, it does not matter that the injury is unusual, or unexpected, or that it is not peculiar to the employment." Id. (citations omitted). The Bommarito Court went on to quote Professor Larson and held that where an injury takes place in an area which is the sole or usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Id. at 195.

In Bommarito the petitioner was employed by a store which required all employees to enter a single door accessed by an alley which was not part of that employer's property. Within eight feet of the employer's door, the petitioner stepped into a hole in the alley causing her injuries. The Court found the accident to be compensable because the respondent created a situation whereby the petitioner was forced to attend to a special risk in order to gain admission to her place of work. Id. at 198.

Further, the mere fact that an employer's premises are accessible by both a petitioner and the public is not the sole determining issue of liability under the Act. Mores-Harvey v. Industrial Comm'n, 345 Ill.App.3d 1034 (2004). In Mores-Harvey, that petitioner sustained injuries when she slipped and fell on snow and ice in a parking lot used by both employees and the public. In affirming the petitioner's benefits, the court found that, by restricting where claimant could park her vehicle, the employer exercised control over its employees' actions. In this way, the employee faced risks to a greater extent than the general public.

Analysis of a work injury caused by a defect upon the respondent's property within a reasonable time before work is defined in Litchfield Healthcare Center v. Industrial Comm'n., 812 N.E.2d 401 (2004) In Litchfield the court held that it is axiomatic that an employee's injury is compensable only if it arises out of and in the course of her employment. "In the course of employment" refers to the time, place, and circumstances under which a petitioner is injured. Injuries sustained on an employer's premises, or at a place where a petitioner might reasonably have been while performing her duties and while a petitioner 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. 812 N.E.2d at 405.

At bar, it is unrebutted that the petitioner was arriving for work on respondent's property specifically to be available to punch in to commence her shift which started at noon; she was in the process of heading directly to the only area available to access the respondent's facility in the Student Union basement. Respondent's witness testified that employees would arrive before their starting time to prepare for their work day.

IN THE COURSE OF :The Arbitrator concludes as follows :Therefore, the petitioner's injury occurred at a place where the petitioner would reasonably been expected to be just before commencing work. Therefore, the "in the course of" prong has been met.

ARISING OUT OF : The "arising out of" prong is also met in this case. The Litchfield Court held the following in analyzing whether an injury to a petitioner, arriving for work, arises out of her employment:

> When… an injury to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act. 812 N.E.2d at 406.

This Commission has used this analysis on a number of occasions. See, e.g., University of Illinois v. Industrial Comm'n., 365 Ill.App.3d 906 (2006). That case also involved an employee entering an Outpatient Care Clinic of UIC. from the parking structure used by employees and the public. While entering the facility via a walkway from the parking structure to the Clinic's second floor, that petitioner tripped on a metal threshold that was extending three inches above the walk surface. That petitioner fell twisting her right knee and causing a tear of her medial meniscus. The petitioner was not required to park in the attached parking facility, nor had she punched in for her job. The Arbitrator found that the petitioner did not sustain an injury arising out of and in the course of her employment with UIC.

Upon Review, the Commission, in a unanimous decision, reversed the Arbitrator and found that her injuries arose out of and in the course of her employment.

In affirming the Commission, the Appellate Court rejected the respondent's argument that the petitioner's injury did not arise out of her employment because she was exposed to no greater risk than the general public, i.e. walking across a threshold. Rather, citing the holding in Lichtfield, the Court held that the Commission correctly found that the raised threshold strip constituted a hazardous condition. The Court further confirmed the Commission's finding that the walkway entrance was a usual access route to the clinic.

Similarly, in Allen v. University of Illinois, 09 W.C. 51695, 15 I.W.C.C. 0375 (2015), the petitioner sustained injuries after falling while in the lobby of the UIC Outpatient Care Clinic building. At the time of her accident she was walking to the elevator bank that would take her to her office. It was stipulated that the lobby was available to both employees and the general public. However, the Commission, in reversing the Arbitrator on the issue of accident, noted that the lobby was the usual and customary route of entry to the petitioner and other coworkers to get to their offices. That route was attendant with a special risk of polished and slippery flooring which became wet when coworkers tracked melting snow in from the outside.

At bar, it is uncontroverted that the petitioner was at the Student Union to go to work at the respondent's facilities located in the basement of that building. The route she took was the usual and customary route used by the petitioner and 99% of her coworkers. Both the petitioner and the respondent's witness agree that the only way to get to the basement was to walk on the slick and slippery flooring to get to either the elevator or stairwell. Respondent's witness testified that all other doors were emergency exits which employees could not use to enter the premises. Both petitioner and respondent's witness agree that both the elevator and the stairwell were in the same area and were attendant with the same special hazard of slick flooring.

That usual and customary route caused the petitioner to cross flooring which became slick and slippery when water was tracked in from the outside. There is no evidence presented to the contrary.

Therefore, based upon totality of evidence , the Arbitrator finds as a matter of law on June 23, 2014 the petitioner sustained an accident which arose out of and in the course of her employment with respondent

F

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

HOLDING: Based upon the totality of the evidence , the Arbitrator concludes as a matter of fact and conclusion of law petitioner's current condition of ill-being is causally related to her accident/injury of June 23, 2014.

Petitioner testified that prior to that date she was not experiencing any pain, soreness or other disability to her right ankle/foot or left side. Immediately after her fall the petitioner complained of right ankle and foot pain which prevented her from standing. At U of I medical Center x-rays disclosed an avulsion fracture of her right medial malleolus with minimal widening of the lateral clear space. (PX1) Thereafter, upon chain of referrals, petitioner came under the care of Dr. Kim Tee, an orthopedic DPM. Dr. Kim noted that the slippery, wet brick floor at the UIC Student Union caused the petitioner to fall on June 23, 2014. The fall caused a traumatic fracture, right ankle. (PX4, office note of 6/28/2014)

Petitioner was provided time off of work and returned to her sedentary duties. She underwent casting, physical therapy then arthroscopic debridement of her right ankle. During the procedure Dr. Tee documented in situ the traumatic synovitis. Hypertrophic synovium was removed.

Petitioner testified that she still notes pain in her right ankle three to four times per week. She describes he pain as sharp, like electric bolts, which continue for five to ten minutes before subsiding. Her right foot begins to throb and cause her to slow down while walking approximately a block and a half. This condition remains the same to the present time. Said testimony and records are adopted herein.

E

Was timely notice of the accident given to Respondent?

HOLDING: Based upon the totality of the evidence at bar, the Arbitrator concludes as a matter of fact and law timely notice of the accident was given to the respondent. Sec. 6(c) of the Illinois Workers' Compensation Act states that "Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident." There is no requirement under Sec. 6(c) that petitioner provide respondent with notice of intent to bring a claim pursuant to the Act.

In the case at bar, no dispute exists respondent was aware of this fall on June 23, 2014. Respondent was aware of where the petitioner fell as well as the condition of the area where she fell. Respondent was aware that petitioner was injured and taken to the emergency room directly from the place of her fall.

Petitioner identified Kathy Nolan, respondent's supervisor, as having come to her aid while petitioner remained on the floor where she had fallen. Petitioner testified that Ms. Nolan was still an employee of the respondent at the time of hearing. Respondent asked for bifurcation of hearing to investigate, and present for testimony at a subsequent hearing date, those individuals identified by the petitioner during her direct examination. Ms. Nolan was identified as the individual having been provided notice on the Request for Hearing form entered into evidence, without objection, as Arb's Ex. #1. The Arbitrator in the interest of due process to all parties plus acknowledging that no discovery exists , of course, granted defense counsel's motion to continue and bifurcate case for additional post testimony investigation by the Respondent (or claims management).

Respondent did not call Ms. Nolan to dispute the petitioner's testimony and said testimony remains unrebutted. It is well-established that if a witness, under the control of a party, could have been produced by reasonable diligence, and that witness was not equally available to the opposing party, a trier of fact can presume that such a witness would have testified adversely to that party. See Wilkerson v. Pittsburgh Corning Corp., 276 Ill.App.3d 1023, 1028-30 (1995); Santucci Construction Co. v. County of Cook, 21 Ill.App.3d 527 (1974). Respondent's witness testified awareness of accident and injury within minutes of the occurrence. Petitioner was hauled away on gurney. Thus a notice defense is troublesome.

J

Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Respondent has disputed liability for medical bills incurred by the petitioner. Based upon the totality of the evidence plus the Arbitrator's findings with regard to accident, causal connection and notice, the Arbitrator concludes as a matter of law under section 8 the Respondent is liable to the Petitioner and her attorney the following medical bills under the fee schedule, as to amounts:

1	University of Illinois Hospital & Health Sciences System	$3,015.65
2	University of Illinois at Chicago Physician Group	$611.00
3 (A)	Cook County Englewood Health Center	$1,268.00
3 (B)	Cook County Englewood Health Center	$405.25
4	Bridgeport Pain Control	$5,342.00

5	American Radiological Services	$67.00
6	Kim K. Tee, DPM, P.C.	$15,018.00
7	Oak Brook Surgical Centre, Inc.	$31,878.00
8	Oak Brook Anesthesiologists, Ltd.	$1,500.00
9	University of Illinois at Chicago EMS	$829.50
10	CVS Pharmacy	$6.44
	GRAND TOTAL:	**$59.940.84**

K

What temporary benefits are in dispute?

HOLDING: Based upon the totality of the evicence plus upon the Arbitrator's findings with regard to accident, causal connection and notice, the Arbitrator concludes as a matter of law the Petitioner is entitled to , and awards the petitioner TTD benefits for 2-1/7 weeks, that being the periods alleged of a) June 24, 2014 through July 1, 2014, and b) August 1, 2014 through August 5, 2014, and c) the individual dates of October 17, 2014 and October 31, 2014. TTD is to be paid at the rate of $220.00 per week as stipulated by the parties. Said payment is to be made to Petitioner and his attorney.

L

What is the nature and extent of the injury?

Pursuant to §8.1(b) of the Act, the Arbitrator takes into consideration the following factors regarding permanency:

1) The reported level of impairment pursuant to Subsection (a) is not in issue: .
2) The occupation of the injured employee: Petitioner is a Customer Service Representative. Her duties are The Arbitrator gives lesser weight to this factor.
3) Age of the employee at the time of the injury: Petitioner was 51-years-old at the time of her injury. While petitioner is not at the beginning of her career, she has a significant work life expectancy and life expectance ahead of her. She will continue to cope with the continuing effects of her injury for quite some time. The Arbitrator gives greater weight to this factor.
4) Employee's future earning capacity: There is no evidence that petitioner's injury will impact her future earning capacity. The Arbitrator gives no weight to this factor

5) Evidence of disability corroborated by the treating medical record: The Petitioner testified that she continues to experience sharp pain in her right ankle numerous times per week. Her injury limits the distance she can ambulate without an increase of pain in her ankle. These complaints are corroborated by the treating records which note that the petitioner sustained a right ankle avulsion fracture. She failed conservative care and eventually required arthroscopic debridement. During the arthroscopy, Dr. Tee noted traumatic synovitis. Hypertrophic synovium was removed. The Arbitrator gives greater weight to this factor. HOLDING: See Decision as to section 8(e).

The Arbitrator further sayeth not.

February 28, 2017.

Page twelve of twelve

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	)	☐ 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

Francisco Guzman,
Petitioner,

No. 14 WC 39499

vs.

Midwest Canvas Company,
Respondent.

19IWCC0158

DECISION AND OPINION ON REVIEW

Petitioner has timely filed a Petition for Review of the August 16, 2017 Decision of the Arbitrator, following §19(b) hearing held on May 4, 2017. Notice has been given to all parties. The Commission, after considering the issues of accident, causal connection, medical expenses including prospective care, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. Particularly, as to Petitioner's current condition of ill-being in his ***low back***, the Commission finds that Petitioner failed to prove causal connection to the asserted accident, and thus affirms Arbitrator's denial of benefits regarding the low back. However, as to Petitioner's ***left shoulder***, the Commission finds that Petitioner sustained a compensable injury thereto, and the Arbitrator's Decision is modified to so reflect.

Accordingly, the Commission finds Petitioner entitled to temporary total disability compensation (TTD) from November 10, 2014 through February 9, 2016, which corresponds to the period of disability arising from the left shoulder injury, as well as for medical expenses relating to the left shoulder. All other and further benefits (including subsequent TTD and prospective lumbar surgery), insofar as these benefits are being sought for the asserted low back condition, is denied.

The Decision of the Arbitrator, a copy of which is attached hereto, is otherwise affirmed and adopted. The Commission remands this case to the Arbitrator for proceedings for a determination of a further amount of compensation for temporary total or permanent disability, if any -- regarding the left shoulder -- pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

Introduction and Summary of Commission's Decision

Petitioner, a 38-year-old laborer, alleges injury on November 8, 2014 while working with a machine that makes plastic bubble wrap. A roller on the machine caught his right hand and was pulling him in, and he had to forcefully jerk his arm back; he twisted his body and fell, hitting his left shoulder. From this accident, he alleges injury affecting an assortment of body parts. His Application for Adjustment of Claim (filed November 21, 2014) asserted injury to "back, [both] arms, right hand" incurred when he "fell at work."

About a year later, Respondent approved benefits -- and made payments -- including TTD and for shoulder surgery (rotator cuff repair) for injury to Petitioner's ***left shoulder.*** These benefits were approved by Respondent's insurance carrier following the results of a Section 12 examination of the left shoulder. Respondent's examiner, orthopedic surgeon Dr. Guido Marra, performed the examination in August 2015 and issued opinions favorable to Petitioner as to his left shoulder injury and causal connectedness to the accident, and made recommendations for treatment including possible surgery.

Petitioner had his left shoulder surgery in November 2015. Concurrently, he treated for low back issues. After recovering from the shoulder surgery, Petitioner returned to work in mid-February 2016. In all, his period of being off-work due to his left shoulder was from November 10, 2014 through February 9, 2016. When he returned to work, Respondent assigned him to light duty, apparently to accommodate work restrictions that were now being promulgated not for his left shoulder but for his ongoing ***low back*** condition, also alleged to have been caused by the November 8, 2014 accident.

At hearing, Petitioner stated that he was laid off on September 3, 2016 (and has since remained off-work) because Respondent could no longer accommodate his low back condition as diagnosed in July 2015 by neurosurgeon Dr. Sean Salehi. Dr. Salehi believed that Petitioner currently suffers from a degenerated disc (with annular tear and herniation) in the lumbar spine at L5-S1, with no nerve root compression, giving rise to disabling mechanical low back pain. Dr. Salehi proposed lumbar fusion surgery to resolve what he called "microinstability" at L5-S1 in Petitioner's lumbar spine. Petitioner now seeks benefits related to this low back condition, including further TTD (commencing on September 3, 2016) and the prospective lumbar surgery.

Before the Arbitrator, the parties' disputed issues were accident, causation as to current condition of ill-being, temporary total disability, prospective care, and certain unpaid medical bills. The Arbitrator denied Petitioner's claim. The Arbitrator found: (i) there was no accident; and (ii) even had there been an accident, Petitioner's claimed current condition of ill-being was not causally related thereto. (Arbitrator's decision at 17- 18).

The Arbitrator believed Petitioner to be less than credible. The Arbitrator pointed to medical records demonstrating that his subjective complaints of pain were out-sized, erratic, and had evolved inconsistently since the incident. Furthermore, the two Section 12 lumbar spine examiners retained by Respondent -- Dr. John Cherf in May 2015 and Dr. Carl Graf in June 2016 – both opined that Petitioner suffered at most a work-related low back strain, had long since reached maximum medical improvement (MMI), and required no further surgery or other medical care. These experts could find no objective evidence to support his ongoing significant complaints, and indeed discerned "abnormal illness behavior" and symptom magnification. The opinions of Respondent's experts were more convincing than that of Dr. Salehi, who opined that, while Petitioner had preexisting degeneration in his lumbar

spine, the accident caused the condition to become symptomatic and manifest as chronic mechanical pain in the low back; this mechanical pain was due to the disc being damaged at L5-S1. With regard to the Arbitrator's finding that Petitioner's low back condition was not caused by the workplace incident, the Commission agrees and affirms the denial of benefits as to the low back.

The Commission notes that, in finding that there was no occurrence of accident, the Arbitrator clearly intended to deny the entirety of the low back claim. As to the left shoulder, the Arbitrator described no express findings directed to that part of the body. However, in the Order section of his decision, the Arbitrator wrote that ***Respondent was to be credited $35,807.77 for medical benefits already paid and $20,188.79 for TTD already paid***. Although not specifically explained, these already-paid benefits were ***for Petitioner's left shoulder injury*** (this is evident from the parties' stipulations in the Request for Hearing form). Thus, it appears that the Arbitrator, in this indirect manner, was signaling a finding that the left shoulder injury was also non-compensable.

With regard to the Arbitrator's Decision as it applies to Petitioner's left shoulder, the Commission disagrees. The Commission finds that the record sufficiently supports: (i) occurrence of work-related accident on November 8, 2014; (ii) that Petitioner sustained injury to the left shoulder as a result; and, therefore, the Commission hereby concludes that (iii) Petitioner is entitled under the Act to TTD and medical expenses related to the left shoulder injury.[1]

I. BACKGROUND

A. Petitioner Alleges Injuries and Treats at Occupational Clinic for Three Weeks.

Petitioner started employment at Respondent about 8 weeks before his accident. (RX 1). On November 8, 2014, he was working as a helper for the machine operator, Steven Cheek, his supervisor. Petitioner testified that his right hand got caught on a roller on the machine and he had to forcefully pull his right arm free (using his left arm to pull his right arm away), which resulted in him twisting his body and then falling to the ground on his left shoulder. (Tr. 12-13). Petitioner stated that he went to the emergency room at MacNeal Hospital that day. The only records of that first visit to be found in the trial exhibits are the reports of x-rays for his right hand and wrist; the radiologist noted that they were unremarkable for acute bony fracture or displacement.

The supervisor, Mr. Cheek, also testified at hearing. Mr. Cheek testified that he was standing next to the Petitioner while operating the machine on November 8, 2014. Mr. Cheek acknowledged that there was an incident where he saw Petitioner's hand touch the material on the roller, but then Petitioner pulled his hand away without struggle. He testified unequivocally that Petitioner did not fall down after freeing himself from the machine, Petitioner continued working his regular duty for another hour, then

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[1] In his review brief, Petitioner writes "it is the Petitioner's contention that the Arbitrator intended to find no accident with regard to a low back claim. However, this case involves alleged injuries to the low back and right [*sic*] shoulder. The Petitioner suggests to this Commission that the Arbitrator's denial of finding accident in this matter extends only to the claim of an accident that injured his lumbar spine." (Petitioner's brief at 13). The Commission questions whether Petitioner meant "left shoulder." If Petitioner indeed meant "right shoulder," the Commission notes here that the medical records do not support any right shoulder injury claim that Petitioner may be trying to preserve.

he started complaining of hand and thumb pain and clocked out to seek medical treatment. (Tr. 46-49). In rebuttal, Petitioner re-asserted that he did indeed fall and strike his shoulder, and that Mr. Cheek was standing some distance away "in back" of the machine and could not have seen him anyway. (Tr. 69-70). He also stated that another supervisor named "Osmel" actually "saw everything" including the fall and yelled out for the machine's emergency shut-off to be activated. (Tr. 29-34).

On November 11, 2014, at Respondent's direction, Petitioner was again at MacNeal Hospital, at its occupational clinic known as Clearing Clinic. There, he was seen by Dr. Tabusum Amir. Petitioner's primary complaints were pain in both shoulders and his right hand; he also complained of low back pain, rated at 8/10. Dr. Amir diagnosed a left shoulder contusion, multiple contusions, and neck strain which were probably work-related. Dr. Amir recommended ibuprofen 200 mg three times per day and icing. He issued work restrictions of no lifting over 10 pounds and no lifting above the shoulders. On November 13, 2014, for follow-up, Petitioner presented to Amy Park, A.P.N. at the clinic. His complaints were pain in the right arm and neck, and again secondarily complained of low back pain. His physical examination findings and diagnoses remained unchanged. More medications (tramadol and cyclobenzaprine) were added to his regimen. Petitioner returned to Clearing Clinic two more times, on November 20 and November 26. His presentation remained essentially the same throughout. More medications (analgesic balm and naproxen) were added to his regimen. At the last visit (November 26, 2014), Petitioner rated his pain at 6/10; Dr. Anita Carani prescribed 500 mg acetaminophen and anticipated returning him to regular duty within the week. (PX 1).

Petitioner's next appointment at Clearing Clinic was for December 3, 2014, but Petitioner was a no-show. By then, he was exclusively treating at Midway Pain Center (which treatment he sought out on his own) for his constellation of pain complaints. The initial visit to Midway Pain Center was on November 10, 2014. He would go on to treat with Midway Pain Center for another five months (until late April 2015) and receive a variety of treatments there including chiropractic adjustments and injections into various body parts. His treatment at Midway Pain Center is discussed below.

B. Petitioner Treats at Midway Pain Center and in Late 2015 Obtains Approval for Left Shoulder Surgery.

(1) Petitioner seeks care at Midway Pain Center. On November 10, 2014, Petitioner presented at Midway Pain Center, where he was seen by chiropractor Dr. Mark Aleman. Petitioner complained of pain in the neck, mid-back, low back, left leg, right forearm, and right wrist, all from a work-related injury of November 8, 2014. He also complained of shooting pain in the low back that radiated into the left leg and shooting pain in the right arm that radiated into the right hand. The details of the mechanism of injury were not documented. Dr. Aleman's diagnoses that day were brachial neuritis or radiculitis, thoracic or lumbosacral neuritis or radiculitis, neck sprain/strain, thoracic sprain/strain, and lumbar sprain/strain. Dr. Aleman's recommended treatment included a mix of home exercises, chiropractic adjustments and thrice-weekly physical therapy. Dr. Aleman took Petitioner off-work. (PX 3).

On November 17, 2014, Petitioner returned to Midway Pain. Dr. Aleman noted that Petitioner was currently in a "relief phase of care" and reiterated his prior treatment recommendations. On November 26, 2014, Petitioner returned to Midway Pain and filled out a Workers' Compensation Questionnaire. Thereon, he reported injuries to the neck, shoulder, right arm, and low back. He also

denied consulting any other doctors for those injuries (a misrepresentation). Over the course of the next few months, Petitioner would receive injections into his left shoulder, lumbar spine, and right wrist, administered by pain specialists Dr. Leon Huddleston and Dr. Thomas Pontinen. (PX 3).

(2) Petitioner receives shoulder surgery following Section 12 exam. Sometime in spring 2015, Dr. Pontinen referred him to a shoulder orthopedic surgeon, Dr. Kevin Tu of G & T Orthopedics. Dr. Tu began treating Petitioner in April 2015, diagnosed tendon tears, and eventually recommended surgery. (PX 2). Petitioner continued to treat concurrently for pain in his low back (and elsewhere) at Midway Pain Center. Around the time that he was referred to Dr. Tu for his shoulder, Petitioner also expressed a desire for low back surgery. (PX 3).

Respondent retained Dr. Guido Marra for a Section 12 exam for the left shoulder. Respondent also retained Dr. John Cherf for a Section 12 exam of the low back. (Dr. Cherf would be the first of two Section 12 examiners retained by Respondent to examine Petitioner's low back. The second was Dr. Carl Graf. Dr. Cherf's and Dr. Graf's opinions are discussed in more detail in Section II below.) Dr. Marra examined Petitioner in August 2015, diagnosed partial thickness rotator cuff tear, opined favorably for Petitioner as to mechanism of injury (relying on Petitioner's account) and made treatment recommendations. (PX 2 at 31-33). Subsequently, Respondent's insurance carrier approved benefits for the left shoulder. Petitioner then received TTD and underwent arthroscopic shoulder surgery in November 2015. His left shoulder reached MMI in February 2016, whereupon Dr. Tu released him to unrestricted work as to the left shoulder. The merits of his left shoulder claim were not addressed – at least not directly -- at the §19(b) proceeding.

At hearing, Petitioner stated that he returned to work but then was laid off by Respondent on September 3, 2016 because his employer could not accommodate ongoing restrictions for his low back condition. (Tr. 40). His low back condition and treatment is discussed more fully below.

C. Petitioner Continues Concurrent Treatment for Low Back.

(1) Midway Pain Center: As mentioned above, by early December 2014, Petitioner was treating exclusively at Midway Pain Center, where he continued to voice complaints of pain in his low back (and pains elsewhere). Dr. Pontinen ordered a lumbar MRI, done on January 2, 2015. In his report, the radiologist indicated he found no definite evidence for an acute osseous abnormality of the lumbar spine. The radiologist noted mild degenerative changes (facet arthropathy) and posterior disc bulges (not herniations) from L3-4 through L5-S1, which, combined with the facet arthropathy, produced varying degrees and types of stenosis, most severe at L5-S1. (PX 2).

Between January 20, 2015 and April 10, 2015, Petitioner underwent epidural steroid injections on at least four separate occasions. The injections were administered at L4-5; at L5-S1 (twice) and at L4 through S1. Petitioner's back pain persisted. On April 24, 2015, Dr. Pontinen wrote that Petitioner's back pain was "unchanged with radiation down the left leg to the foot." Dr. Pontinen noted that Petitioner had obtained an appointment with a shoulder surgeon by then and "also wants to see a back surgeon for his low back. He doesn't feel that the injections are helping and would like to discuss surgery. To date, he has had more than 4 months of physical therapy, has had 4 epidural steroid injections, a medial branch nerve block in the low back (that didn't help), and has had MRIs and proper medication management." (PX 3 at 8). Dr. Pontinen indicated that he would refer him to a spine surgeon for ongoing "lumbar radicular pain." (PX 3 at 9).

19IWCC0158

(2) Dr. Sean Salehi: On July 10, 2015 (8 months after the accident) Petitioner presented to Dr. Sean Salehi of Neurological Surgery & Spine Surgery. Dr. Salehi diagnosed degenerative disc disease at L5-S1 and prescribed conservative care including physical therapy. On September 3, 2015, because Petitioner still had constant pain in the low back radiating down into the left posterior leg, Dr. Salehi recommended proceeding with lumbar fusion at L5-S1.

Petitioner was seen by Dr. Salehi again on December 29, 2015 and February 9, 2016. After Petitioner was returned to work in February 2016, having recovered from the left shoulder surgery, Dr. Salehi maintained him on light duty restrictions. Dr. Salehi saw Petitioner for the last time on November 15, 2016. Petitioner's presentation remained essentially unchanged. Dr. Salehi maintained his diagnosis, work restrictions, and fusion surgery recommendation. (PX 4).

At hearing, Petitioner attested to ongoing symptoms. He stated that there was "like a needle in my back pinching me little by little, but still bothering me all day," especially after prolonged sitting or when he tries to bend just a little bit. He rates the pain at a 6 to 7 out of 10, and that the pain is fairly constant throughout the day. "I can't do nothing. I cannot pick nothing off the floor. If I do, I have to go and lay down for like 30 minutes or so to relax all my body." (Tr. 24-25). He claims he never had issues with his low back (or left shoulder) prior to the accident.

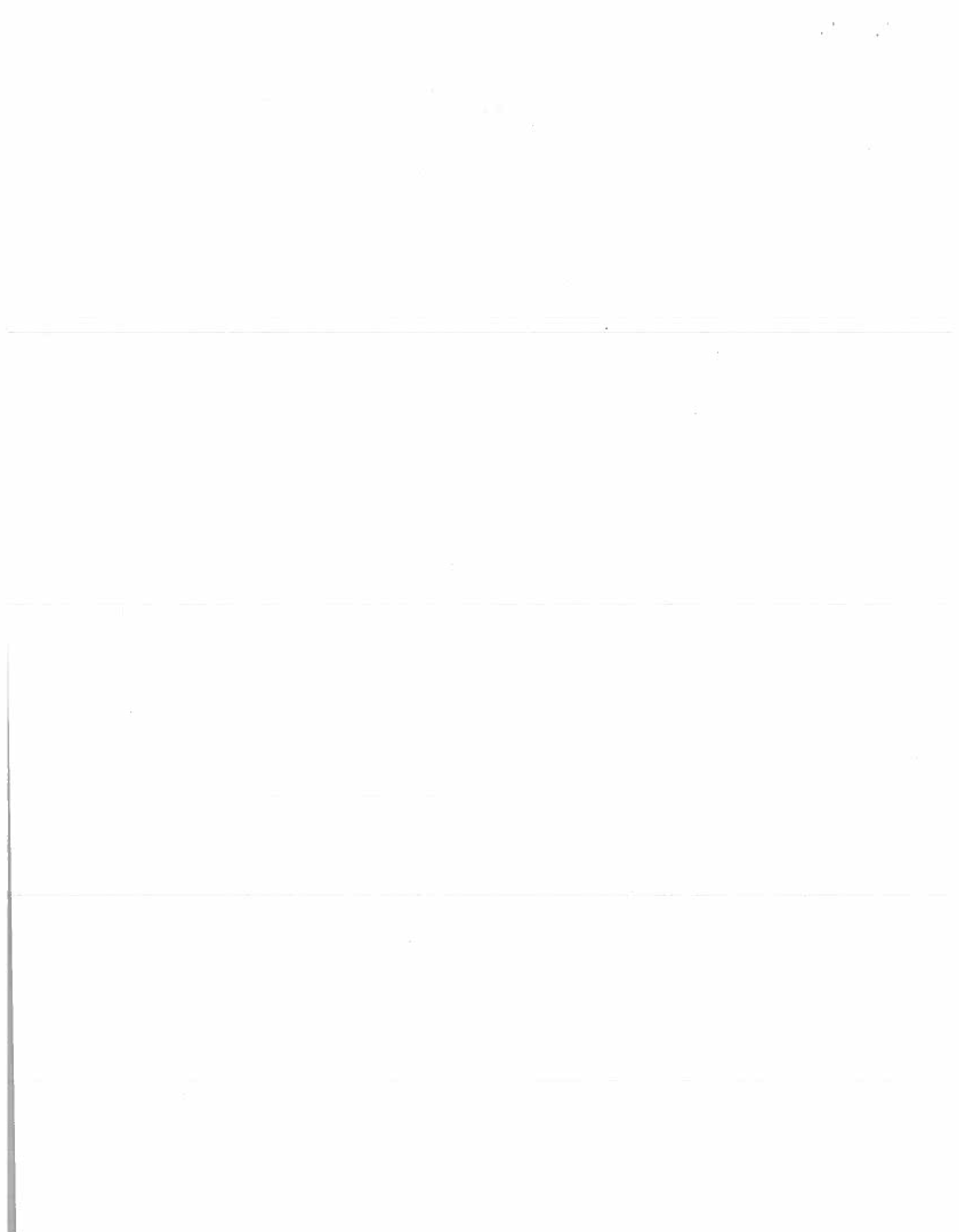
II. MEDICAL OPINION EVIDENCE

A. Section 12 Reports Regarding Lumbar Spine

(1) Dr. John Cherf's report of May 13, 2015. Orthopedic surgeon Dr. John Cherf examined Petitioner on May 13, 2015 and generated a written report. (RX 1). Dr. Cherf had reviewed Petitioner's lumbar MRI of January 2015 and prior medical records including from Midway Pain Center and the occupational clinic. Dr. Cherf diagnosed a work-related lumbar sprain/strain that had long since resolved. He noted, *inter alia,* that there were no objective findings on Petitioner's physical exam indicating significant pathology of the lumbar spine, that his complaint of 8/10 pain seemed excessive, inconsistencies with his straight leg raise test between the supine and seated position, and his display of abnormal illness behavior that appeared to be symptom magnification. While the early treatment received for his low back pain was reasonable and related to the injury, the injections and prolonged chiropractic treatments for nearly six months were excessive. Dr. Cherf also documented his AMA impairment assessment – 1% whole person impairment. (RX 2 and RX 3).

(2) Dr. Carl Graf's reports of June 15, 2016 and April 6, 2017. Orthopedic surgeon Dr. Graf examined Petitioner on June 15, 2016 and generated a written report. (RX 4). Dr. Graf reviewed the prior medical records, including the lumbar MRI, and also reviewed the Section 12 reports from Dr. Cherf and Dr. Marra (regarding the left shoulder). Dr. Graf's findings and ultimate opinions were essentially the same as Dr. Cherf's.

Dr. Graf noted that on physical examination "Mr. Guzman demonstrates a myriad of inconsistences. He has no hard neurologic findings and demonstrates pain and functional improvement with distraction." Dr. Graf wrote, as to current diagnosis, "It is possible Mr. Guzman suffered a [work-related] lumbar strain. I am unable to substantiate his ongoing subjective complaints of pain given the



lack of objective findings." (RX 4 at 24). Dr. Graf also opined that a lumbar strain diagnosis, but not the disc degeneration, could be considered causally related to the work incident. (RX 4 at 26).

On April 6, 2017, Dr. Graf saw Petitioner again for another Section 12 exam. Dr. Graf was provided with records generated subsequent to the earlier exam, including Dr. Salehi's deposition transcript. Dr. Graf generated a supplemental report. (RX 5). In this supplemental report, Dr. Graf wrote again that Petitioner demonstrated multiple inconsistencies and non-organic pain signs during his physical exam. Dr. Graf's opinions overall remained the same as stated in the previous Section 12 report.

B. Dr. Sean Salehi's Evidence Deposition Testimony

Dr. Salehi, board-certified neurosurgeon, sat for evidence deposition on February 7, 2017. (PX 5). Dr. Salehi disagreed that Petitioner suffered just a lumbar strain. Dr. Salehi believed that, because Petitioner continued to voice severe low back pain a year after the accident, he had to be suffering from something worse than a strain. Dr. Salehi pointed to the January 2015 MRI, which he interpreted as revealing disc herniation and annular tear at L5-S1. Dr. Salehi opined the back pain was "mechanical back pain" with no nerve compression involved (and thus this was not a case of lumbar radiculopathy). Regarding this mechanical back pain, Dr. Salehi further testified that "microinstability" between those segments of L5-S1 was generating the pain and that fusion surgery would stabilize the segments and relieve the pain. (PX 5 at 44-45).

As to causation, Dr. Salehi stated that he "made the causal connection on the first visit based on the fact that he denied any prior history of lower back pain and the fact that there was a consistent mechanism of jerking his back and falling down." (PX 5 at 14). Dr. Salehi's opinion was that Petitioner was suffering from persistent mechanical back pain secondary to a permanent exacerbation of preexisting disc disease and annular tear at L5-S1, which exacerbation was caused by the alleged work injury.

Dr. Salehi acknowledged that the radiologist who performed the January 2015 MRI found only a disc bulge and made no mention of any annular tear. Dr. Salehi also acknowledged that both Dr. Cherf and Dr. Graf reached similar opinions regarding Petitioner's work injury being at worst a lumbar strain that needed no further care. Regarding these differences of opinion among learned physicians, Dr. Salehi could only offer that all these assessments (including his own) were "based on subjectivity." (PX 5 at 9). That is, Dr. Salehi could not suggest that there was anything unreasonable, much less arguably erroneous, about the conclusions reached by Respondent's experts.

III. DISCUSSION

The Arbitrator clearly felt that Petitioner's presentation was overall just not credible. As to his finding that there was no accident whatsoever, the Arbitrator wrote that this was "primarily based on Petitioner's inability to give a coherent and plausible description of the alleged event, as well as other factors adversely affecting his credibility." (Arbitrator's decision at 17).

In any event, regardless of whether an accident occurred, the Arbitrator explained that he "would otherwise find that petitioner failed to prove that his claimed current condition of ill-being is causally related to the claimed work accident." (Arbitrator's decision at 18). The Arbitrator discussed the

opinions of Drs. Cherf, Graf, and Salehi, and found that Respondent's experts were more persuasive. The Arbitrator noted that, while Dr. Salehi testified that Petitioner had "microinstability" at L5-S1, "he did not note [this 'microinstability'] in any clinical record and [it] was not observed on any imaging. One would normally expect documentation of such an opinion." (Arbitrator's decision at 19).

The Arbitrator also discussed the inconsistencies and symptom magnification observed by Dr. Cherf and Dr. Graf at some length. Regarding Petitioner's leg complaints, he wrote, "Petitioner's subjective complaints of leg pain and paresthesias morphed and evolved in an inconsistent manner over time. Sometimes, he reported reduced sensation over the entire right leg and then over the entire left leg. He reported reduced sensation over different parts of his left leg from time to time. The Arbitrator notes Dr. Salehi's lack of explanation for these variances in light of his opinion there was no nerve compression or impingement. Nerve compression or impingement would be the likely cause of genuine sensory loss." (Arb. decision at 17).

The Commission concurs with the Arbitrator's finding regarding lack of causation between the work incident and Petitioner's condition of ill-being in the low back. And as to this claimed condition, Petitioner has not credibly shown that he had sustained damage (much less damage to a disabling degree) to his lumbar spine. The Commission notes here that among all the physicians expressing opinions on the January 2015 lumbar MRI images, only Dr. Salehi discerned a herniation and annular tear. The others – the radiologist who performed the MRI, Dr. Cherf, and Dr. Graf – noted only a bulge.

Regarding the Arbitrator's rejection of Petitioner's account of the accident, the Arbitrator did not specify whether he rejected all or only some details of that account. But by rejecting "accident" categorically, it appears that the Arbitrator thereby was telegraphing that not only was the low back injury non-compensable, but the left shoulder injury was non-compensable too. As discussed above, the Commission finds that Petitioner has proven that a work-related accident did occur, but that the injury sustained as a result was only to his left shoulder and any current condition of ill-being to the low back is not related.

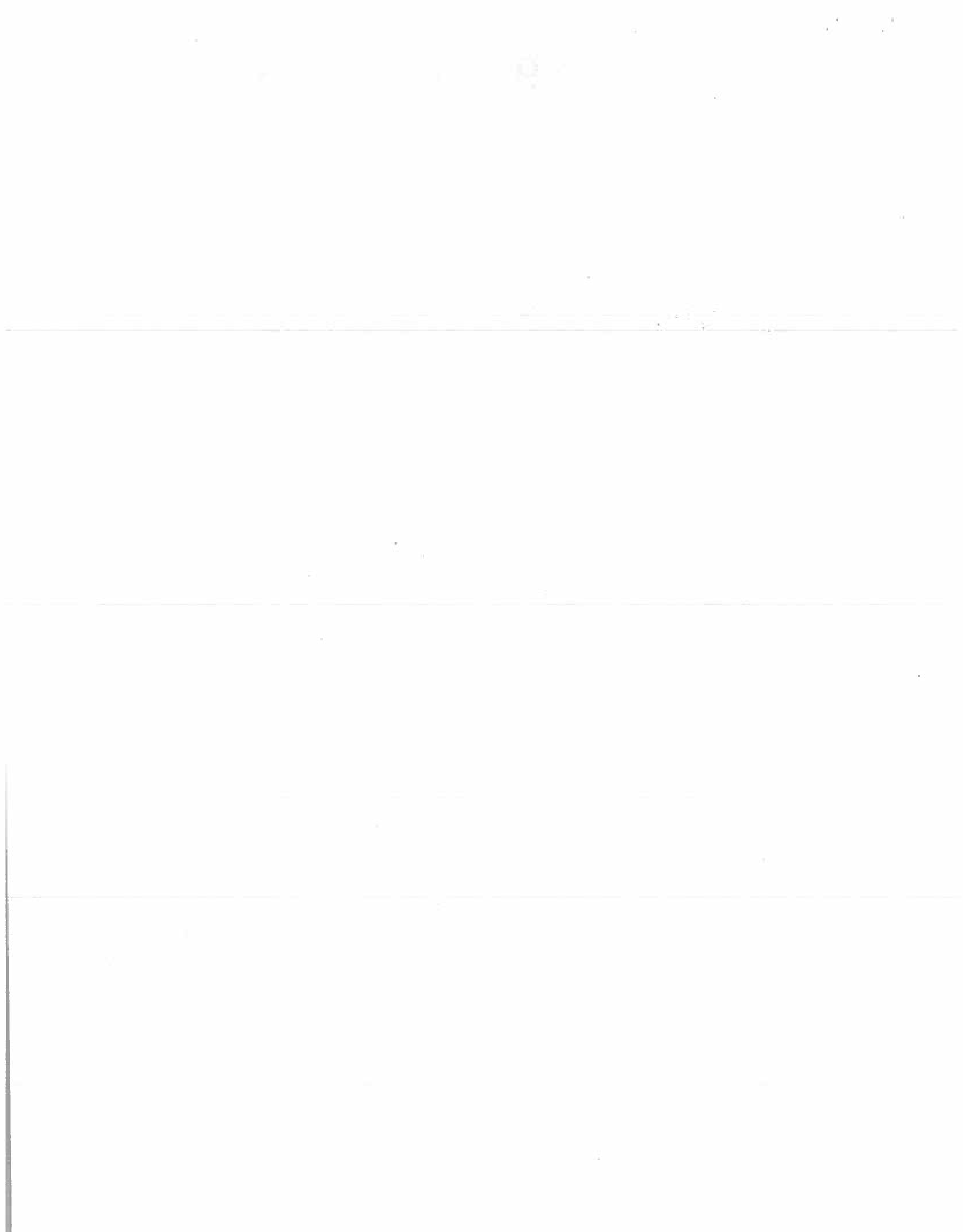
IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 16, 2017 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 319.00 per week commencing November 10, 2014 through February 9, 2014, as provided under Section 8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred for treatment to his left shoulder as provided under Section 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall 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 to or on behalf of Petitioner on account of the accidental injury, including but not limited to $ $35,807.77 in medical benefits and $20,188.79 in temporary total disability payments as set forth in the Arbitrator's Decision.



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 $57,000.00. 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: MAR 13 2019

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jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

GUZMAN, FRANCISCO
Employee/Petitioner

Case# **14WC039499**

MIDWEST CANVAS CO
Employer/Respondent

19IWCC0158

On 8/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

4128 RUBENS AND KRESS
FRANK KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

4866 KNELL O'CONNOR & DANIELEWICZ
STEVEN M REISING
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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)

Francisco Guzman Case # **14 WC 39499**
Employee/Petitioner

v.

Midwest Canvas Co.
Employer/Respondent

19IWCC0158

An *Application for Adjustment 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 **May 4, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to 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 **November 8, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to the lumbar spine ***is not*** causally related to the accident.

In the 52 weeks preceding the injury, Petitioner earned ***$1,893.38***; the average weekly wage was ***$315.56.***

On the date of accident, Petitioner was ***38*** years of age, ***married*** with ***3*** dependent children.

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

Respondent shall be given a credit of **$20,188.79** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$36,807.77** for medical benefits, for a total credit of **$56,996.56.**

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained a claimed low back injury in a work accident on November 8, 2014 that arose out of and in the course of his employment by Respondent.

Medical Benefits
Petitioner failed to prove that he received reasonable and necessary medical care for his claimed low back injury inasmuch as Petitioner failed to meet his burden of proof that he sustained a work accident on November 8, 2014 pursuant to §8(a) of the Act. Furthermore, Respondent shall be given a credit of $36,807.77 for medical benefits that have been paid.

Temporary Total Disability
Petitioner shall not receive any temporary total disability benefits since Petitioner has failed to meet his burden of proof in demonstrating to the Arbitrator that he sustained a work accident occurring on November 8, 2014 pursuant to Section 8(b) of the Act. Furthermore, Respondent shall be given a credit of $20,188.79 for temporary total disability benefits that have been paid.

Prospective Medical Treatment
Petitioner failed to prove that he is entitled to prospective medical treatment for his claimed low back injury, inasmuch as he failed meet his burden of proof that he sustained a work accident to the claimed lumbar spine on November 8, 2014 pursuant to §8(e) of the Act. Petitioner also failed to prove that the proposed prospective medical treatment was medically necessary to cure or relieve that effects of his claimed low back injury.

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

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

AUG 1 6 2017

Francisco Guzman v. Midwest Canvas Co.
14 WC 39499

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD

FINDINGS OF FACT

Petitioner Francisco Guzman worked as a general laborer for Respondent Midwest Canvas. As a general laborer, Petitioner worked a machine that manufactured and packaged bubble wrap into 150 pound rolls. He had to bring material to machines in order to make rolls of product. Petitioner further explained that it was a requirement of his job that he load the rolls of tarp once they were complete. He would then place these rolls onto a dolly for transport 12 hours per day, approximately 5 or 6 days per week.

On November 8, 2014, Petitioner was working the bubble wrap machine when his right glove got caught inside of the machine. Using his left hand, Petitioner tried to pull his right arm out of the machine. Petitioner continued to pull on his right arm and, in doing so, twisted his lower back. When Petitioner was finally able to release his hand from the machine, he fell approximately five feet six inches (5'6") to the ground and landed on his left shoulder. Petitioner testified that while he was working with this machine, Steven Cheek was working on the same machine approximately 10 or 15 feet away. Petitioner was working beneath the machine, while Mr. Cheek was working behind the machine. He testified that a tarp blocked their view of one another. After he fell to the ground, his supervisor noticed and instructed another employee to stop the machine.

Petitioner testified that immediately following this incident, he felt tremendous pain in his right hand as it was swelling due to having been in the rollers of the machine. He testified that at that point in time, the only thing he could do was sit and wait to be taken for medical treatment. Petitioner was taken to MacNeal Hospital. No records from MacNeal Hospital were offered in evidence.

Petitioner denied any injuries or problems with his lower back or left shoulder prior to November 8, 2014.

Petitioner was seen at Midway Pain Center (Midway Pain) on November 10, 2014 by chiropractor Dr. Mark Aleman (PX #3). He presented with complaints of neck pain, mid back pain, low back pain, left leg pain, and right forearm and wrist pain from a work-related injury November 8. The details of the mechanism of injury were not documented. He complained of dull, sharp, aching, shooting pain in the low back which radiated into the left leg. He also complained of dull, sharp, aching, shooting pain with numbness and tingling in the left leg. He complained of dull, sharp, aching pain in the mid back. Petitioner also complained of dull, sharp, aching shooting pain in the right arm which radiated into the right hand. Finally, he complained of dull, aching pain in the neck.

On the Midway Pain registration form Petitioner marked the location of his pain on body diagrams (PX #3). He marked both shoulders, his right hand/wrist, and mid-back. He did not mark his low back or legs as areas of pain.

On exam Dr. Aleman noted Kemp's test was positive bilaterally, as well as cervical distraction, Goldthwait's, and Yeoman's. Double leg-raise, Soto-Hall, and Gaenslen's were positive. Valsalva's was positive on the left, as well as Bechterew's, Braggard's, Hibbs, and Laseque's. Shoulder depression was positive on the right. No x-rays were taken.

Dr. Aleman diagnosed brachial neuritis or radiculitis, thoracic or lumbosacral neuritis or radiculitis, neck sprain/strain, thoracic sprain/strain, and lumbar sprain/strain. Dr. Aleman recommended home exercise, electrical muscle stimulation, trigger point therapy, chiropractic adjustments, and physical therapy 3 times per week. He also took Petitioner off work until November 17, 2014.

Petitioner was referred to Clearing Clinic (MacNeal Occupational Health & Immediate Care) by Respondent on November 11 (PX #1). Petitioner's primary complaints were pain in both shoulders and his right hand. He also complained of low back pain. Petitioner reported his pain was 8/10. The Clearing Clinic notes contained Petitioner's description of the accident as follows: "I was putting a roller on the machine and it jammed. I tried to pull back but I fell down on the floor. I hurt both my shoulders and back."

Dr. Tabasum Amir noted a painful arc in both shoulders. Motion of both shoulders was limited; shoulder strength was diminished. Finkelstein's was positive in the right hand with snuff box tenderness. Neck and back motion were also decreased, although he could bend forward to the toes. X-rays were negative for fracture. Dr. Amir diagnosed with a left shoulder contusion, multiple contusions, and neck strain which were probably work related. Dr. Amir recommended 200 mg ibuprofen 3 times a day and ice twice per

day for 15 minutes at a time. He restricted Petitioner's work status to 10-pound lifting and no lifting over the shoulders.

Petitioner was seen by APN Amy Parker at Clearing Clinic on November 13, 2014. His primary complaint was right arm and neck pain. Pain was 9/10. The exam and diagnoses were unchanged. Work restrictions were continued. He was to continue with ibuprofen but Tramadol and cyclobenzaprine were added. Petitioner returned November 20 to see Dr. Anita Carani. He presentation was essentially the same. The diagnoses were the same. Work restrictions were continued. Dr. Carani added analgesic balm and Naproxen to the treatment regimen. Petitioner saw Dr. Carani one last time on November 26, 2014. His presentation was essentially the same, although his pain level was 6/10. She prescribed 500 mg Acetaminophen and anticipated regular duty within the week.

A note from Clearing Clinic indicated that Petitioner was a no show for his appointment December 3, 2014 (PX #1).

Petitioner returned to Midway Pain on November 17, 2014 (PX #3). Dr. Aleman noted that Petitioner was currently in a "relief phase of care". Dr. Aleman reiterated his recommendation for treatment including a mix of home exercises, chiropractic adjustments and physical therapy.

Petitioner returned to Midway Pain November 26, 2014 (PX #3). He filled out a Worker's Compensation Questionnaire. He reported neck, shoulder, right arm, and low back injury. He denied consulting any other doctors for those injuries. There were no clinical notes for November 26. However, Petitioner was examined and treated by Leon Huddleston, M.D. and by Dr. Aleman. Dr. Huddleston ordered a lumbar MRI which was performed January 5, 2015. According to Dr. Amar Shah the MRI showed spondylosis with degenerative disc disease at L5-S1. There were also posterior disc bulges from L3 through S1, most severe at L5-S1. There was varying degrees of facet arthropathy from L3 through S1.

Petitioner had 4 epidural steroid injections (PX #3): January 20, 2015 by Dr. Huddleston to L4-5; February 10, 2015 by Dr. Huddleston to L5-S1; February 24, 2015 by Dr. Huddleston to L5-S1; and April 10, 2015 by Dr. Thomas Pontinen of Midwest Anesthesia & Pain Specialists from L4 through S1. Dr. Pontinen also performed medial branch nerve blocks from L3 through S1. Petitioner testified that the injections provided temporary relief at best.

Petitioner testified that on July 10, 2015 he consulted with neurosurgeon Dr. Sean Salehi (PX #4). Dr. Salehi noted Petitioner's complaints of low back pain radiating down the back of his left leg to the knee. Petitioner reported that he had injured his right

shoulder and back in the work injury on November 8, 2014 when fell onto his low back and left shoulder. He complained of 8/10 pain for which he was taking Tramadol. Petitioner had 6 weeks of physical therapy and 3 injections without relief. Petitioner denied any prior history of low back pain or work-related injuries.

On examination Dr. Salehi found reduced lumbar motion. Sitting straight-leg was negative on the right but positive for back pain on the left. Patrick's maneuver was negative both right and left. Dr. Salehi he noted normal gait and posture and found no paraspinal muscle spasm. Light touch sensation was intact. Deep tendon reflexes were diminished but symmetric. Left psoas muscle strength was diminished. Dr. Salehi noted Petitioner's January 2, 2015 lumbar MRI showed disc disease at L5 S1 with a mild herniated disc without neural compression. Salehi diagnosed mechanical low back pain secondary to aggravation of a pre-existing disc disease/annular tear at L5 S1. He recommended a course of physical therapy for 4 to 6 weeks. He noted that if Petitioner continued to be symptomatic he would discuss a single level lumbar fusion.

Petitioner returned to Dr. Salehi September 3, 2015. Petitioner's son served as the interpreter. Petitioner had continued complaints of low back pain radiating down the back of the left leg. He reported that recent physical therapy did not relieve his pain. There were no other changes in history. Lumbar range of motion was still decreased. Sitting straight-leg raise was now positive for back pain, both left and right. Petitioner's gait was still normal. Light touch sensation over the left lateral calf and thigh was diminished. Left psoas muscle strength was still diminished. Dr. Salehi continued with his diagnosis of low back pain secondary to a permanent exacerbation of the pre-existing disc disease and degenerative disc disease. He noted it was related to the work injury of November 8, 2014. In light of failed conservative treatment Dr. Salehi recommended a left L5-S1 transforaminal lumbar interbody fusion.

Petitioner testified that Dr. Salehi recommended a lumbar fusion at L5-S1. Petitioner continued to see Dr. Salehi for treatment of his lumbar spine, which included 10-pound lifting restrictions. Dr. Salehi consistently recommended a lumbar fusion, which was never authorized. Petitioner testified that he has continued to experience pain rated 6/10 when he sits for a long time or tries to bend over.

On July 14, 2015, Petitioner presented to Total Rehab, P.C. for an initial physical therapy examination (PX #4). Petitioner reported injuries at work when his gloves got caught in one of the machines which caused him to twist his trunk and fall on the floor hitting the left side of his body. Petitioner complained of pain, tightness, and weakness on the lumbar area. He rated his pain 7-9/10. On exam Petitioner was noted to be able to reach his hands to the mid-thighs when bending forward, as well as to the right and left.

Petitioner was able to achieve a 20% backward bend, a 30% right rotation, and a 10% left rotation. Petitioner was to undergo physical therapy 2-3 times per week for 6 weeks.

Petitioner returned to Dr. Salehi on September 3, 2015 with ongoing complaints of constant pain in the low back radiating down into the left posterior leg. He complained of feeling weak in the legs, but denied any falls and continued to take Tramadol or Tylenol for the pain. Petitioner had physical therapy which did not relieve his pain. Dr. Salehi noted that Petitioner had recently been approved for left shoulder surgery and was waiting for it to be scheduled. Petitioner had 30° forward flexion, 0° hyperextension, 15° right lateral bend, and 20° left lateral bend. Sitting straight-leg raise was positive bilaterally in the back only. Strength in the lower extremities was normal except for the left psoas (4+/5 secondary to pain). Dr. Salehi noted a decreased sensation in the left lateral calf and thigh. Deep tendon reflexes in the lower extremities were diminished, but symmetric bilaterally. Dr. Salehi diagnosed lumbar degenerative disc disease. He noted that Petitioner had persistent mechanical back pain secondary to a permanent exacerbation of a preexisting disc disease/annular tear at L5-S1, secondary to the alleged work injury. Dr. Salehi concluded that Petitioner had failed conservative treatment and recommended a left L5-S1 transforaminal lumbar interbody fusion (TLIF).

Dr. Salehi noted Petitioner wanted to proceed with surgery. Post-operatively, Petitioner would start a 4-6 week course of physical therapy. At that point, Petitioner would be able to return to work with a 20 lb. lifting restriction, a 35 lb. push/pull restriction, no repetitive bending/twisting, and alternate between sitting/standing every 30-45 minutes. He would have these restrictions post-operatively until completion of a work conditioning starting no sooner than 6 months post-op. Work conditioning would be for 4 weeks, 5 days per week. Petitioner would then be released to work following a valid FCE (PX #4).

On December 29, 2015, Petitioner presented to Dr. Salehi reporting that he had a left rotator cuff repair and was currently undergoing physical therapy for that. He anticipated being released with respect to the shoulder in about a month. Petitioner continued to complain of pain in the low back radiating down both legs, left more than the right. Dr. Salehi's exam findings were consistent with his prior exam, with the exception of 40° forward flexion, 5° hyperextension, 15° right lateral bend, and 20° left lateral bend. Dr. Salehi reiterated his diagnosis, causational opinion, and recommendation for TLIF surgery consistent with his September 3 note. Dr. Salehi noted that Petitioner's work status would be consistent with the orthopedist (PX #4).

On February 4, 2016, Dr. Salehi restricted Petitioner from work until February 9, 2016 (PX #4).

On February 9, 2016, Petitioner saw Dr. Salehi reporting that he continued with therapy for the left shoulder following rotator cuff surgery (PX #4). Petitioner was to see his orthopedist in 2 weeks and anticipated a release at that time. Petitioner continued to complain of constant low back pain radiating down both legs, left worse than right. He stated that he had difficulty bending forwards and sometimes would get "stuck" and shakes when he straightened up. Dr. Salehi's findings were consistent with his prior exam, with the exception that he noted 30° forward flexion. Dr. Salehi's diagnosis, causational opinion, and recommendation for TLIF surgery remained the same. Dr. Salehi provided work restrictions of no lifting/pushing/pulling more than 10 lbs, no bending/twisting more than 3 times per hour, and to alternate between sitting or standing as needed. Petitioner was given a prescription for Mobic for pain.

On March 8, 2016, Petitioner saw Dr. Salehi with ongoing complaints of low back pain radiating into both legs (PX #4). Petitioner reported difficulty with bending and going from sitting to standing. He denied numbness, weakness, falls, and bowel/bladder incontinence. Dr. Salehi's objective findings were consistent with his prior exam, with the exception of lumbosacral tenderness to palpation (there was no tenderness of the left posterior iliac crest), 30° forward flexion, and 15° left lateral bending. Dr. Salehi continued with his diagnosis, causational opinion, recommendation for TLIF surgery, and work restrictions consistent with his prior records.

On May 3, 2016, Petitioner saw Dr. Salehi with continued complaints of low back pain radiating down both thighs to the knees, left worse than right (PX #4). Dr. Salehi's clinical findings were consistent with prior exams. Dr. Salehi had the same diagnosis, causational opinion, recommendation for TLIF surgery, and work restrictions consistent with his last exam.

On June 28, 2016, Petitioner presented to Dr. Salehi with complaints of low back pain radiating into both thighs (PX #4). Exam findings were unchanged with the exception that Dr. Salehi noted 40° forward flexion and 10° left lateral bend. Dr. Salehi noted that Petitioner had presented for an IME and they were waiting on the results.

Petitioner saw Dr. Salehi August 9, 2016 with complaints of constant pain in the low back which radiated into both thighs, left worse than right. Petitioner rated the pain as 8-9 out of 10. Petitioner reported shaking of his legs, but denied any falls. Dr. Salehi noted 45° forward flexion, 5° hyperextension, 10° right and left lateral bending. Dr. Salehi noted that he continued to await the results of the IME evaluation and anticipated that surgery would be authorized once the IME report was received.

On October 18, 2016, Petitioner presented to Dr. Salehi complaining of constant low back pain radiating down both legs, which he rated as 8/10 (PX #4). Petitioner was alternating Mobic with Tylenol. Dr. Salehi noted 10° hyperextension and 15° right lateral bending. Dr. Salehi had reviewed Dr. Cherf's IME report and disagreed with the conclusions contained therein. Dr. Salehi commented that disc disease and annular tears can result in mechanical back pain and the treatment for such a diagnosis would be a lumbar fusion. Dr. Salehi also commented that a lumbar strain should have resolved within a few weeks and not lasted this long. Dr. Salehi referred Petitioner for a pre-operative psychological evaluation to ascertain that Petitioner's expectations of surgery are reasonable. Dr. Salehi refilled the Mobic and prescribed lidocaine patches.

On November 1, 2016, a letter from Clinical Psychologist Patricia Andrise, Ph.D. stated that she is unable to perform an assessment or treat Petitioner because of a lack of approval from the WC carrier (PX # 4).

On November 15, 2016, Petitioner presented to Dr. Salehi with complaints of low back pain radiating down both posterior legs. Dr. Salehi repeated his diagnosis, recommendation for surgery, and work restrictions consistent with prior records.

Steven Cheek testified on behalf of Respondent. He has worked for Respondent as a machine operator for the last 3 years. As a machine operator, Mr. Cheek would oversee 3 machines and the materials that went into each. On November 8, 2014, Mr. Cheek was both a machine operator and Petitioner's immediate supervisor.

Mr. Cheek testified that on November 8, 2014 he was working with Petitioner on a machine approximately one foot away from him making "heavy blue" bubble wrap. To make a roll of this material, Mr. Cheek testified that the process takes approximately 7 to 9 minutes to complete. Mr. Cheek testified that Petitioner was assisting him with this material when he saw him reach his right hand over to pull plastic out and his glove, primarily his four fingers, caught on the tape found on the plastic. Within seconds, Mr. Cheek saw Petitioner snatch his hand out of the machine. Mr. Cheek testified that he did not witness Petitioner struggle or engage in any jerking movement other than Petitioner yanking his hand out of the machine quickly. Moreover, Mr. Cheek testified that he did not witness Petitioner fall or call out for help, and neither him nor another employee hit the emergency shut-off on the machine.

Once Petitioner freed his right hand from the machine, Mr. Cheek testified that Petitioner did not complain of pain until approximately an hour following the incident. Petitioner's primary complaint was with his right thumb. Mr. Cheek testified that Petitioner continued to perform his full job duties, including carrying a roll of bubble wrap over to another machine. Petitioner left work that day following his complaint regarding

his right thumb. Mr. Cheek testified that he did not create an accident report and is unaware of whether Petitioner sought medical attention on that day. He further testified that Petitioner did return to work later.

On cross-examination Mr. Cheek testified that Petitioner was his helper the day of the accident. He generally works at the front of the machine, making sure the machine is doing what it's supposed to and his helpers are doing what they're supposed to. Helpers are positioned in front of the machine also. In his opinion, based on his experience with the machine, had Petitioner not pulled back his right hand so quickly, he would be in no more danger due to the speed of the machine and the plastic occupying the space between the rollers inside.

Dr. Salehi testified by evidence deposition February 7, 2017 (PX #5). Dr. Salehi is a board certified neurosurgeon. His specialty is the spine, seeing 60 patients per week with approximately half experiencing lumbar pathologies. Depending on the diagnosis, Dr. Salehi makes a determination regarding treatment, usually trying conservative care first. Conservative care includes physical therapy, injections, and medications, in addition to the passage of time. If conservative care fails, surgery may be offered where pathology lends itself to it, and generally could include microdiscectomy, laminectomy, or fusion surgery. He testified from his clinical records. He confirmed that he relied on Petitioner's accuracy in reporting his history and subjective complaints.

Dr. Salehi treated Petitioner for his lumbar injury only. Dr. Salehi reviewed his encounter with petitioner on July 10, 2015. He repeated the findings he documented in his clinical chart. Dr. Salehi reviewed the MRI films and radiologist's report of Petitioner's lumbar spine dated January 2, 2015. Dr. Salehi diagnosed Petitioner with a disc herniation and lumbar degenerative disc disease caused by annular tears. He acknowledged that the radiologist read bulging discs only.

Dr. Salehi initially recommended physical therapy but held out the possibility of single level lumbar fusion as a secondary treatment method at L5-S1. After a nearly a year had passed since Petitioner's injury and no improvement with physical therapy, Dr. Salehi testified that Petitioner required a lumbar fusion.

Dr. Salehi reviewed his care of Petitioner through November 2016 as documented in his chart. He continued with his recommendation for lumbar fusion surgery.

On cross-examination, Dr. Salehi testified that he had a different opinion than the interpreting radiologist as to what the MRI showed. Specifically, the interpreting radiologist saw a disc bulge on the MRI rather than a herniation, which is a less severe. Dr. Salehi testified that the radiologist also found arthropathy present in each level

between L1 and S1, but Dr. Salehi did not feel that the degenerative changes he viewed passed the threshold of calling arthropathy. Regardless, Dr. Salehi concluded that any arthropathy seen on the MRI would have been a pre-existing condition. He further testified that Petitioner did not show signs of stenosis within his spinal canal. Dr. Salehi testified that there was no objective medical evidence substantiating Petitioner's complaints of pain radiating into the left buttock or posterior thigh. He also testified that an individual cannot accurately date an injury on an MRI unless there is a prior MRI immediately before the accident.

Dr. Salehi further testified that Petitioner's leg pain was probably referred and not radicular. There was no evidence of nerve compression in the spine. He added that he believed there was microinstability in petitioner's lumbar spine. The goal of the proposed fusion was relief of Petitioner's low back pain.

Dr. Salehi testified that he did not review any medical records other than the lumbar MRI. He did not review Clearing Clinic or Midwest Pain Center records. Dr. Salehi also testified that he had already formulated his diagnosis, recommendation for surgery, and causational opinion by Dr. Cherf's IME on October 18, 2016. Dr. Salehi reviewed Dr. Cherf's IME report, and disagreed with his assessment of Petitioner's condition. Similarly, Dr. Salehi testified that he disagreed with Dr. Graf's conclusion in the IME performed by him, diagnosing Petitioner with a lumbar strain with present degeneration. Dr. Salehi confirmed that he did not note nonorganic signs in Petitioner's case.

Dr. Salehi did not express any opinions regarding the cervical spine, thoracic spine, left or right shoulders, or the right hand or wrist.

On May 13, 2015, Petitioner presented to Dr. John Cherf at Chicago Institute of Orthopedics for a §12 IME of the lumbar spine (RX #1). Petitioner was accompanied by his wife but she was not present for the IME itself. Dr. Cherf had reviewed petitioner's records from Mark Aleman, D.C., Midway Pain Clinic, Clearing Clinic, Vanguard Occupation Health Services, and Leon Huddleston, M.D. He also reviewed the report of Petitioner's lumbar MRI on January 2, 2015. Dr. Cherf summarized Petitioner's history from those records.

Petitioner stated that he had been working with Respondent for approximately 8 weeks prior to his accident on November 8, 2014. He was employed as an assistant operator, typically working from 8:00 am to 8:00 pm. At approximately 1:50 pm on November 8, 2014, Petitioner's right hand got caught in a machine and was headed towards a roller. He used his left hand to grab his right wrist to pull himself free from the machine. When his right hand broke free, he fell backwards and landed on his left

shoulder and left buttock area. Petitioner complained of 8/10 back pain, and described his back function at 70%. Petitioner stated that his symptoms were exacerbated with lifting and bending; symptoms are relieved with rest. His pain was located in the midline of his lumbar spine and radiated in the posterior thigh. Petitioner denied any numbness, tingling, weakness, or bowel or bladder dysfunction. Petitioner also denied any prior problems with his lumbar spine. Petitioner reported taking Tramadol 2-3 times per day, which was prescribed by Dr. Thomas for the left shoulder. Petitioner had not worked since November 8, 2014.

On exam Dr. Cherf noted that there was no soft tissue swelling, erythema, or ecchymosis about the lumbar spine. Dr. Cherf noted tenderness in the lumbar spine without paraspinal muscle spasm. Petitioner exhibited a decreased range of motion of flexion, extension, lateral bend, and rotation. Petitioner had a normal gait, including toe-heel walk and heel walk. Muscle strength in the lower extremities was normal. Sensation was intact to light touch. Straight leg-raise was negative in the seated position. Petitioner reported discomfort at approximately 70° of hip flexion in the supine position.

Dr. Cherf diagnosed a work-related lumbar sprain/strain. Dr. Cherf noted that there were no objective findings on his physical exam indicating significant pathology of the lumbar spine as a result of the alleged injury. Dr. Cherf noted that degenerative changes in the lumbar spine were a pre-existing and independent of the alleged work incident. Dr. Cherf commented that Petitioner's complaint of 8/10 pain seemed excessive and noted inconsistencies with straight leg-raise between the supine and seated positions. Dr. Cherf noted Petitioner's display of abnormal illness behavior, which appeared to be symptom magnification. Dr. Cherf concluded that Petitioner did not sustain a permanent aggravation or any acceleration of the degenerative findings in the lumbar spine. He further opined that the early treatment received for the lumbar issues was reasonable, necessary, and related to the alleged injury. However, the injections and prolonged chiropractic treatments for nearly 6 months were excessive. Dr. Cherf concluded that Petitioner did not require any additional treatment for the work-related lumbar spine injury. Dr. Cherf stated that it was unlikely that Petitioner would require any restrictions as a result of the alleged work injury, but suggested that a valid FCE may be considered. Dr. Cherf opined that Petitioner had reached MMI.

In a supplemental report dated May 14, 2015 Dr. Cherf documented his AMA impairment assessment (RX #2). Respondent's Exhibit #3 was the Quick Report from May 13. He found a 1% whole person AMA impairment rating.

On June 15, 2016, Petitioner presented to orthopedic surgeon Dr. Carl Graf at the Illinois Spine Institute for a §12 IME (RX #4). Petitioner acknowledged that the consultation was for IME and not for care or treatement. Dr. Graf summarized

Petitioner's medical care with Dr. Aleman, Midway Pain Center, Clearing Clinic, Dr. Huddleston, and Dr. Salehi. Dr. Graf also reviewed IME reports from Drs. Cherf and Guido Marra.

Dr. Graf noted Dr. Cherf's observation of mild inconsistencies between the two versions of straight-leg raise and excessive 8/10 pain complaints in light of objective findings. He also noted Dr. Marra's assessment of Petitioner right shoulder. He noted that Dr. Marra opined that Petitioner should reach MMI with his shoulder about 6 months after surgery.

Petitioner reported working for a company that makes tarps used for covering pools and cars and worked on a machine which made "bubble tarps." This machine required 2 operators and he was working as an assistant operator. He took plastic rolls weighing up to 150 lbs. and put them through the machine. He lifts 60-70 rolls per day. The machine needs to be restocked when it stops. To restock the machine, the plastic had to go through 2 large tubes that open and close. On November 8, 2014, Petitioner was putting the plastic in the machine and he got pulled "all the way inside." The machine is loud and the other operator did not hear him call out. Petitioner stated that he got out of the machine and twisted his back.

Petitioner denied any prior or pre-existing low back conditions. Petitioner complained of low back pain which encompassed the entire back. Petitioner rated the pain as 8/10 without medication and 4-5/10 with medication. Petitioner also stated that the pain radiated into both legs. His legs would shake and he had numbness all the time. Petitioner reported working light duty at the time of the IME.

Dr. Graf noted that Petitioner demonstrated an antalgic gait. Petitioner stated that he had to walk with his feet externally rotated to avoid pain. Petitioner had no difficulty stepping up on his tiptoes or onto his heels. Petitioner performed a 1/6 squat, but was not able to go any further citing a pull in his low back. Petitioner demonstrated a forward bend reaching his fingertips to the level of his thighs; extension was to 5°. Petitioner complained of low back pain with both maneuvers. Petitioner subjectively had a decreased sensation in the right leg, encompassing the entire leg with no specific anatomic nerve root distribution. Dr. Graf noted that distracted sitting straight leg-raise was negative at 90°, but Petitioner had a positive straight- leg raise bilaterally, right greater than left at 20°, in an informed scenario. Supine straight-leg raise was positive at 10° bilaterally. Dr. Graf noted that Petitioner demonstrated 5 non-organic pain signs which included: (1) pain out of proportion to the evaluation, (2) nonanatomic loss of motor strength to the bilateral lower extremities, (3) motor strength improvement with distraction, (4) nonanatomic distribution of subjective sensation loss to the entire right lower extremity, and (5) pain improvement with distraction.

Dr. Graf reviewed the MRI report and scan. He found mild degenerative changes at L5-S1 where there was a mild disc bulge with no nerve root encroachment or otherwise. Dr. Graf noted that he was unable to substantiate Petitioner's ongoing subjective complaints given the lack of objective findings and concluded that Petitioner was not a surgical candidate. Dr. Graf found Petitioner at MMI and that no further medical care was necessary. He further opined that Petitioner could return to full duty. Dr. Graf diagnosed a lumbar strain which was related to the work accident. Dr. Graf opined that the lumbar disc degeneration was not causally related to the alleged injury. Dr. Graf also provided a 1% whole person AMA impairment rating.

On April 6, 2017, Petitioner presented to Dr. Graf for another §12 IME for his back (RX #5). Dr. Graf then reviewed additional records from Dr. Salehi and Dr. Salehi's February 7, 2017 deposition. He also reviewed physical therapy records. Petitioner reported that his treatment had been suspended since September of 2016 and that he had not undergone any further treatment since the last visit with Dr. Graf on June 15, 2016. Petitioner further stated that he had only received anti-inflammatory medication. Petitioner rated his pain 6-7/10 in his lower back, but had not experienced radiating pain other than leg cramping bilaterally (more so on the right than the left). Petitioner informed Dr. Graf of his desire to move forward with an L5-S1 lumbar fusion. Petitioner was not working with Respondent at the time of this IME. He complained of pain in his bilateral shoulders, bilateral wrists, and left shoulder. He rated his shoulder and bilateral wrist pain 5-6/10. Petitioner marked a pain diagram indicating pain in both shoulders and wrists. He also gave a history of his shoulder surgery in September 2015.

Dr. Graf noted that Petitioner demonstrated a normal gait and had no difficulty stepping up on his toes or heels. Petitioner performed a 1/3 squat and raise from a squatting position. Petitioner complained that it felt like his nerves were pulling in his right leg. Petitioner could forward bend, reaching his fingertips to his thighs; extension was to 0°. While doing so, Petitioner complained of low back pain and weakness in his legs. Dr. Graf noted pain to palpation of light one finger touch throughout the low back. No paraspinal muscular spasm was present. Motor strength in both legs was normal. Petitioner complained of numbness throughout his entire left lower extremity, primarily concentrated on his right side below the knee. He reported numbness Petitioner over his entire right leg except the anterior thigh. He had a negative distracted sitting straight leg-raise, but reported greater pain on his right side, rated 7/10 in the informed scenario. The supine straight-leg raise was positive, right greater than left. Petitioner reported low back pain with bilateral leg pain when hip range of motion was tested. Dr. Graf found 8 non-organic pain signs, which included: (1) pain in the low back to light one finger touch, (2) pain in the low back to simulated axial rotation, (3) pain in the low back to simulated axial compression, (4) palpation of the thoracic spine produced low back pain, (5) neck forward

flexion produced low back pain, (6) give-away weakness in the bilateral lower extremities, (7) motor strength improvement with distraction, and (8) pain movement with distraction.

Petitioner's Pain Disability Questionnaire placed Petitioner in the "moderate disability" self-rated category.

Dr. Graf's opinions remained unchanged from the June 15 IME. Dr. Graf was unable to substantiate Petitioner's subjective complaints of pain given the lack of objective findings. Dr. Graf also relied on the multiple inconsistencies and non-organic pain signs in arriving at his conclusions and opinions. Dr. Graf concluded that Petitioner was not a surgical candidate and did not required further treatment for his work injury. Dr. Graf saw no objective reason preventing Petitioner from returning to his full duty level job as he had described. Dr. Graf further noted that Petitioner was at MMI.

Wage Statement – 10/10/2014 through 12/5/2014 (RX #6)

Petitioner began working for Respondent in October 2014. Petitioner continued working for Respondent into December 2014.

Wage Statement – 2/19/2016 through 9/9/2016 (RX #7)

Petitioner returned to work for Respondent in mid-February 2016 and continued working for Respondent through early September 2016.

Petitioner consulted orthopedist Dr. Kevin Tu of G & T Orthopaedics and Sports Medicine on April 29, 2015 for his left shoulder complaints (PX #2). Petitioner gave a history of his right hand being caught in a machine and falling onto his left shoulder as he forcefully pulled his hand free. Based on a clinical exam and review of an April 17, 2015 left shoulder MRI Dr. Tu diagnosed a focal full thickness rotator cuff tear. Dr. Tu performed an arthroscopic subacromial decompression, distal clavicle excision, and extensive debridement of a loose body on November 13, 2015. The operative report recites that the procedure was performed on the right shoulder. Dr. Tu noted that there was a partial tear of the rotator cuff and labrum tearing, which was debrided. He also noted a mild chondral defect above the glenoid, extensive bursitis, and a large subacromial spur. Dr. Tu followed Petitioner post-operatively and oversaw his rehabilitative therapy.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that he sustained a compensable work injury to the lumbar spine on November 8, 2014. The Arbitrator's finding is primarily based on Petitioner's inability to give a coherent and plausible description of the alleged event, as well as other factors adversely affecting his credibility.

Petitioner testified that his right hand was caught in a machine at work. He could not coherently describe the operation of the machine or the mechanism leading to the entrapment of his hand. He claims injuries to low back and left shoulder when he fell to the floor after pulling his hand free.

Steven Cheek also testified as a witness to the alleged incident. Mr. Cheek was the operator of the machine on the alleged date of injury and also was Petitioner's immediate supervisor. Mr. Cheek testified that he was working next to Petitioner. Mr. Cheek saw Petitioner reach over the material that was being run through the machine. Mr. Cheek saw Petitioner's hand touch the material, but then Petitioner immediately pulled has hand away without any struggle. Mr. Cheek testified that Petitioner did not fall down after freeing himself from the machine and the emergency shut off on the machine was never pushed. Mr. Cheek agreed that Petitioner was wearing gloves at the time, but the glove remained on his hand after the incident. Mr. Cheek testified that Petitioner continued working full duty after the incident, but started complaining of hand/thumb pain about an hour later and clocked out to seek medical treatment.

The Arbitrator also notes that at Midway Pain Center on November 10, 2014 Petitioner marked body diagrams indicating areas which did not include his low back or legs. On his November 26, 2014 Workers' Compensation Questionnaire, he wrote in his own hand that he had not consulted any other doctor. Further, Petitioner's subjective complaints of leg pain and paresthesias morphed and evolved in an inconsistent manner over time. Sometimes he reported reduced sensation over the entire right leg and then over the entire left leg. He reported reduced sensation over different parts of his left leg from time to time. The Arbitrator notes Dr. Salehi's lack of explanation for these variances in light of opinion there was no nerve compression or impingement. Nerve compression or impingement would be the likely cause of genuine sensory loss.

The Arbitrator notes that Petitioner gave a consistent history of the mechanism of his injury to medical care providers, save for Dr. Aleman at Midwest Pain Center. In light of the wealth of contractions, inconsistencies, and inplausibles this artifact does not support a finding in favor of Petitioner's claim.

Given the credible testimony of Steven Cheeks and Petitioner's questionable credibility due to contradictions and inconsistencies noted above that Arbitrator finds that Petitioner failed to prove that he was injured in a compensable accident that arose out of and in the course of his employment.

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

In light of the Arbitrator's finding that Petitioner failed to prove that he suffered a compensable work injury, this issue is moot.

Nonetheless the Arbitrator would otherwise find that petitioner failed to prove that his claimed current condition of ill-being is causally related to the claimed work accident.

Deference is often given to the opinions of treating physicians compared to the opinions of retained examining physicians. However, in this case, the Arbitrator finds that the opinions of Drs. Cherf and Graf, examining physicians retained by Respondent, are more persuasive than the opinions of Dr. Salehi. Drs. Cherf and Graf performed §12 IMEs. Each found inconsistencies and contradictions in Petitioner's clinical presentations at the various IMEs.

Aside from the clinical examination of Petitioner Dr. Cherf reviewed Petitioner's records from chiropractor Dr. Mark Aleman of Midway Pain Center, Clearing Clinic, Vanguard Occupational Health Services, and Dr. Leon Huddleston. On clinical examination Dr. Cherf noted Petitioner's normal gait including heel/toe walk and heel walk. He found normal muscle strength and sensation. He noted inconsistent straight-leg findings between the supine and seated positions. Dr. Cherf opined that Petitioner exhibited symptom magnification and was at MMI. In the end, he diagnosed a lumbar strain for which no further medical care was required.

Dr. Graf performed two IMEs, June 15, 2016 and April 6, 2017. On June 15 Dr Graf reviewed Petitioner's records from Dr. Aleman at Midway Pain Center, Clearing Clinic, Dr. Leon Huddleston, physical therapy records, Dr. Guido Marra, Dr. Salehi, and the January 2, 2015 lumbar MRI. He also reviewed Dr. Cherf's May 13, 2015 IME report. Petitioner complained of non-anatomic decreased sensation over the entire right leg. Seated straight-leg was negative at 90° when distracted but Petitioner complained of right greater than left pain at 20° when informed. In supine, straight-leg was positive at 10° bilaterally. He was able to stand on his tiptoes and his heels. Dr. Graf opined that Petitioner had a lumbar strain and did not require surgery or other medical care. He found Petitioner at MMI for his back.

On April 6 Dr. Graf had reviewed additional records of Dr. Salehi and Dr. Salehi's deposition. Petitioner complained of leg pain symptoms greater on the right than the left. He complained of numbness over the entire right leg. There were inconsistent clinical responses to testing muscle strength. Again, straight-leg testing was inconsistent between distracted seated and informed seated and supine positions. Dr. Graf was unable to substantiate Petitioner's ongoing subjective complaints with the lack of objective findings he noted his findings of multiple inconsistencies on clinical exam differed from the findings of Dr. Salehi. Dr. Graff continued with his opinion that Petitioner was at MMI, was capable of full duty work, and required no further medical care for his low back.

Dr. Salehi had the perspective of evaluating Petitioner from July 2015 through November 2016. Such a breadth of time would ordinarily give a physician a broader view of the patient's case. However, that is not the case here. Dr. Salehi relied on Petitioner's accuracy and reliability as a historian and reporter of his subjective complaints. The Arbitrator has previously found Petitioner's credibility questionable. Of note here is the well documented record of clinical contradictions and consistencies by Drs. Cherf and Graf, as well as Petitioner denial at Clearing Clinic that he had not consulted other doctors when he was seeing Dr. Aleman at Midway Pain Center.

Both Dr. Cherf and Dr. Graf observed non-anatomic and magnified subjective complaints. Dr. Salehi reviewed these findings but ignored them or otherwise failed to explain them away. He did not repeat testing by Drs. Cherf and Graf which had revealed the inconsistencies and contradictions. At deposition Dr. Salehi testified that he did not find nonorganic symptomology. It is noteworthy that Dr. Salehi did not note the inconsistencies within his own chart: Petitioner's complaints of leg pain and numbness drifting from side to side and from location to location from time to time.

In addition, Dr. Salehi did not review Petitioner's clinical records from Clearing Clinic or Midway Pain Center until they were summarized by Drs. Cherf and Graf. Also, Dr. Salehi noted a herniated L5-S1 disc on the January 2, 2015 MRI while the radiologist read a bulging disc. Finally, Dr. Salehi testified at deposition that Petitioner had "microinstability" at L5-S1 which he did not note in any clinical record and which was not observed on any imaging. One would normally expect documentation of such an opinion.

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?

In light of the Arbitrator's previous findings, this issue is moot.

Nonetheless, that Arbitrator would find that the diagnoses of Drs. Cherf and Graf are persuasive. Petitioner clearly had pre-existing degenerative changes in his lumbar

spine. His course of medical care and treatment hinged on his accuracy and reliability in reporting his subjective complaints. Petitioner's varying subjective complaints and nonorganic signs demonstrated at IMEs clearly showed that Petitioner was neither accurate nor reliable in reporting his problems to his health care providers.

Petitioner's course of care and treatment at Midway Pain Center and with Dr. Salehi was dependent on the accuracy and reliability as a historian. Diagnoses and treatment plans based on inaccurate and unreliable histories and subjective complaints cannot be reliable themselves. Moreover, Petitioner was subjected a series of ineffective spinal injections based on the questionable credibility of Petitioner's complaints.

The Arbitrator also finds, for the reasons stated above, that the MMI opinions and opinions that Petitioner did not require further medical care of Drs. Cherf and Graf are persuasive. The Arbitrator, therefore, would find that Petitioner failed to prove that the medical care and treatement provided at Midway Pain Center and by Dr. Sean Salehi was reasonable and necessary to cure or relieve that effects of Petitioner's claimed work injury.

K: Is Petitioner entitled to prospective medical care?

Aside from the Arbitrator's findings stated above, the Arbitrator finds that Petitioner failed to prove that he is entitled to the prospective medical care recommended by Dr. Sean Salehi

Deference is often given to the opinions of treating physicians compared to the opinions of retained examining physicians. However, in this case, the Arbitrator finds that the opinions of Drs. Cherf and Graf, examining physicians retained by Respondent, are more persuasive than the opinions of Dr. Salehi. Drs. Cherf and Graf performed §12 IMEs. Each found inconsistencies and contradictions in Petitioner's clinical presentation at the various IMEs.

Aside from the clinical examination of Petitioner Dr. Cherf reviewed Petitioner's records from chiropractor Dr. Mark Aleman, of Midway Pain Center, Clearing Clinic, Vanguard Occupational Health Services, and Dr. Leon Huddleston. On clinical examination Dr. Cherf noted Petitioner's normal gait including heel toe walk and heel walk. He found normal muscle strength and sensation. He noted inconsistent straight-leg findings between the supine and seated positions. Dr. Cherf opined that Petitioner exhibited symptom magnification and was at MMI. In the end, he diagnosed a lumbar strain for which no further medical care was required.

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Dr. Leon Huddleston, physical therapy records, Dr. Guido Marra, Dr. Salehi, and the January 2, 2015 lumbar MRI. He also reviewed Dr. Cherf's May 13, 2015 IME report. Petitioner complained of non-anatomic decreased sensation over the entire right leg. Seated straight-leg was negative at 90° when distracted but Petitioner complained of right greater than left pain at 20° when informed. In supine, straight-leg was positive at 10° bilaterally. He was able to stand on his tiptoes and his heels. Dr. Graf opined that Petitioner had a lumbar strain and did not require surgery or other medical care. He found Petitioner at MMI for his back.

On April 6 Dr. Graf had reviewed additional records of Dr. Salehi and Dr. Salehi's deposition. Petitioner complained of leg pain symptoms greater on the right than the left. He complained of numbness over the entire right leg. There were inconsistent clinical responses to testing muscle strength. Again, straight-leg testing was inconsistent between distracted seated and informed seated and supine positions. Dr. Graf was unable to substantiate Petitioner's ongoing subjective complaints with the lack of objective findings he noted his findings of multiple inconsistencies on clinical exam differed from the findings of Dr. Salehi. Dr. Graff continued with his opinion that Petitioner was at MMI, was capable of full duty work, and required no further medical care for his low back.

Dr. Salehi had the perspective of evaluating Petitioner from July 2015 through November 2016. Such a breadth of time would ordinarily give a physician a broader view of the patient's case. However, that is not the case here. Dr. Salehi relied on Petitioner's accuracy and reliability as a historian. The Arbitrator has previously found Petitioner's credibility questionable. Of note here is the well documented record of clinical contradictions and consistencies by Drs. Cherf and Graf, as well as Petitioner denial at Clearing Clinic that he had not consulted other doctors when he was seeing Dr. Aleman at Midway Pain Center.

Both Dr. Cherf and Dr. Graf observed non-anatomic and magnified subjective complaints. Dr. Salehi reviewed these findings but ignored them or otherwise failed to explain them away. He did not repeat testing by Drs. Cherf and Graf which had revealed the inconsistencies and contradictions. At deposition Dr. Salehi testified that he did not find nonorganic symptomology. It is noteworthy that Dr. Salehi did not note the inconsistencies within his own chart: Petitioner's complaints of leg pain and numbness drifted from side to side from time to time.

In addition, Dr. Salehi did not review Petitioner's clinical records from Clearing Clinic or Midway Pain Center until they were summarized by Drs. Cherf and Graf. Also, Dr. Salehi noted a herniated L5-S1 disc on the January 2, 2015 MRI while the radiologist read a bulging disc. Finally, Dr. Salehi testified at deposition that Petitioner had

"microinstability" at L5-S1 which he did not notes in any clinical record and which was not observed on any imaging.

The Arbitrator finds that the opinions of Drs. Cherf and Graf regarding the lack of need for prospective medical care were more persuasive that the recommendation of Dr. Salehi for L5-S1 fusion. Dr. Salehi turned a blind eye to clinical records demonstrating that Petitioner was not a reliable or accurate historian. Opinions based on unreliable sources cannot themselves be reliable. Petitioner's request for authorization for prospective medical care recommended by Dr. Salehi is denied.

L: What temporary benefits are in dispute? TTD

In light of the Arbitrator's previous findings that Petitioner failed to establish that a compensable injury arising out of and in the course of his employment with Respondent occurred and also that Petitioner's current condition of ill-being is not causally related to the alleged incident, the Arbitrator concludes that Respondent is not liable for payment of any additional temporary total disability benefits.

Respondent would be due a credit in the amount of $20,188.79 for TTD benefits paid to Petitioner.

Steven J. Fruth, Arbitrator

August 15, 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Myrna Hernandez,

Petitioner,

vs. NO: 14 WC 18289

El Valor Corporation,

Respondent.

19IWCC0159

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical, prospective medical, wage rate 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, 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.

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: MAR 14 2019
o22119
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

HERNANDEZ, MYRNA
Employee/Petitioner

Case# **14WC018289**

EL VALOR
Employer/Respondent

19IWCC0159

On 7/17/2018, 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 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
HOWARD H ANKIN
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Myrna Hernandez
Employee/Petitioner
v.
El Valor
Employer/Respondent

Case # 14 WC 018289

19IWCC0159

An *Application for Adjustment 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 **02/14/2018**. 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. [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] 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, **05/01/2014**, 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 **$18,829.20**; the average weekly wage was **$362.10**.

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 **$29,707.85** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$29,707.85**.

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 $330.00/week for 121-1/7 weeks, commencing 05/13/2014 through 09/07/2014 and from 05/09/2015 through 05/07/2017, as provided in Section 8(b) of the Act, subject to the above credit for benefits paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $19,211.89 to Chestnut Medical/Dr. Harsoor; $2,289.00 to Stroger Hospital; $4,210.00 to The Spine Center, $1,700.00 to American Diagnostic, $1,630.38 to Rx Development, $1,136.20 to Advocate Medical Group, $492.00 to Best Practices Inpatient Care and $14.23 to Integrated Imaging Consultants, as provided in Sections 8(a) and 8.2 of the Act and as explained below.

Respondent shall authorize, approve and pay for the L5/S1 fusion surgery as offered by Dr. Avi Bernstein, along with all related services, in accordance with 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

July 17, 2018
Date

JUL 17 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a health and nutrition assistant, working at the Guadalupe Reyes Center. The program that she works in provides meals to children under 5 years old. Petitioner's job responsibilities included taking care of children in the program, making meals and health assessments, counseling parents on nutrition and working in the kitchen. As of May 9, 2017, Petitioner has been working a light duty job in Respondent's main office, as a receptionist and answering the phone.

The Parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of her employment by Respondent on May 1, 2014. Petitioner was helping in the kitchen and she hurt her back. She tried to lift a box of milk that was stuck to the floor. Her back hurt. Petitioner received assistance from a co-worker and her supervisor. She went to the office and rested. She later went home. Petitioner felt back pain, going down her left leg.

Petitioner was sent by Respondent to Concentra, where she first received treatment on May 3, 2014. The history of accident states: "I tried to take out a box of milk from the fridge I felt a pain in back, left side and leg" and "2 days ago while at work she went to lift a heavy box of milk from the refrigerator when she felt a sharp pain in her back. Initially the pain was not severe so she continued to work but overnight and with continued regular work activity the back pain became more severe." She was diagnosed with lumbar strain and radiculopathy and prescribed medication, physical therapy and light duty work. The physical therapy records detail pain, loss of range of motion and subjective complaints consistent with objective findings. On May 6, 2014, it was noted that Petitioner was working restricted duty and her symptoms were unchanged. The exam revealed negative Waddell's signs and the diagnosis was lumbar strain. Petitioner was evaluated on May 12, 2014. At that time, she continued to complain of stiffness and sharp intermittent pain radiating into the left leg that was exacerbated by bending, extending, sitting, walking and twisting. She was said to be not working "because the provider took her off work." We do not know who the provider is. An MRI of the lumbar spine was ordered and performed on May 13,2014. The findings were: L3/4: persistent minimal annular disc bulge. No significant spinal canal/neural foraminal stenosis. L4/5: no disc herniation or significant spinal canal/neural foraminal stenosis. L5-S1: slightly more pronounced small broad-based central disc protrusion with superimposed annular fissure. No significant spinal canal/neural foraminal stenosis. The Impression was: Relatively stable lumbar spine MRI when compared to 7/2012 as discussed above; no significant interval abnormality. (PX 1)

Petitioner testified that she fell down stairs at work in 2012 resulting in a back injury requiring physical therapy before returning to work at full duty. She lost 3 or for days from work and had PT for 2 weeks. She did not have any more back symptoms thereafter. She did not file a prior workers' compensation claim.

According to Petitioner, the physicians at Concentra told her that her back was fine and she could go back to work. Concentra records show that Petitioner was seen for the last time on May 13, 2014. She presented in a wheelchair. She was not working because she was taken off work. The MRI was unchanged from 2012. There were degenerative changes, but no disc nerve impingement. She has pain standing. She refused an exam because she had one yesterday. She was given the same meds, released to restricted duty and was told to continue PT and HEP and follow up in a week. Petitioner refused PT on May 13. (PX 1)

Petitioner testified that she went to the ER at Stroger Hospital on May 13, 2014 due to her pain complaints that she felt were not appropriately addressed at the company clinic. She gave a history of lifting a heavy box when she "threw out her back at work" and was diagnosed with a back strain. It does not appear that she presented

with a wheelchair. She was given work restrictions for 7 days and prescribed Ibuprofen. This does appear to be the first medically authorized lost time. She again presented to the Stroger ER on May 20, 2014. She was taken off work from 5/20-6/3/2014 and then was to have a 20 pound lifting restriction. The chart form May 30, 2014 is incomplete. (PX 2)

Petitioner began treating with Dr. Harsoor on June 3, 2014 because was not satisfied with the company's clinic, per the chart. Her chief complaint was low back, mid back and neck pain after an injury on May 1, 2014. "The patient describes the pain as constant all day. The pain is throbbing and tingling. The pain radiates to the left buttock. Patient says, at its worse her pain is 10/10, at least its least it is 4/10, and right now it is 8/10. The pain is made worse by walking, standing a long time, sitting a long time and movement, whereas it gets better by taking medications." Petitioner was using a cane as assistive device. There is no mention of a wheelchair. She was not working. The last day of work was "May 8, 2013." She denied being on disability or workers' compensation. Dr. Harsoor reviewed the 05/13/2014 MRI and found an L3/4 minimal annular disc bulge and L5/S1 central disc protrusion with superimposed annular fissure. Dr. Harsoor diagnosed cervicalgia, radiculopathy of the lumbar spine and myofascial pain. On 07/08/2014, she performed a Lumbar epidural injection at L5/S1 and trigger point injections at all three levels. On 07/24/2014, Petitioner reported 50% relief of back pain but continued left leg numbness. (PX 3)

Dr. Edward Goldberg, Respondent's Section 12 physician, examined Petitioner on August 15, 2014. The working diagnosis was degenerative disc with an annular tear, L5-S1 causing some low back pain and lumbar radiculitis. There is no physical compression of the nerve and no herniation. Her condition of ill-being is due to the accident on May 1, 2014. Dr. Goldberg could not discern whether the annular tear is acute or not. They may arise due to trauma or be degenerative. Her symptoms, however, appear to be acute. He thought that her low back and left leg radiculitis can come from degenerative disease and the annular tear at L5-S1. Additionally, she reported improvement after the epidural injection. Prognosis is good. He recommended1-2 more epidural injections. She should continue therapy over the next 1 month. If her symptoms resolve, she can return to work full duty. Hopefully, she will be at MMI at that time. She can work at a sedentary position while receiving treatment. (RX 1; PX 3)

On September 8, 2014, Petitioner returned to work pursuant to Dr. Goldberg's recommendations. Dr. Goldberg prescribed "a sedentary position." Petitioner testified that she was returned to her regular job, which is not a sedentary position.

On September 11, 2014, Dr. Harsoor performed a left transforaminal epidural steroid injection that partially relieved the leg pain but did not improve the stabbing pains in the low back. Dr. Harssor released Petitioner to light duty work as of September 15, 2014. On October 21, 2014, Dr. Harsoor performed an L5/S1 interlaminar epidural injection. The result was neck and midback pain subsiding but her low back pain remaining 5/10. Petitioner attended PT prescribed by Dr. Harsoor through Pain Specialist of IL from June 3, 2014 to November 7, 2014. Ultimately, Dr. Harssor referred Petitioner to a spine surgeon. (PX 3)

Petitioner was sent for another Section 12 exam with Dr. Goldberg. Dr. Goldberg's December 15, 2014 report stated that the diagnosis is degenerative disk with annular tear causing low back and left leg radiculitis. Her condition of ill being is due to the accident of May 1, 2014. The MRI finding of degeneration and annular tear may be causing her low back and left leg pain. There was no evidence of symptom magnification. Dr. Goldberg recommended an FCE to determine return to work with or without restrictions. She should be at MMI after the FCE. Dr. Goldberg thought that Petitioner's use of a cane was to provide security for her and he was not critical of the cane use. There was no actual objective evidence that she requires a cane. She is

neurologically intact. The MRI shows no nerve compression. Petitioner is capable of working a sedentary position. These restrictions are due to the work accident. Upon completing the FCE, she can return to work per the FCE. She may continue the methocarbamol. (RX 1)

Petitioner continued treatment with Dr. Harsoor and worked at her regular, not sedentary, job. This resulted in several ER visits to Stroger due to severe pain. Dr. Harsoor continued to refer her to a spinal surgeon while prescribing the FCE recommended by Dr. Goldberg. (PX 3)

The January 13, 2015 FCE reveals that Petitioner's effort was reliable. It was found that she was unable to return to her pre-injury job of Health and Nutrition Aide. Specifically: unable to perform lift, carry, push, pull, bend, squat tasks associated with kitchen work. She was to perform light duty, seated work. (PX 3)

On January 15, 2015, Dr. Harsoor prescribed light duty restrictions pursuant to the FCE or "desk job only, no bending, no pushing/pulling/lifting more than 10 lbs, 10 min break every 2 hrs, no walking." Petitioner continued to work in her original position as a Nutrition Aid, in apparent violation of her work restrictions by Dr. Goldberg, the FCE and Dr. Harsoor. (PX 3)

Through January, February and March of 2015, Dr. Harsoor documents episodes of severe pain due to the work being performed and the treatment not being authorized. Specifically, Petitioner was denied (1) sedentary work, (2) an EMG, (3) continued pain management and (4) a surgical evaluation. This resulted in emergency medical treatment for pain control at Stroger. The EMG was performed on March 27, 2015 and was said to confirm radiculopathy at L5/S1. (PX 3)

Ultimately, Petitioner was unable to continue to work at her position as a Nutrition Aid and was taken off work as of May 9, /2015. Dr. Harsoor notes continued back complaints and ER visits due to pain. Hernandez continued to be denied (1) sedentary work, (2) continued pain management and (3) a surgical evaluation through June 2015. (PX 3)

On June 8, 2015, Dr. Avi Bernstein, a spine surgeon, saw Petitioner on the referral of Dr. Harsoor. Dr. Bernstein documents the 3 epidural steroid injections with only temporary relief. Pain radiating down the left in the sciatic distribution, but low back and left buttock pain were her main complaints. Assessment: "I believe this patient is suffering from discogenic low back pain at the L5/S1 level. I believe she has an annular tear which is responsible for her symptoms." Dr. Bernstein recommended an updated MRI scan to see if there has been any change in the appearance of her lumber spine. He also recommended a multilevel lumbar discogram from L3-S1 to confirm the pain generator. (PX 4; PX 5)

The June 29, 2015 MRI shows: "L3-L4: 2 mm left neural foraminal /lateral protrusion with mild to moderate left neural foraminal stenosis exacerbated by mild facet hypertrophy. Central canal is patent." And "L5-S1: Intervertebral disc is intact. Patent neural foraminal and spinal canal. Lateral recesses are patent. Facet articulations are intact. There is bilateral facet hypertrophy." (PX 12)

On October 5, 2015, Dr. Harsoor performed the discogram prescribed by Dr. Bernstein. The discogram found moderate resistance at L5-S1 and L4-L5 levels. There was low resistance at L3-L4 level. Dumb-bell disc pattern of dye spread was noted at L4-L5 and L5-S1 with a leak at the L3-L4 level. Concordance of pain was 6/10 at the L4-L5 and L5-S1 levels and remained throughout. The L3-L4 level had a baseline of 6/10 pain that increased to 9/10 with the contrast injection and concordant pain down the left leg. The CT without contrast revealed: At level L3-L4, there is a disc bulge asymmetrically greater on the left and/or broad-based left

paramedian/foraminal disc protrusion and there is disc bulge level L2-L3, L4-L5, and L5-S1 with evidence of discogram performed at level L3-L4, L4-L5, L5-S1 as described above. (PX 4)

On October 13, 2015, Dr. Harsoor documents that the discogram revealed complaints of concordant pain at the L3-4 level. On October 26, 2015, Dr. Bernstein noted that the discogram provoked a pain response at L3/L4 but not at L4/5 or L5/S1. The CT that follows is consistent with an L3/L4 annular disruption that does not appear at L4/5 or L5/S1. The patient's recollection was that of "severe recreated pain at the time of the discogram." Dr. Bernstein went so far as to call Dr. Harsoor to confirm the pain generator was L3/4. Based upon the above, he prescribed L3/4 fusion surgery. (PX 5)

On November 25, 2015, Dr. Goldberg re-reviewed the MRI films from May 2014 and found foraminal disc herniation to the left at L3-L4 and disc degeneration L5-S1. He reviewed the June 29, 2015 MRI films and found "there is foraminal disc herniation with some disc degeneration at L3-L4. It is compressing the left L3 nerve root. There is mild disc degeneration with an annular tear at L5-S1." Dr. Goldberg did not personally review the discogram nor the post discogram CAT scan that found concordant pain at L3-L4 reproducing low back and left leg radicular pain. He stated: "I do believe the patient sustained a new disc herniation to the left at L3-L4 in the neural foramen. Although she had prior problems, she never had left leg radicular pain. The discogram confirms L3-L4 as the pain generator." Options for treatment at this time were an FCE to determine return to work with or without restriction or consideration of a discectomy and fusion at L3-L4. Her condition of ill being is due to the accident of May 2014. She is capable of working with a 10-pound lifting restriction at this time She is not a MMI. If she does not have surgery and has FCE, she will be at MMI. If she undergoes surgery, she will likely be at MMI nine months after the procedure. (RX 1)

On January 7, 2016, Dr. Bernstein saw Petitioner following L3/4 fusion surgery approval. The L3/4 discectomy and anterior fusion surgery was performed by Dr. Bernstein on February 3, 2016. At the February 15, 2016 visit, Dr. Bernstein documented that the pre-operative back pain and leg pain are gone. On February 18, 2016, Petitioner did not have radicular pain. On February 22, 2016, Dr. Bernstein diagnosed bilateral leg swelling that is suggestive of edema due to inactivity. Petitioner testified that she felt better for a few weeks following the surgery due to the pain medication and the fact that she was not moving. (PX 4; PX 5)

On March 3, 2016, Dr. Bernstein noted an acute flare up of pain. On March 14, 2016, Dr. Bernstein noted the same symptoms as before surgery of back pain radiating into the left leg. His concern was the L5/S1 condition. A March 24, 2016 lumbar spine MRI at Hawthorne works shows: "minimal L2-3 right paracentral disc bulge. Mild L5-S1 central disc protrusion." (PX 4; PX 3)

On March 28, 2016, Dr. Bernstein documents the same pain as before surgery with severe low black and left radiating pain. Symptoms into the left small toe are consistent with L5/S1 level. Despite the prior discogram, L5/S1 may be the real cause of the pain. (PX 4)

Dr. Bernstein performed a lumbar discogram on April 12, 2016, which shows diffuse disc degeneration and annular disruption at the L5/S1 level. Partial annular injection at the L4/L5 level which is morphologically intact. The CT following discogram shows: diffuse disc degeneration and annular disruption at L5-S1. The study was performed by Dr. Bernstein due to discogenic low back pain following the L3-L4 fusion. At the L4-L5 level, there was no pain reproduction. At the L5-S1 level, injection caused a severe pain reproduction causing pain identical to her low back pain. Pain was 8 out of 10 and again 10 out of 10. (PX 3, PX 4)

On May 5, 2016, Dr. Bernstein notes continued severe bilateral low back pain. He further states: "I believe that this patient is suffering from discogenic low back pain and left lower extremity sciatica on the basis of a

discogenic injury at the L5-S1 level this level was the one that I felt was responsible for her symptoms when I first evaluated her. Unfortunately, I was led astray by a lumbar discogram resulting in a fusion at the L3/4 level. The surgery has clearly not adequately relieved her pain and I believe she requires further surgery at L5/S1 level..." (PX 4)

On July 1, 2016, another Section 12 examination was performed by Dr. Goldberg. At this time, the diagnosis is stable post fusion from L3-L4. The patient continues to have subjective complaints of low back and left leg pain that are unchanged since the surgery. The surgery at L3-4 was appropriate. Her discogram performed by Dr. Harsoor in 2015 reproduced concordant pain. There was some disc degeneration with a true foraminal disc herniation to the left at L3-4. Dr. Goldberg strongly recommended psychological evaluation and an FCE. This will allow a determination as to whether her complaints are valid or not. Dr. Goldberg recommended this is because the patient states that she had no improvement after her surgery. A new discogram performed by Dr. Bernstein now indicates L5-S1 is the source of the pain. However, Dr. Harsoor in 2015 noted that it was L3-4. I also found inconsistencies upon exam. I do believe that an FCE would determine the validity of her complaints and a psychology evaluation would determine if there is any overlay. He did not agree with an L5-S1 fusion at this time. She is capable of working at a sedentary level. She is not at MMI. Dr. Goldberg would not comment upon MMI until Petitioner completed the recommended evaluations. (RX 1)

Petitioner underwent an FCE on November 10, 2016. It is noted that the FCE results are valid and she provided full physical effort throughout. The FCE found she is unable to lift, bend, squat, crouch, with occasional standing and walking., as required by her job. (PX 3)

On December 10, 2016, the Section 12 psychological evaluation by Ronald J. Ganellen, PhD. found there are no psychological factors that contraindicate surgery. In addition, he anticipates that the patient would be compliant and did not exhibit emotional, psychological or personality issues that could complicate that treatment. Dr. Ganellen also found that there were no signs of symptom magnification and/or malingering. Lastly, he concluded that Petitioner did not report symptoms consistent with a diagnosis of a psychological disorder. (PX 16)

On January 30, 2017, Dr. Bernstein documented that Petitioner would like to proceed with surgery, which includes an L5/S1 interbody fusion and left-sided discectomy. On January 31, 2017, Dr. Harsoor released Petitioner to sedentary work pursuant to the FCE of November 10, 2016. (PX 4; PX 3)

Another Section 12 examination by Dr. Goldberg took place on March 20, 2017. Dr. Goldberg' diagnosis was status post L3-L4 fusion. She continues to have ongoing back and left leg pain. Dr. Bernstein feels L5-S1 is the pain generator. However, L5-S1 was not symptomatic from the work accident based on the discogram performed by Dr. Harsoor in 2015. Dr. Goldberg believes that the fusion at L3-L4 was appropriate for her work accident. L5-S1 appears to be the source of pain now, but it was not aggravated by the accident as outlined above per the prior discogram results. She can return to work at a sedentary work. She can be maintained on medications. Petitioner is a candidate for L5-S1 fusion. Dr. Goldberg did not believe that the fusion recommended by Dr. Bernstein is due to the work accident. Regarding her lumbar spine, she is at MMI from the work accident, except for oral medications. (RX 1)

On May 1, 2017, Dr. Bernstein responded: "I understand Dr. Goldberg's reasoning however, I do feel that the initial discogram in terms of its reporting was likely flawed, especially considering the appearance of the L5/S1 disc. There was s high intensity zone at the L5/S1 level on her initial radiographic studies. There was evidence of annular disruption in both of her discograms. I do not feel that this level became symptomatic after her prior

surgery. I feel instead that it is likely been her pain generator throughout her care." Dr. Bernstein also released Petitioner to return to sedentary work. (PX 4)

The medical treatment since May 2017 documents continued pain and disability complaints, the prescription for the L5/S1 fusion surgery by Dr. Bernstein and the recommendation for a spinal cord stimulator by Dr. Harsoor. (PX 3; PX 5)

Petitioner continues to work at a sedentary position for Respondent, having returned to work on May 8, 2017, answering the phone and acting as a receptionist. She takes Tylenol III and Gabapentin Petitioner wants to undergo the surgery that has been offered by Dr. Bernstein. She wants to try to get better and move forward with her life.

The Parties submitted the evidence depositions of Dr. Avi Bernstein (PX 5) and Dr. Edward Goldberg (RX 1) in support of their positions in this case.

Dr. Bernstein thinks that the October 5, 2015 discogram was flawed and led to a false positive, which led to the L3-L4 fusion that did not alleviate Petitioner's complaints. The April 12, 2016 discogram performed by Dr. Bernstein (with "sham injections" to verify that the patient was being honest) showed concordant pain at L5-S1. Dr. Bernstein recommends a L5-S1 fusion. The procedure is causally related to the injury. Petitioner never had complete relief of pain. She is functionally limited. Her options other than surgery are to live with the pain or a course of chronic pain management (spinal cord stimulator, medications). Dr. Bernstein is a board certified orthopedic surgeon, specializing in spinal surgery. He is fellowship trained in spinal surgery. (PX 5)

Dr. Goldberg is a board certified orthopedic surgeon, specializing in spine surgery. He is also fellowship trained in spinal surgery. Dr. Goldberg agrees that Petitioner is a candidate for L5-S1 fusion surgery. He does not believe that the proposed L5-S1 procedure is causally related to the May 1, 2014 injury. Dr. Goldberg would have expected positive findings at L5-S1 on the October, 2015 discogram if the L5-S1 pathology was related to the May, 2014 injury. On cross examination, Dr. Goldberg was ok with the patient's care and treatment up to the time of his deposition. The proposed L5-S1 fusion was reasonable and necessary, but was not causally related. Dr. Goldberg's working diagnosis before the discogram was that the L5-S1 pathology was the problem. When he first saw Petitioner's lumbar MRI, he noted an annular tear at L5-S1, which could be a pain generator. Without surgery, Petitioner would have sedentary restrictions and would continue to take medications like Gabapentin. (RX 1)

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 her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)).

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

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

Petitioner's current condition of ill-being regarding her lumbar spine is causally related to the work injury of May 1, 2014.

The Arbitrator relies on the testimony of Petitioner, the medical records and the opinions of Dr. Bernstein. Drs. Bernstein and Goldberg are well-respected spinal surgeons with impressive credentials. Dr. Bernstein's opinion on causal connection best comports with the evidence and is found to be persuasive. The L5-S1 pathology is causing Petitioner's problems and it is related to the May 1, 2014 work accident.

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

The Average Weekly Wage is $362.10.

The payroll audit was submitted by Respondent as RX 5. No testimony was provided by either Party regarding wages. The audit is for a 48 week time period, beginning with the period ending 4/30/2013 and ending with the period ending 4/15/2014. The Arbitrator accepts RX 5, although it does not completely comport with the requirements of §10 of the Act.

It does appear that Petitioner worked a little overtime during the audit period. The Arbitrator thinks that the best calculation of the AWW based on RX 5 is: $17,424.73 net wages, less $43.47 in overtime premium equals $17,381.26 gross wages, divided by 48 = **$362.10.**

WITH RESPECT TO ISSUE (J): 1. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND 2. HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSEARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Medical services provided to Petitioner were both reasonable and necessary.

Petitioner's claimed bills were set forth on PX 15, totaling $30,683.70. The claimed bills are awarded, based upon the above finding and the Arbitrator's finding on the issue of causal connection, above, in accordance with and subject to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid. To the extent that any of the awarded bills are in excess of the Fee Schedule amounts, they are denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE ? , THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is entitled to the recommended L5-S1 fusion procedure offered by Dr. Bernstein. This finding is based on Petitioner's credible testimony, the persuasive opinions of Dr. Bernstein and the Arbitrator's finding on the issue of causation, above.

Accordingly, Respondent shall authorize, approve and pay for the said L5-S1 fusion, along with all related services, in accordance with §§8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (L): WHAT AMOUNT OF COMEPNSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The first medically authorized off work slip was generated by Stroger Hospital on May 13, 2014. Thereafter, Petitioner was off work through September 7, 2014. She returned to work on September 8, 2014. This time period is 16-6/7 weeks.

Petitioner again began losing time from work, as authorized by a physician, beginning May 9, 2015. Petitioner returned to work on May 9, 2017. This time period is 104-2/7 weeks.

The Parties advised the Arbitrator that Respondent disputed TTD from August 14, 2015 through November 24, 2015. The medical records and Petitioner's testimony support Petitioner's claim for TTD for this time period.

Respondent did pay $29,707. 85 in indemnity benefits and it is entitled to a credit for same.

Accordingly, the Arbitrator finds that Petitioner is entitled to TTD benefits of $330.00/week, commencing May 13, 2014 through September 7, 2014 and from May 9, 2015 through May 9, 2017, a total of 121-1/7 weeks. Respondent shall be given a credit for the benefits that it has paid.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sherry Popejoy,
Petitioner,

vs. NO: 15 WC 39284

Southern Illinois University Carbondale,
Respondent.

19IWCC0160

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 12, 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.

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

DATED: MAR 14 2019
o030719
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

POPEJOY, SHERRY
Employee/Petitioner

Case# **15WC039284**

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

19IWCC0160

On 7/12/2018, 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:

4377 MICHAEL MILES ATTORNEY AT LAW
3200 FISHBACK RD
PO BOX 907
CARBONDALE, IL 62903

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JUL 12 2018

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHERRY POPEJOY
Employee/Petitioner

v.

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

Case # **15** WC **39284**

Consolidated cases: ____

19IWCC0160

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 13, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 9, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,782.00**; the average weekly wage was **$553.50**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit for any and all medical expenses paid via group health coverage under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of her employment with the Respondent on April 9, 2015. The Arbitrator further finds that the Petitioner's bilateral carpal tunnel syndrome conditions are causally related to the April 9, 2015 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$369.00 per week** for **6/7 weeks**, commencing **November 21, 2015 through November 26, 2015** as provided in Section 8(b) of the Act.

Respondent shall pay the causally related reasonable and necessary medical expenses contained in Petitioner's Exhibit 5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for the awarded medical benefits that have been paid via workers' compensation and/or group health coverage, 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 **$332.10 per week** for 19 weeks, because the injuries sustained caused the loss of use of **10% of the right hand**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$332.10 per week** for 5.7 weeks, because the injuries sustained caused the loss of use of **3% of the left hand**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **January 5, 2016** through **December 13, 2017**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

July 10, 2018
Date

JUL 12 2018

STATEMENT OF FACTS

Petitioner worked at the Respondent's physical plant accounting office as an Account Tech 2. She started there working part time in August 2007 until January 2009, when she became a full time statistical clerk. She became an Account Tech II in March 2013.

Petitioner testified she reviewed the Respondent's written job description for her Account Tech II position, titled "Demands of the Job" (Rx5), dated 6/20/13, and agreed it was an accurate description as of that date. However, she testified that between that time and 4/9/15 there was an increase in her workload due to a number of large construction projects having begun at around the same time. As a result, the construction management staff doubled. Meanwhile, in July 2014, her department lost an employee and became more short-staffed.

The "Demands of the Job" description is a four-page document that lists the function, organizational relationships, duties and responsibilities, knowledge required, responsibilities, difficulties, personal relationships, and environmental demands for the job Account Technician II in the Plant and Service Operations. The document also contains the essential physical requirements for the job. In the activity identified as "Find hand manipulation" the column for "Constant – 67%-100% > 800 reps/Day" is checked. On 6/20/13, the document was signed by the Petitioner and her supervisor, S. Beckmann, and the department head. (Rx5).

Data entry sheets were prepared for each day, employee hours and materials for the contractors. Because the computer program they had didn't work well, the data entry sheets were individually typed. She testified that, again, the number of contractors involved doubled around this time.

Petitioner testified she started to gradually develop bilateral wrist burning and irritation that got worse in the spring of 2015. This included burning pain and night waking with numbness. She believed that she notified "Sophie" it was getting worse at that time, but that is the time of year when all the purchase requests must be submitted for approval before the

end of the fiscal year on June 30th for 2016 work, while also trying to close everything out for that prior fiscal year. The right side was worse, and Petitioner indicated she is right hand dominant. The left bothered her as well but was more tolerable.

Petitioner testified she sought treatment at Shawnee Health Care for bilateral wrist problems on 4/9/15. There she was examined by Marcia Scott, PAC, and indicated complaints of pain, numbness, and tingling in her right arm. Petitioner indicated she had trouble sleeping and grasping items. Petitioner noted her job required a lot of typing. It was also noted Petitioner has hypertension and a BMI of 28.23. Petitioner was referred to Dr. Alam for diagnostic testing for possible carpal tunnel. (Px2).

On 4/24/15, Petitioner presented to Dr. Alam at SI Neurology & Sleep Medicine and underwent EMG/NCV testing. The impressions were: 1) mild bilateral carpal tunnel syndrome; 2) no evidence of ulnar neuropathy on either side; and 3) no evidence of cervical radiculopathy on either side. (Px2). On 5/28/15, Petitioner returned to Shawnee Health Care with complaints of significant right hand pain, and was diagnosed with mild carpal tunnel syndrome. She reported the wrist splint helped a little and the Mobic relieved the pain somewhat, but upset her stomach. She was referred for surgical evaluation. (Px2). Following the EMG/NCV, Petitioner testified she was referred to Dr. Young, whom she initially saw on 6/18/15.

Petitioner testified she completed an intake form for Dr. Young on 6/18/15, and where asked about how her condition happened, Petitioner indicated increase in data entry of contracts and prep for FY 2016, and agreed that she also reported this to Dr. Young on that date. The 6/18/15 "Patient Intake form and Hand Questionnaire" completed for the Orthopaedic Institute of Southern Illinois indicated she worked as an account technician performed her present job duties for two years. She listed her current job duties as: contract job detail w-sheets, data entry- vouchers, signing vouchers, purchase requisitions, H/W IDFs, entry spreadsheets, contract IDFs, and AIS entry/ILSS vouchers. In answering the question "How did this happen" the Petitioner wrote "increase Data Entry of Contracts in prep for FY16." (Px3).

Petitioner saw surgeon Dr. Young on 6/18/15 with a chief complaint of bilateral upper extremity numbness, tingling, and pain. Petitioner indicated she had an increase of symptoms with an increase in her work duties. X-rays showed mild arthritic changes at the right thumb CMC joint. Petitioner was diagnosed with bilateral carpal tunnel syndrome and right thumb CMC arthrosis. She was prescribed splints and given a prescription for Voltaren gel. She also was returned to work with no restriction and was to follow up in one month. (Px3). Given how busy it was at work, the Petitioner testified that she first wanted to try conservative care, including splints, but that this ultimately didn't work. On 7/23/15, Petitioner followed up with Dr. Young and indicated that she had been wearing the splints, but her symptoms still bothered her and woke her up at night. Dr. Young recommended Petitioner proceed with carpal tunnel release surgery, and allowed her to continue working full duty pending same. (Px3).

Petitioner returned to Dr. Young on 10/28/15 with ongoing complaints. A pre-op history and physical was performed, and Petitioner was placed on the surgical schedule. Right carpal tunnel release was performed by Dr. Young on 11/18/15. (Px3).

On 11/25/15, Petitioner was released to modified duty as of 11/26/15 with no use of the right hand until 12/2/15. On 11/30/15, an addendum was issued indicating Petitioner could type with the right upper extremity. On 12/2/15, Petitioner followed up with Dr. Young and indicated she was doing better overall better and that the numbness and tingling had resolved. She was able to form a fist and had full range of motion. There was some mild swelling at the incision. Petitioner was to continue with the five-pound lifting restriction. She also indicated she did not wish to proceed

with surgery on the left side at that time. On 1/5/16, Petitioner returned to Dr. Young. She reported that while she had some sensitivity at the incision, she was overall much better than before the surgery. She had good range of motion and no swelling on exam. Petitioner indicated she would call when she was ready to schedule surgery for the left side. Dr. Young released her from care at maximum medical improvement and returned her to unrestricted work duties. (Px3).

On 6/21/16, Petitioner underwent a Section 12 examination with Dr. Sudekum at the request of the Respondent. Petitioner reported performing data entry approximately 7.5 hours a day, five days a week as an account technician, indicating she would type more or less continuously throughout the day. Dr. Sudekum reviewed among other things, the 4/9/15 records from Shawnee Health care, the 4/27/15, Illinois Form 45, first report of injury, the Employee's Notice of Injury and Supervisor's Report of Injury dated 4/30/15, as well as the records from Dr. Young beginning on June 18th, 2015. Following his physical examination, Dr. Sudekum diagnosed Petitioner with left carpal tunnel syndrome and resolved right carpal tunnel syndrome, and opined that the Petitioner's employment activities were a contributing factor in the onset of Petitioner's bilateral CTS. (Rx6).

Petitioner testified that she had a good result with the right CTS surgery. She was treated but did not have surgery on the left, and has had no further treatment for either side since January 2016. Her right hand is currently fine. She testified that she is currently off work on short term disability due to a non-work related medical back condition, but remains employed by the Respondent. Petitioner testified she relied on her doctor's opinions regarding diagnosis and treatment, and did not rely on any non-medical professionals.

On cross-examination, the Petitioner acknowledged that she has been diagnosed with hypertension, for which she takes medication. She was not diagnosed with cubital tunnel. When she last saw Dr. Young in January 2016, he advised her to return if needed, and she agreed she hasn't needed to and is not currently treating for either hand. She was not provided with any work restrictions based on the carpal tunnel conditions. She doesn't wear a brace but not she still has one available if needed.

Asked about what her other job duties were outside of typing, Petitioner responded that 98% of her job required typing. There was some copying and filing, but she testified that there were student workers available to help with that "at the end."

Ms. Sonia Beckmann was called by the Petitioner to testify at the hearing. She is the assistant chief accountant in Respondent's plant and service operations, the same position she had in 2015. As to the Petitioner's testimony regarding having increased job duties from June 2013 to April 2015, Ms. Beckmann also testified that the construction on campus "increased dramatically" during that time. Her educational degree is in accounting, not medicine.

Ms. Beckmann testified that she signed the Supervisor's Report of Injury (Rx3), and agreed Petitioner indicated a worsening pain during work and that Beckmann told her not to wait too long to seek treatment to avoid any possible permanent nerve damage. She testified that her own supervisor had waited too long to have hand surgery for CTS, and was then told that it was emergent to try to avoid permanent nerve damage.

In questioning from Respondent's counsel, Ms. Beckmann testified she was Petitioner's supervisor in 2015 and was very familiar with Petitioner's job duties. In addition to typing, she testified the Petitioner's job also involved opening the mail, making photocopies of payments, routing payments for signature, answering calls from vendors, answering questions from other employees from plant and service operations. Ms. Beckmann testified that in 2014/2015, the Petitioner would have student workers to help her if needed, and they would handle equipment rental and entering data for that, opening some mail and doing some data entry for utility bills into spreadsheets.

Ms. Beckmann testified that the Petitioner would perform a variety of activities through the day. She estimated Petitioner's work day involved about 50% typing, and this would be interspersed throughout the day with periods of relative rest.

Ms. Beckmann testified: "Well, she would be typing, and then she would print stuff up, and she would have to go to the printer and get it. She would have to match paperwork up. They would have to be stapled, but she had an automatic stapler, so she wasn't having to squeeze her hand. She would walk the folders around and put them in the various mailboxes. We had a lot of traffic in our office for people to ask questions, and she would have to stop and answer the questions. The students did the filing pretty much, so there wasn't a continuous, you know, getting into the filing cabinets. If a vendor called, she would have to take that call. She would be calling purchasing to ask them questions. There was - - it was not any one thing that I would say was continuous. I mean, it was back and forth, back and forth, back and forth on just about everything."

The Petitioner then testified on rebuttal following the testimony of Ms. Beckmann. She indicated Beckmann's testimony was accurate as far as routing and students to open mail, but Petitioner reiterated her time was spent mostly on the computer, and that everything she did involved entering data into the computer. Things would stack up. They did not take breaks and would eat at their desks. There were piles of work and time lines had to be met, so she just worked as continuously as she could, noting co-workers would remind her it was time to go home.

Ms. Beckmann was then called for further rebuttal, indicating that Petitioner would walk payments around, as this would give her a chance to stretch her legs. They also had times where they needed to walk and talk to other coworkers. While payments increased during the applicable time period, but so did the need for copying, which would be a break from typing. There were no official "breaks", but workers like Petitioner could get up or go and visit with another employee, as long as the work was getting done.

Dr. Young testified via deposition on 10/31/17. A board-certified orthopedic surgeon, he testified the majority of his practice focuses on the upper extremities from elbow to fingers. Petitioner gave a history of being right hand dominant and working for 8 years doing secretarial work. She reported her symptoms of pain, numbness and tingling had been present for at least a year and worsened with her increased job duties. Dr. Young noted the EMG/NCV indicated mild bilateral carpal tunnel syndrome. (CTS), and that on examination Petitioner had positive Tinel's and median nerve flexion compression tests of both upper extremities. She also had right thumb CMC joint pain, and the diagnoses were bilateral CTS and right thumb CMC joint arthritis. When conservative treatment failed, he recommended surgery. Dr. Young testified Petitioner's work duties likely contributed to her CTS symptoms, given her repetitive work, the cumulative nature of it over several years, and the more recent increase in activity. Dr. Young testified that Petitioner listed eight specific job duties on the hand questionnaire she completed, and which ones tended to aggravate her symptoms. During surgery, he viewed some thickening of the transverse carpal ligaments, which indicated to him moderate to severe pressure on the median nerve. On the left side, while the Petitioner indicated she needed to find out what date she could undergo surgery and get back to the doctor's office, they never heard back from her after January 2016. Given no significant CMC complaints after surgery, it appeared the CTS symptoms had been more significant pre-surgery. He agreed his expenses had been paid through group health. (Px4).

On cross-examination, Dr. Young testified that he was not relating Petitioner's CMC joint arthritis to her work duties. He also agreed that Petitioner's questionnaire indicated she had worked as an account technician for only two years. He was not aware of what was involved in "IDF's" she listed. Asked what job duties he was relating to the Petitioner's CTS, Dr. Young testified: "Um, I think it is probably all cumulative. She has listed them in order. The first would be

contract job detail worksheets. Number two was data entry vouchers. Number three was signing vouchers. And then the fourth one was actually the ICSS vouchers. That would be the order that tends to bother her the most." However, he testified that with regard to these activities, he couldn't say if she was writing or typing, how long she performed any given activities per day or week, or if she had intermittent rest periods. He agreed that this information would be "helpful" in determining causation, but that he didn't need to know the information specifically. He agreed that Petitioner did not describe any forceful gripping, pinching or lifting, which he agreed can definitely cause CTS. He had no knowledge of her workstation ergonomics. Dr. Young testified that Petitioner's hypertension, weight, age and gender could be risk factors in CTS development. He agreed that medical literature exists which concludes that typing is not contributory to CTS. As to a necessary threshold of activity to conclude there is causation, Dr. Young testified that how much would be enough would differ for each person, that Petitioner having breaks between the activities would not likely change his opinions, and that an hour of typing per day could be enough to relate the activity to CTS. (Px4).

On redirect, Dr. Young testified that a person with multiple CTS risk factors would be more susceptible to developing CTS via cumulative trauma than someone without such risk factors. On recross, he agreed that CTS can be idiopathic, and that the Petitioner, given her other risk factors, could have developed CTS without ever working. (Px4).

Dr. Sudekum testified via evidence deposition on 6/29/17. Dr. Sudekum testified he is board certified in both plastic/reconstructive surgery and surgery of the upper extremity and his practice is focused on the upper extremities. He listed a number of possible causes for CTS, including strenuous manual activities involving heavy impact or vibration, and testified it can usually be considered multifactorial and can also occur idiopathically. He reviewed medical records and performed a physical examination on 6/21/16. Petitioner reported that she typed all day every day for 7.5 hours a day, five days a week. Dr. Sudekum agreed with the diagnoses of bilateral CTS and thumb basilar joint arthritis. As he did not have a formal job description, his opinion that her job duties could serve as an aggravating factor in the etiology of her bilateral CTS was based on the Petitioner's stated job duties. At the time of his initial 6/21/16 report, Dr. Sudekum recommended conservative treatment for left CTS and reevaluation. She was at MMI on the right side. (Rx8).

Dr. Sudekum testified he was provided with a formal job description for Petitioner's position and authored an addendum on 2/28/17. He testified that this description outlined several different clerical and managerial tasks, some that would involve typing, but others that would not involve continuous typing. He noted it reflected 1/3 to 2/3 of the day involves sitting, meaning she isn't sitting the entire day, which he believed indicated she would not have been constantly typing. It also noted activities including email, copying and filing, and meeting and conversing with other employees. Dr. Sudekum testified that this differed from the job description Petitioner provided in that it did not reflect her sitting and typing for 7.5 hours per day. (Rx8).

Dr. Sudekum testified that the medical literature indicates no real support for the conclusion that typing or keyboard entry causes CTS, or that performing such duties would be a significant risk factor for CTS. Dr. Sudekum also testified Petitioner had multiple risk factors for the development of carpal tunnel syndrome including her gender, age, hypertension and bilateral basilar joint arthritis. Dr. Sudekum opined that Petitioner would have developed bilateral carpal tunnel syndrome regardless of her employment activities, and that he did not believe her work duties served to cause or aggravate CTS. While he indicated it's possible for anyone with CTS to have symptoms at work, the need for surgical treatment wouldn't be secondary to the work activities. (Rx8).

On cross examination, Dr. Sudekum questioned whether the Petitioner had undergone sufficient conservative measures prior to attempting surgery, but testified he did not know this for certain. He noted the Petitioner, and it appeared her supervisor, were pushing for surgery. Dr. Sudekum agreed that he changed his original 6/21/16 causation opinion in his

2/28/17 addendum report. He indicated that the formal job description he received from the Respondent was dated 6/20/13. (Rx8).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner sustained an accident that arose out of and in the course of her employment with the Respondent. Her work duties involved the constant fine hand manipulation from data entry during a period of increased work load which caused cumulative trauma injuries to both her right and left hands. The injuries manifested on April 9, 2015.

The Petitioner became an account technician in 2013. She testified that shortly after the 6/20/13 "Demands of the Job" analysis had been prepared, her typing/data entry duties significantly increased due to an increase in construction projects on the Respondent's campus. This was confirmed by Ms. Beckmann. The Petitioner testified essentially that she would be constantly behind in terms of entering this data and would have piles to work through. While Ms. Beckmann disputed that the Petitioner would sit at her desk entering data without doing any other job duties, the Arbitrator found the Petitioner's testimony generally credible. While it may not be accurate that she spent 7.5 hours per day entering data, it does appear to the Arbitrator, based on both the Petitioner's and Ms. Beckmann's testimony, that there was a significant uptick in the Petitioner's data entry duties between 2013 and 2015, when she developed symptoms. Overall, the greater weight of the evidence supports that the Petitioner was performing significant data entry duties and keyboarding during that 2013 to 2015 period. This appears to coincide directly with the Petitioner's development of worsening symptoms in her hands. The Petitioner consistently reported her history of work and symptoms to both her employer and to Drs. Young and Sudekum. Based on that history, both Dr. Young and Dr. Sudekum (at least initially) provided opinions that her work activities were a causative factor in the onset of bilateral carpal tunnel syndrome.

The Arbitrator must note that Dr. Young testified that he really could not specifically say what activities the Petitioner performed at work based on her questionnaire answers. At the same time, it is clear to the Arbitrator that he based his causation opinion on the Petitioner performing significant data entry activities and her relation that she would have increased symptoms with such activities. While his opinion is not the strongest the Arbitrator has seen in a carpal tunnel claim, it nevertheless was sufficient to support a causation finding, particularly given the agreement in that opinion from Respondent's Section 12 examiner, Dr. Sudekum.

As to Dr. Sudekum, the Arbitrator accepts his initial causal connection opinion and rejects his reversal the opinion in his addendum report dated 2/27/17. Dr. Sudekum's initial opinion was based on the job description the Petitioner provided to him. As noted above, the Arbitrator finds that the Petitioner credibly described her job duties, particularly after the noted work increase, as involving a significant amount of data entry. Dr. Sudekum's testimony then attempts to support his change of opinion, in part, by citing medical literature that has determined that typing and data entry have not been shown to cause or be a significant risk factor in carpal tunnel syndrome. However, this position makes no sense given he had already previously opined that a causal connection existed based on the Petitioner's report of 7.5 hours of typing

per day. His reliance on the written job description, in the Arbitrator's view, leads the Arbitrator to conclude that his denial of causation is not persuasive. Not only does the Arbitrator find the Petitioner's testimony regarding her job duties credible, both she and Ms. Beckmann agreed that the Petitioner's job duties increased significantly when the construction on campus had so increased.

Ultimately, under Illinois Workers' Compensation law, the Petitioner must prove, via the preponderance of the evidence, that her work duties were a contributing cause to the development of her CTS. She is not required to prove that the work duties were the sole, proximate or primary cause of the condition. Here, the Petitioner has fulfilled this burden of proof. While she clearly has other CTS risk factors (hypertension, gender, age), this does not rule out the job duties as also being a contributing cause. Under the law, all of these factors along with the work duties could have been causative factors in the condition, and this would not preclude a finding of causation to the work duties in this claim.

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

The Arbitrator finds that the Petitioner is entitled to the causally related medical expenses contained in Petitioner's Exhibit 5, which includes the expenses of Shawnee Health Care of Carbondale, SI Neurology, The Orthopedic Institute of Southern Illinois/Dr. Young, SIOC, Bingham Anesthesia and Herrin Hospital.

The Arbitrator finds that the medical services related to these expenses were reasonable and necessary. Pursuant to a stipulation between the parties, the Respondent will receive a credit pursuant to 8(j) for any of the awarded medical expenses that were paid by its group health provider and will pay any balances directly to the provider pursuant to the Fee Schedule or a negotiated rate. In return, the Respondent shall hold the Petitioner harmless against any attempts by such providers and group carrier(s) for reimbursement, again pursuant to Section 8(j) 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 Arbitrator finds the Petitioner is entitled to TTD from 11/18/15, the date of surgery, through 11/26/15, the date Dr. Young released her to light duty. The Petitioner did not provide any testimony as to whether she did or did not return to work on 11/26/15, and therefore the Arbitrator finds that the release date terminated her entitlement to TTD.

The Petitioner is entitled to 6/7 weeks of TTD after deducting the first three days, pursuant to Section 8(b) of the Act, because she was not off work for more than 14 days.

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

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of

motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no AMA permanent partial impairment rating or analysis was submitted into evidence by either party. Therefore, the Arbitrator gives this factor no weight.

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 Account Tech II at the time of the accident, and has returned to that position on a full duty basis. The Arbitrator does note that the Petitioner continues to perform job duties which have been determined to have been causative of her CTS condition. However, it is also the case that the Petitioner did not testify that the current activities continue to involve the increased workload she had between 2013 and 2015 due to construction activity. The Arbitrator gives this factor a medium level of weight in the permanency determination, noting that in part this factor tends to show a lesser level of permanency (full duty return) and a greater level of permanency (continuing to perform data entry work).

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. Neither party has submitted evidence which would tend to show the impact of the Petitioner's age on any permanent disability that may result from this claim. As such, the Arbitrator gives this factor no weight in the permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner did not offer any evidence in this regard. The Arbitrator would conclude that the Petitioner has not suffered any loss of future earnings as a result of this claim. The Arbitrator finds that this factor carries a minimal level of weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that both the Petitioner's testimony and the records of Dr. Young indicate a very good result for the right hand following CTS release surgery. With regard to the left hand, both Dr. Young and Dr. Sudekum found evidence of bilateral CTS on examination, the EMG/NCV testing indicated a mild level of left CTS. That said, the records show very minimal treatment was provided as to the left hand/wrist, and the Petitioner never followed up for treatment. Again, the evidence appears to indicate she continued to work her full duties following her release in January 2016 until she apparently went off work for an unrelated condition. The Petitioner did not testify as to when she initially

went off work for this condition. The Arbitrator finds that this factor carries the greatest weight in the permanency determination.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the right hand and 3% loss of use of the 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 WILLIAMSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jay McMillan,

Petitioner,

vs. NO: 15 WC 27406

Menard Correctional Center,

Respondent.

19IWCC0161

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 14, 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.

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

15WC27406
Page2

19IWCC0161

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

DATED: MAR 14 2019
o030719
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

McMILLAN, JAY
Employee/Petitioner

Case# **15WC027406**

MENARD CORRECTIONAL CENTER
Employer/Respondent

19IWCC0161

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

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

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

4075 FISHER KERHOVER COFFEY ET AL
JASON COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

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

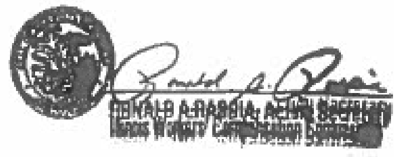
0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

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

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

MAY 14 2018



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)

Jay McMillan
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # **15** WC **27406**

Consolidated cases: **None**

19IWCC0161

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 15, 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. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

19IWCC0161

On the date of accident, **April 27, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**58,491.24**; the average weekly wage was $**1,124.83**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services. However, Respondent agreed that it would pay reasonable and necessary medical services as provided in Petitioner's Group Exhibit #6, which was admitted at arbitration, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of for all TTD paid prior to arbitration, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits.

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

ORDER

Respondent shall pay reasonable and necessary medical services as provided in Petitioner's Group Exhibit #6 subject to the Medical Fee Schedule or contract, whichever is less, 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 by its group medical plan, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the right carpal tunnel surgery as currently recommended by Dr. Steven Young, if still felt to be appropriate.

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

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

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

Signature of Arbitrator

May 9, 2018
Date

MAY 14 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges bilateral hand/wrist injuries due to repetitive trauma as a result of his work duties for Respondent. He claims a manifestation/accident date of April 27, 2015. Respondent has admitted liability for Petitioner's left-sided carpal tunnel syndrome; however, it disputes liability for any right hand injury. (AX 1)

The Arbitrator finds:

Petitioner began working for Respondent in 2012 as a corrections officer. (RX 8)

In January of 2015 Petitioner started working as a writ officer. (RX 8)

Petitioner initially sought medical treatment on April 15, 2015 with Dr. Amar Sawar, a neurologist, complaining of numbness and tingling of the hands, left more than right (PX 2). Petitioner provided a history that he was a 41-year-old prison guard that had been experiencing numbness and tingling for the past year in all the fingers of the hands, but mainly the first, second and third ones (PX 2). The numbness and tingling had been constant, awakened him at night, and was aggravated by driving (PX 2). Petitioner also complained of low back pain and numbness in his leg (PX 2). Dr. Sawar performed a physical examination which included a positive Tinel sign on the right upper extremity and a positive Phalen's sign bilaterally (PX 2). Based upon these findings, Dr. Sawar recommended a nerve conduction study to rule out carpal tunnel syndrome (PX 2).

Petitioner underwent both a nerve conduction study (NCS) and EMG on April 27, 2015 which revealed evidence of mild bilateral median mononeuropathy at the wrist (i.e. bilateral carpal tunnel syndrome) with the left upper extremity being worse than the right (PX 2). There was no electrodiagnostic evidence of ulnar mononeuropathy or cervical radiculopathy (PX 2).

Following the NCS and EMG, Petitioner followed-up with Dr. Sawar on June 2, 2015 and was diagnosed with bilateral carpal tunnel syndrome and low back pain (PX 2). Dr. Sawar referred Petitioner to an orthopedist for carpal tunnel repair (PX 2).

Petitioner presented for treatment and consultation with Dr. Steven Young on August 25, 2015 at the request of Dr. Amar Sawar for his bilateral upper extremity numbness, tingling, and pain (PX 3). Dr. Young noted Petitioner's symptoms had been present for about a year beginning in September of 2014 (PX 3). Dr. Young further noted Petitioner was a correctional officer who would lock and unlock doors with heavy keys multiple times per day almost up to as much as 100 times per day and had to do a lot of bar rapping which caused vibration in Petitioner's hands (PX 3). Petitioner had decreased grip strength which was affecting his work (PX 3). Dr. Young performed a physical examination indicating positive Tinel's and median nerve compression tests at the wrists bilaterally (PX 3). Dr. Young also reviewed the Dr. Sawar's NCS and EMG (PX 3). Dr. Young diagnosed Petitioner with bilateral carpal tunnel syndrome (PX 3). Because the symptoms had been going on for a year and Petitioner had already tried splinting his upper extremities without relief, Dr. Young felt surgery should be recommended (PX 3). Dr.

Young explained to Petitioner he would need to request approval from "Workmen's Comp since this is work-related" (PX 3).

Petitioner signed his Application for Adjustment of Claim herein on September 25, 2015. (AX 2)

At the request of Respondent, Petitioner underwent a Section 12 exam with Dr. Sudekum on December 3, 2015. A lengthy report followed in which the doctor, having reviewed medical records, the previous EMG/NCS, having Petitioner undergo another NCS while there and examining Petitioner concluded that the objective findings on physical examination included calluses on both hands consistent with Petitioner's weight lifting hobby. Dr. Sudekum noted that Petitioner had a history of lumbar disc disease having undergone an L3-4 and L5-S1 discectomy with plating eight years earlier. Petitioner's hobbies included weight lifting and use of the elliptical and treadmill.

On physical examination Petitioner had positive Phalen's signs in the wrists bilaterally. The doctor performed nerve conduction studies that day which revealed findings consistent with mild left carpal tunnel syndrome. He did not find evidence of carpal tunnel syndrome or "significant median neuropathy" on the right side. (RX 3, dep. Ex. 2, p. 7/19)

In the latter pages of his report Dr. Sudekum was asked to address various questions. When asked to list Petitioner's pre-existing injuries or health conditions, he listed hypertension, lumbar disc disease, lower extremity neuropathies, and lumbar radiculopathy. (RX 3, dep. Ex. 2, p. 15/19) Dr. Sudekum stated that Petitioner's nerve conduction studies revealed "findings consistent with mild LEFT carpal tunnel syndrome in the nondominant LEFT hand. There was no evidence of median neuropathy or carpal tunnel syndrome on the RIGHT and there was no evidence of ulnar neuropathy or cubital tunnel syndrome on either side. Dr. Sudekum felt Petitioner had mild left carpal tunnel syndrome and nothing more. Regarding causation, he wrote, "It is my opinion, with a reasonable degree of medical certainty that his job activities as a correctional officer at the Menard correctional center may have served as a minor aggravating factor in the aggravation and/or progression of his LEFT carpal tunnel syndrome." (RX 3, dep. Ex. 2, p. 17/19) He further discussed additional medical treatment, his prognosis, Petitioner's work and life capabilities and whether he was at maximum medical improvement (he was not as he needed to undergo surgery). (RX 3, dep. Ex. 2, P. 18/19)

Petitioner next saw Dr. Young on January 12, 2016. He reported having been "sent for IME" who told him he needed the surgery (PX 3). Dr. Young agreed with the "IME" physician and stated Petitioner needed the surgery (PX 3). Dr. Young kept Petitioner on full duty work and instructed Petitioner to contact him when he was able to schedule the surgery.

Deposition of Dr. Sudekum

The deposition of Dr. Sudekum was taken on June 2, 2016. (RX 3) Dr. Sudekum testified consistent with his earlier report. Dr. Sudekum testified he is licensed to practice medicine in the State of Missouri (RX 3). Dr. Sudekum's current practice is called the Missouri Hand Center, also known as Midwest Special Surgery (RX 3). A large part of Dr. Sudekum's practice involves the evaluation and treatment of the most common conditions of the upper extremities, including conditions such as carpal tunnel syndrome (RX 3). Dr. Sudekum is board certified in plastic and reconstructive surgery and also holds a separate board certification in surgery of the upper extremity (RX 3).

Dr. Sudekum testified that he performs independent medical exams as part of his practice which he broke down into several ways including 5% of the total patients he sees, 40% of the total time he spends working, and approximately 15% of his total income (RX 3). Dr. Sudekum treats approximately one hundred patients a year for carpal tunnel syndrome (RX 3).

Dr. Sudekum reviewed two medical notes relating to Petitioner during his evaluation including the nerve conduction study performed by Dr. Sawar on April 27, 2015 and an office note from the Orthopedic Institute dated October [August] 25, 2015 (RX 3). Dr. Sudekum physically examined Petitioner describing him as a very large muscular man with calluses on both hands and creases on the fingers he felt were consistent with weightlifting. He acknowledged that Petitioner, on exam, had positive Phalen's signs at the wrists bilaterally.

Dr. Sudekum testified he performed his own nerve conduction study on Petitioner and the test revealed mild left median neuropathy (left carpal tunnel syndrome), but he found no evidence of "significant median neuropathy" or right-sided carpal tunnel syndrome (RX 3, pp. 1 – 24).

Dr. Sudekum testified that he reviewed a position description for Petitioner's job duties, a job site analysis, and personally toured the Menard Correctional facility for four hours approximately four years ago observing correctional officer performing job duties including bar rapping, keying, opening and closing doors, and handling materials (RX 3). From this direct observation, Dr. Sudekum opined that the job duties performed by correctional officers at the Menard Correctional Center could potentially serve to aggravate carpal tunnel syndrome (RX 3). Specifically, the job duties were bar rapping and sliding open and close the large heavy cell doors that were on tracks, not hinges (RX 3, pp. 24-32).

Dr. Sudekum diagnosed Petitioner with mild left carpal tunnel syndrome (RX 3, p. 26). Dr. Sudekum did not feel Petitioner was suffering from right carpal tunnel syndrome based upon his examination, as well as the nerve conduction study he performed on Petitioner at the time of his evaluation (RX 3, p. 34).

Dr. Sudekum opined that Petitioner's employment activities could have served as a relatively minor aggravating factor in the development of Petitioner's left carpal tunnel syndrome (RX 3, p. 35). Dr. Sudekum did not feel surgery was required at that time because he saw no medical records which referenced Petitioner doing any conservative treatment measures (RX 3, pp. 35-37).

On cross-examination, Dr. Sudekum testified that carpal tunnel syndrome is multi-factorial in that it can be caused by many things (RX 3). Dr. Sudekum believed Petitioner's work activities was one of those aggravating factors potentially bringing on Petitioner's left carpal tunnel syndrome (RX 3, p. 38). Dr. Sudekum also believed that Petitioner's work activities most likely would have served as an aggravating factor in bringing on Petitioner's right carpal tunnel syndrome if he had made such a finding. (RX 3, p. 39)

Dr. Sudekum found no evidence of cervical radiculopathy during his examination of Petitioner (RX 3). During cross-examination, it was pointed out to Dr. Sudekum that one of the medical notes he reviewed dated August 25, 2015 indicated Petitioner had been using carpal tunnel splints. He agreed that would indicate Petitioner had attempted conservative measures to treat his condition (RX 3, pp. 41-42).

Dr. Sudekum acknowledged that Petitioner had positive Phalen's signs at the wrists when he examined him. (RX 3, p. 44)

Dr. Sudekum has seen approximately 190 Menard employees over the past five and one-half years as a Section 12 examiner (RX 3, p. 51).

Additional Treatment

Petitioner stopped working for Respondent in mid-July of 2016 due to a right shoulder problem unrelated to this claim. He returned to work, full duty, as a corrections officer on December 15, 2016. In April of 2017 Petitioner became a Food Service Supervisor. (RX 8)

Petitioner did not return to see Dr. Young until June 8, 2017. At that time Petitioner presented to Dr. Young with continuing bilateral hand numbness and tingling. Dr. Young performed another physical examination and requested an updated nerve conduction study due to the time which had passed since the last nerve conduction study of April 27, 2015 (PX 3).

Petitioner underwent a second nerve conduction study on July 21, 2017 at Southern Illinois Healthcare (PX 5). The results of the study indicated moderate bilateral median neuropathy at the wrist (carpal tunnel syndrome) (PX 5). There was no evidence of ulnar neuropathy at the elbow or cervical radiculopathy in the nerves that were tested (PX 5).

Petitioner returned to see Dr. Young following this second nerve conduction study at which time Dr. Young again recommended surgery with the left hand/wrist being operated on first (PX 3).

Petitioner underwent a left carpal tunnel release per Dr. Young on September 13, 2017 (PX 3). Following the surgical procedure, Petitioner was referred for physical therapy at Apex Physical Therapy (PX 4). Petitioner began physical therapy on September 15, 2017 and continued therein until September 27, 2017 (PX 4).

Petitioner was returned to work full duty as a Food Service Operator and followed up with Dr. Young on September 28, 2017 (PX 3). Petitioner reported he was very happy with the procedure stating it made "a world of difference" (PX 3). Petitioner was still having some issues with his right hand but was waiting to see when surgery could potentially be approved (PX 3).

Petitioner has not been back to see Dr. Young since September 28, 2017.

Deposition of Dr. Young

The evidence deposition of Dr. Young was taken on January 30, 2018. (PX 3) Dr. Young testified he is a board-certified orthopedic surgeon who practices at the Orthopedic Institute of Southern Illinois (PX 3). Dr. Young dedicated approximately 85-90 percent of his surgeries to the hand/wrist area and sees between two and three-hundred patients a week (PX 3). Dr. Young will perform approximately fifteen hundred surgeries annually (PX 3). Dr. Young testified consistent with his medical records regarding his care and treatment of Petitioner (PX 3). Dr. Young noted Petitioner was performing job duties which would exacerbate his upper extremity symptoms (PX 3).

Dr. Young testified that locking and unlocking doors with heavy metal keys multiple times per day seemed to exacerbate Petitioner's symptoms, and that Petitioner was doing this up to 100 times per day, as well as bar rapping and the vibration bar rapping would produce (PX 3). Dr. Young testified he had

treated other employees at Menard Correctional Center and had a good understanding of their job duties (PX 3).

Dr. Young believed, based upon his physical examination, Petitioner's history, and the two nerve conductions studies he was able to review, that Petitioner was suffering from bilateral carpal tunnel syndrome (PX 3). Dr. Young testified that the repetitive usage of turning keys and bar rapping were contributing factors in the development of Petitioner's bilateral carpal tunnel syndrome (PX 3). Dr. Young noted that Petitioner did have some co-morbidities that could potentially predispose Petitioner to carpal tunnel syndrome such as obesity and hypertension, but that his work activities served as a contributing factor as well (PX 3).

Dr. Young opined that surgical intervention to address the bilateral carpal tunnel syndrome diagnosis was reasonable and necessary at this time (PX 3).

On cross-examination, Dr. Young indicated that Petitioner's weightlifting could lead to the development of carpal tunnel syndrome, as well as his age (PX 3). Dr. Young also testified that being off of work for an extended period of time or being placed in a job position that was less hand intensive than a correctional officer could occasionally alleviate the symptoms (PX 3).

On re-direct examination, Dr. Young testified that not everybody who has a high BMI or is the same age as Petitioner would develop carpal tunnel syndrome (PX 3). Dr. Young also testified that carpal tunnel syndrome does not always disappear just because a person changes jobs to less hand-intensive activities. (PX 3)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on March 15, 2018 pursuant to a 19(b) Petition. Respondent's attorney stated, at arbitration, its agreement that Petitioner's left upper extremity was compensable under the Illinois Workers' Compensation Act. Thus, the 19(b) hearing was limited solely to compensability and prospective medical care for an alleged right upper extremity repetitive trauma injury. Petitioner was the only witness testifying at the hearing. Major Steve Rathke was present on behalf of Respondent.

Petitioner testified he was a 44-year-old employee of the State of Illinois assigned to the Menard Correctional Center. Petitioner had worked at Menard Correctional Center for nearly eight years. Petitioner began his employment on October 6, 2010 where he was working the 3-11 pm shift in "probably the east or west house." Petitioner was a correctional officer at that time.

Petitioner testified, that as a correctional officer, one of the job duties was "bar rapping." Petitioner explained that bar rapping was taking a piece of stock metal about 16 inches long and striking the cell bars with the piece of metal to ensure the cell bars have not been manipulated and kept their integrity. The bar rapping would have to be done on every cell in the gallery Petitioner was assigned. Bar rapping was performed one time per shift on a daily basis. The process of checking each cell would take about 12 to 15 minutes. Petitioner testified bar rapping would most definitely cause vibration in his hands. Petitioner would alternate hands while performing this job duty.

Petitioner testified that he also checked cell doors as a correctional officer. Petitioner would walk down a gallery of cells and pull and push on every cell door to ensure they were locked shut. The doors

were very old sliding doors and are extremely difficult to pull and push. Petitioner approximated he would be checking cell doors this way at least one hundred times per shift. Petitioner used both upper extremities to check the cell doors.

Petitioner testified that he was also required to turn Folger-Adams keys multiple times per shift on a daily basis. Petitioner explained these keys are approximately ten to twelve inches long and oversized. The base of the key would be in his palm and the stem of the key would be laying between two fingers extending out of his hand. In order to turn the key, Petitioner would have to turn his entire wrist over. Petitioner would alternate his hands while turning the Folger-Adams keys.

Petitioner is right hand dominant. Although Petitioner testified he uses both upper extremities in the performance of his job duties, he admitted he used his right hand more than his left because it was his dominant hand.

Petitioner testified that he has been assigned to various areas of the facility during his career at Menard Correctional Center. He began having numbness and tingling in his upper extremities prior to April 27, 2015. At that time, Petitioner was assigned to the north 2 segregation unit. While working in "seg," Petitioner would be performing bar rapping, sliding cell doors which were difficult to open, and using Folger-Adams keys. The segregation unit is for the worst of the prison population where inmates go if they are having behavioral issues. The segregation unit does not allow mass movements of prisoners. Every door must be keyed individually causing Petitioner to turn keys "hundreds" of times per day. Petitioner explained that every door in segregation is double-locked and every inmate is one on one so while he was working in segregation he would be turning Folger-Adams keys hundreds of times per day, as well as bar rapping and checking heavy old cell doors. There were quite a few of the cell locks that were so difficult to open they required the use of both hands just to turn the Folger-Adams key.

Petitioner testified consistent with the medical treatment records. Petitioner tried wrist splints and anti-inflammatory medications which did not permanently alleviate his symptoms. Petitioner acknowledged undergoing left carpal tunnel surgery prior to arbitration. Petitioner felt the surgery "most definitely" improved his symptoms in his left hand.

Petitioner further testified that since being diagnosed with bilateral carpal tunnel syndrome, he has also served as a writ officer at Menard Correctional Center. A writ officer transports inmates by vehicle to court appearances and healthcare located outside the facility. Petitioner also served as a correctional officer in other cell houses during his time at Menard Correctional facility since being diagnosed. Currently, Petitioner is temporarily assigned as a food supervisor in the kitchen of the facility. Petitioner has been in the kitchen for approximately one year with this temporary assignment.

Petitioner testified that, since being reassigned away from segregation, his right upper extremity symptoms have not gone away. Petitioner still turns keys in the kitchen and still makes meals using his upper extremities at present, but he feels it was his time working in the segregation unit that brought about his bilateral upper extremity condition.

Petitioner acknowledged he is currently awaiting approval for surgery on his right hand and wishes to proceed with the carpal tunnel release procedure.

On cross-examination, Petitioner testified he is six feet four inches tall and weighs 305 pounds. Petitioner agreed that the job duties of a food supervisor were less hand intensive than that of a correctional officer at Menard Correctional Center.

Petitioner testified that he worked on a catwalk in October of 2010 where he would monitor inmates on an elevated platform. This job assignment required no bar rapping. There was also an entry in the job history in which Petitioner was a south lowers crank officer which did not require any bar rapping.

Since being diagnosed with bilateral carpal tunnel syndrome, Petitioner has been assigned as a writ officer beginning in January 2015. There is no bar rapping required of a writ officer.

Petitioner testified that he suffered a work-related right shoulder injury in April 2016. Petitioner had right shoulder surgery in August 2016 and returned to work light duty a week after surgery doing mainly one-arm job duties until December 2016 when he was then assigned to the south lower 1 gallery as a correctional officer performing the normal duties of a correctional officer.

In April 2017, Petitioner was then temporarily assigned as a Food Service Supervisor and he has continued in that position up through the date of arbitration.

Petitioner testified he likes to go camping and fish in his spare time. He also lifts free weights and goes to a gym a couple of times per week.

At the time of arbitration Respondent submitted a Job Analysis prepared by Genex for a Corrections Food Supervisor I and II. (RX 4) A copy of a Food Supervisor I and II DVD was admitted as RX 5 and viewed by the Arbitrator. Respondent further submitted a CMS Position Description for a Food Supervisor I (RX 6) and Food Supervisor II (RX 7) Said descriptions set forth the general duties of those positions with no discussion of the ergonomics or manner in which said jobs were to be physically performed.

Petitioner's Staff Assignment History with Respondent was admitted as RX 8.

The Arbitrator concludes:

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

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

Petitioner sustained an accident on April 27, 2015 that arose out of and in the course of his employment with Respondent and his current condition of ill-being in his right hand/wrist is causally related to his work accident and employment duties with Respondent. In so concluding the Arbitrator relies upon Petitioner's credible testimony and the more persuasive opinion of Dr. Young over that of Dr. Sudekum regarding whether Petitioner has right carpal tunnel syndrome. Both doctors agreed that the job duties of a corrections officer could be a factor in the development of carpal tunnel syndrome.

The pivotal issue in this case is not whether Petitioner's job duties as a corrections officer caused or aggravated Petitioner's carpal tunnel syndrome as Dr. Sudekum acknowledged as much in his report and

deposition. The issue is whether Petitioner has right carpal tunnel syndrome. Dr. Sudekum's contention was that Petitioner did not have right carpal tunnel syndrome when he examined him in December of 2015. That, however, was not entirely correct. The NCS/EMG report reviewed by Dr. Sudekum and dated December 3, 2015 acknowledged that Petitioner's right median MUD sensory was "outside normal limits." (RX 3, dep. ex. 3) In his written report, Dr. Sudekum stated on page 7, when discussing the nerve conduction studies, "There was no evidence of carpal tunnel syndrome or significant median neuropathy on the RIGHT side…." (RX 3, dep. ex. 2, p. 7/19) Dr. Sudekum then went on to state in the conclusions of his report regarding objective findings that Petitioner had "no evidence of median neuropathy or carpal tunnel syndrome on the RIGHT…..) (RX 3, dep. ex. 3, p. 17/19). That statement was incorrect as the study showed some median neuropathy – Dr. Sudekum simply felt it was not "significant." Dr. Sudekum seemingly ignored objective findings presented to him – a positive Phalen's sign on the right and positive median sensory testing results. He also felt Petitioner had lower extremity neuropathy; however, no medical records corroborate that. It appears to the Arbitrator that Dr. Sudekum's review of records and his own testing was not as accurate as it should have been. The Arbitrator finds that Petitioner has right-sided carpal tunnel syndrome.

In a repetitive trauma case, issues of accident and causation are intertwined (*Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 IIC 0961). The word accident is not a technical legal term, and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens, and compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor (*Laclede Steel Co. v. Industrial Commission*, 6 Ill.2d 296). Under Illinois law, an injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor (*Sisboro, Inc. v. Industrial Commission*, 207 Ill.2d 193). Even when other non-occupational factors contribute to the condition of ill-being, a petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury (*Fierke v. Industrial Commisssion*, 309 Ill.App.3d 1037).

Petitioner, who is right hand dominant, credibly testified to several repetitive and forceful job duties in the course of his employment with Respondent as a corrections officer. These job duties included bar rapping, repetitive turning of Folger-Adams keys, and pushing and pulling cell doors to ensure they were locked. These job duties were performed, at varying degrees, over one hundred times per day on a daily basis at Menard Correctional Center. Petitioner conceded that his job duties and requirements have varied over the years, but the Arbitrator notes "there is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma" (*Edward Hines Precision Components v. Industrial Commission*, 365 Ill.App.3d 186). In Illinois, there is no specific threshold for the amount of repetition a petitioner must first endure before having a compensable injury.

It cannot be overlooked that Respondent accepted Petitioner's left hand carpal tunnel syndrome as a work-related injury, but disputed his right hand carpal tunnel syndrome being work-related. This, in spite of the fact, that Petitioner is right-hand dominant and credibly testified he performs his job duties more with his right hand than with his left hand. While Petitioner may have a few medical conditions that could lead to carpal tunnel syndrome, his repetitive job duties need only be a factor under Illinois law. Indeed these underlying conditions may have made it easier for Petitioner to develop the condition; however, an employer takes an employee has he is.

In his testimony Dr. Sudekum acknowledged that if Petitioner had right-sided carpal tunnel syndrome, the job duties as a correctional officer would have aggravated it. Petitioner also underwent

another EMG/NCS in July of 2017. It showed ongoing bilateral carpal tunnel syndrome, now described as "moderate" rather than "mild." Petitioner was not re-examined by Dr. Sudekum at any time.

Respondent also seems to suggest that Petitioner no longer needs surgery or may no longer have right carpal tunnel syndrome because he has gone on to more varied job duties or less repetitive job duties. Dr. Young testified that despite a job change Petitioner has remained symptomatic and still needs surgery. Dr. Young persuasively explained how Petitioner's condition could progress despite changes in his jobs and Petitioner's nerve conductions studies confirmed progression of the condition. Dr. Young was recommending bilateral carpal tunnel releases as early as 2015 when he first began treating Petitioner. Both he and Dr. Sudekum agreed that Petitioner's job duties as a corrections officer could cause or aggravate carpal tunnel syndrome. Petitioner has continued to remain symptomatic despite changes in his job duties While there have been times he wasn't working as a corrections officer, he testified to remaining symptomatic. By June of 2017 his right hand was more bothersome and he had resumed working full duty after his shoulder injury and had only recently become a Food Service Supervisor, having returned to work as a corrections officer from December of 2016 to April of 2017. Dr. Young was asked about job changes and removal from work and he acknowledged that "occasionally it can alleviate symptoms." However, Dr. Young was not asked if it had done so in Petitioner's case. Furthermore, Dr. Young credibly and persuasively testified that symptoms of carpal tunnel syndrome can progress regardless of a job change involving less strenuous duties. Dr. Sudekum did not re-examine Petitioner. He did not address progression of the condition. While Dr. Sudekum may have an added qualification in hand surgery that does not necessarily mean that his opinion on the existence/non-existence of a condition should be given more weight, especially given important inconsistencies in his one-time report.

Issue (K) Is Petitioner entitled to any prospective medical care?

Dr. Young and Dr. Sudekum opined Petitioner's medical care has been both reasonable and necessary to date. Dr. Young has attempted conservative measures to treat Petitioner. The evidence presented at hearing demonstrates these conservative measures have not been successful to alleviate Petitioner's symptoms. The next option to treat Petitioner herein is surgical intervention. Dr. Young has recommended surgical intervention and Petitioner wishes to proceed with surgical intervention. Therefore, Respondent shall approve and authorize the right carpal tunnel release surgery recommended by Dr. Young if the doctor still deems it to be appropriate.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosa Cetera,

Petitioner,

vs. NO: 16 WC 14373

Atlas Employment,

19IWCC0162

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice provided to all parties, the Commission, after considering the sole issue of nature and extent of permanent disability and being advised of the facts and the law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with supporting analysis.

The Arbitrator concluded Petitioner sustained 50% loss of use of the person as a whole. The Commission agrees with the permanence determination but believes a more detailed explanation of the weight placed upon factors (ii), (iii), and (iv) is necessary to satisfy the requirements of Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101.

Section 8.1b(b)(ii) – occupation of the injured employee

At the time of the April 22, 2016 accident, Petitioner was employed as a punch press machine operator. Petitioner underwent a functional capacity evaluation on October 21, 2016 which determined she is capable of working at a sedentary physical demand classification. Petitioner's job description was described as frequent lifting up to 40 pounds, frequent

pushing/pulling up to 20 pounds and frequent hand use to operate machines. According to the Dictionary of Occupational Titles, her job was a medium physical demand classification. PX4. Petitioner returned to work with restriction to the borrowing employer CCS on March 12, 2018 with her sedentary work restriction being accommodated. T. 18. The Commission finds this weighs in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 34 years-old on the date of accident. The Commission observes Petitioner has a greater work life expectancy which will require her to manage the effects of her injury for a greater period of time. The Commission finds this weighs in favor of an increased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Both Petitioner's treating physician, Dr. Wiesman, and Respondent's examining expert, Dr. Fernandez, found Petitioner capable of returning to work with permanent sedentary restrictions based upon the valid FCE performed on October 21, 2016. When Petitioner initially presented her restrictions to Respondent in November of 2016, no job offer was tendered. T. 17-18. On March 12, 2018 approximately 16-months later, a job offer was extended by Respondent. T. 18. The Commission finds such delay suspect, but it does not rise to the level of a sham job offer. See *Reliance Elevator Co. v. Industrial Commission*, 309 Ill. App. 3d 987, 723 N.E.2d 326 (1999).

Even such, Petitioner's earning potential is severely compromised by her injury. Section 8(d)2 of the Act is applicable in three scenarios:

> When the claimant's injuries do not prevent her from pursuing the duties of her employment but she is disabled from pursuing other occupations or is otherwise physically impaired; when her "*injuries partially incapacitate [her] from pursuing the duties of [her] usual and customary line of employment but do not result in an impairment or earning capacity*;" or when the claimant having suffered an "*impairment or earning capacity* *** elects to waive [her] right to recover under [*8(d)(1)*]." (Emphasis added.) *820 ILCS 305/8(d)(2)* (West 2012). *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 142431WC, ¶ 41.

In the present matter, Petitioner has returned to work in her usual and customary line of employment albeit with some difficulties, but her injuries have left her physically impaired. Moreover, it is questionable regarding her abilities to pursue other suitable occupations. The Commission finds this weighs in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained a 50% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

The Commission strikes the following from Page 8 of the Arbitrator's Decision: "Given the permanent sedentary restriction and loss of three digits, Petitioner is forever impaired from engaging in two-handed work. Absent Respondent's accommodation of the permanent sedentary restrictions, Petitioner would highly likely be considered an odd-lot permanent total." The Commission finds such statement to be mere speculation. Petitioner has not established she is entitled to permanent total disability benefits under the odd-lot category by proving the unavailability of employment to persons in her circumstances. Petitioner has not shown that because of her age, skills, training and work history, she will not be regularly employed in a well-known branch of the labor market. The FCE demonstrated Petitioner was able to perform at a sedentary physical demand level, and she was indeed working under that restriction.

The Commission corrects the face sheet of the Arbitrator's Decision to reflect the correct number of weeks of the award. On the face sheet, the Arbitrator incorrectly indicted the permanent partial disability award was for 500 weeks when the award is 250 weeks.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's July 19, 2018 decision is affirmed with supporting analysis and corrections stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 27-6/7 weeks, representing April 23, 2016 through November 4, 2016, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 65-5/7 weeks, representing November 5, 2016 through March 11, 2018, that being the period of maintenance pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the following medical expenses pursuant to §8(a) of the Act and subject to the Medical Fee Schedule pursuant to §8.2 of the Act: Elmhurst Emergency Medical Services for $1,487.00 (PX1b) and Village of Bellwood ambulance service for $1,219.00 (PX1a). The total of the medical expenses is $2,706.00.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 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 permanent disability of the person as a whole to the extent of 50%.

19IWCC0162

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $7,260.00 in temporary total disability benefits and $22,808.79 in statutory amputation benefits, for a total credit of $30,068.79.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2019
LEC/maw
o02/06/19
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CETERA, ROSA
Employee/Petitioner

Case# **16WC014373**

ATLAS EMPLOYMENT
Employer/Respondent

19IWCC0162

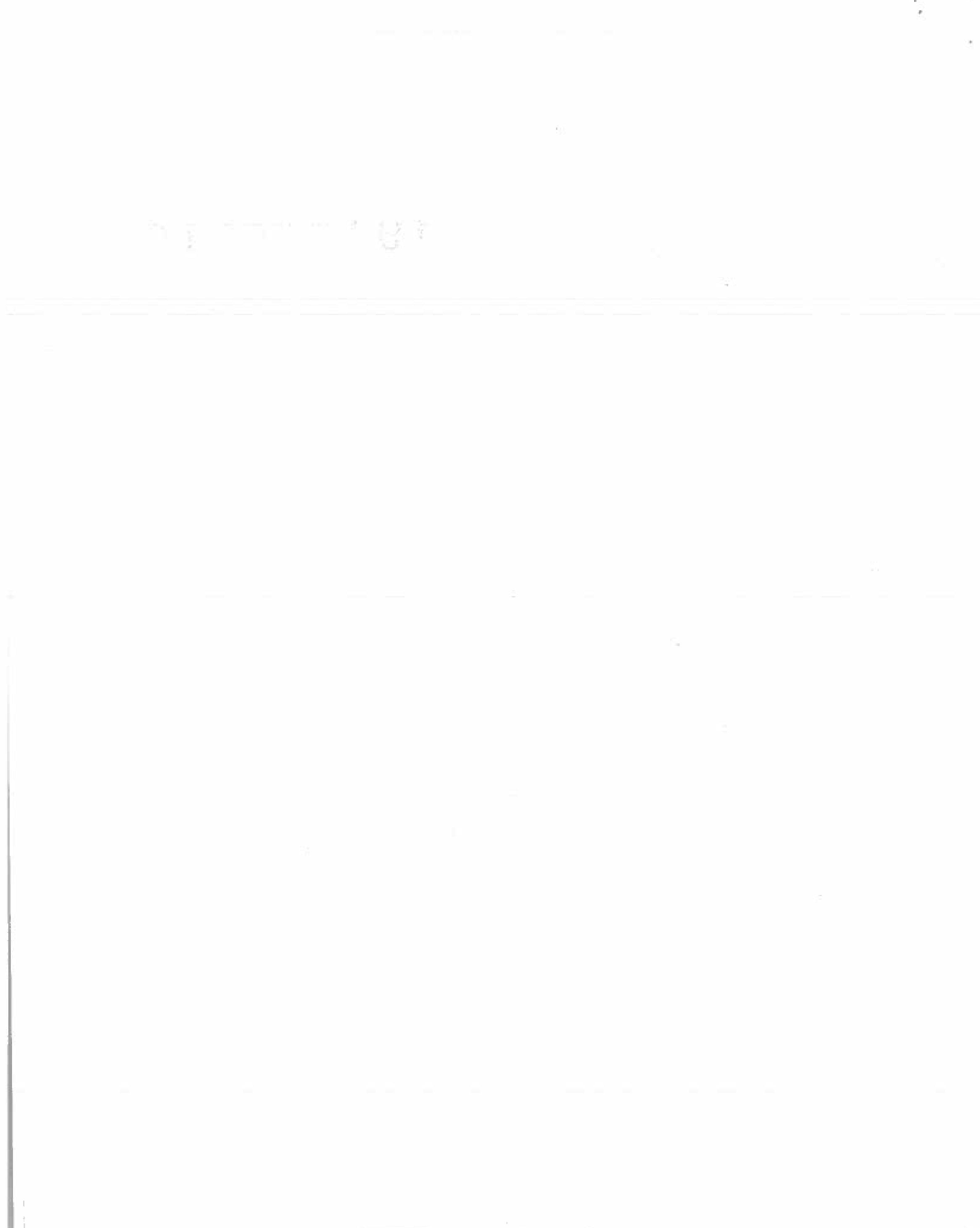
On 7/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0815 ACEVES & PEREZ PC
LUIS A ACEVES
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

5001 GAIDO & FINTZEN
ROBERT L SMITH
30 N LASALLE ST SUITE 3010
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

Rosa Cetera,
Employee/Petitioner

v.

Atlas Employment,
Employer/Respondent

Case # **16** WC **014373**

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 **Chicago**, on **June 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. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [x] Maintenance [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 **Prior Statutory Amputation Payment**

FINDINGS

On **4/22/16**, 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 $**Various**; the average weekly wage was $**420.00**.

On the date of accident, Petitioner was **34** years of age, *single* with **4** dependent children.

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

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

Respondent shall be given a credit of $**7,260.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**22,808.79** for other benefits, for a total credit of $**30,068.79 [including $22,808.79 in prior statutory amputation payments]**.

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

ORDER

Respondent shall pay 27- 6/7 weeks of TTD for the periods 4/23/16 through 9/23/16 and 9/24/16 through 11/04/16. Respondent shall pay 65-5/7 weeks of TTD/maintenance for the period 11/05/16 through 03/11/18. Respondent is entitled to a credit for $7,260 in temporary benefits previously paid.

Respondent shall pay, as prescribed pursuant by Sections 8(a) and 8.2, the medical bill of Elmhurst Emergency Medical Services (Px 1b) $1,487.00 as-billed and Village of Bellwood (Px1a) $1,219.00, as-billed.

Petitioner is entitled to have and receive an additional sum of $330.00/week for the further period of 500 weeks, as the injuries sustained resulted in permanent partial disability to the person as a whole to the extent of 50% thereof under 8(d)2.

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

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

Dated: July 19, 2018

JUL 1 9 2018

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSA CETERA,)
)
Petitioner,)
)
vs.) I.W.C.C. No.: 16 WC 14373
)
ATLAS EMPLOYMENT)
)
Respondent.)

MEMORANDUM DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that at the time of the stipulated accident, she was 34 years of age and employed by Respondent for a few weeks as a machine operator of a punch press machine.

Petitioner testified that on April 22, 2016, her glove was caught in the punch press machine, causing crush injuries to the tips of the right third, fourth, and fifth fingers of her right hand. Petitioner testified she is right hand dominant. The parties stipulated to Notice.

Immediately following this accident, Petitioner was transported via ambulance to Elmhurst Memorial Hospital where she was informed she had sustained post-traumatic amputations. The medical records show Petitioner sustained post-traumatic amputations of the distal phalangeal tufts of the third, fourth and fifth fingers of the right hand. Petitioner was splinted and referred to a specialist for surgery (Px 1, pg. 8).

On April 25, 2016, Dr. Barakat at Midwest Hand Surgery performed surgical revisions of the traumatic amputations of the three fingers on the right hand.

On May 2, 2016, Petitioner was seen in follow up and sent for Physical Therapy. A course of occupational therapy started the next day at Midwest Hand Surgery (Px 2, pg. 29).

On September 23, 2016 at Respondent's request, Dr. Vender examined Petitioner pursuant to Section 12. (Rx1). Dr. Vender opined causation ("Ms. Cetera's complaints and findings are related to her reported injury on April22, 2016."). However, he found Petitioner to have reached maximum medical improvement and opined she could return to work ("There is no reason for Ms. Cetera to be off work.") While Dr. Vender agreed "there are some limitations, mostly with regard to gripping...", he opined "Without a more detailed assessment of her workplace and her work activities, it is difficult to predict whether she may have difficulties returning to her previous work." Dr. Vender's opinions, therefore were incomplete and premature. As noted below, a FCE was performed a month later, but apparently Dr. Vender did not offer any further updated opinions.

Petitioner continued her care with Dr. Wiesman at Illinois Orthopedic Network (Px 3). Petitioner underwent a course of physical therapy as prescribed by Dr. Wiesman. This was followed by a period of work conditioning and a functional capacity evaluation ("FCE").

The FCE was performed on October 21, 2016 (Px 4). The FCE determined Petitioner could only perform at a permanent sedentary work level.

On November 2, 2016, Dr. John J. Fernandez, MD at Midwest Orthopedics at Rush conducted a thorough Section 12 Examination at Respondent's request. (Rx 2). Dr. Fernandez opined, "I believe that her condition should be treated as work related." Dr. Fernandez diagnosed Petitioner with a "complete amputation through the distal joint level involving the right middle, ring, and small finger." Dr. Fernandez indicated there is clear object evidence of a complete amputation through the distal joint, causing some loss in motion and strength. Dr. Fernandez "felt that her subjective complaints were well-supported by the objective findings..." Dr. Fernandez further opined the FCE was valid and consistent and found the permanent sedentary restriction to be reasonable (Rx 2). Dr. Fernandez further opined the FCE "appears to be reasonable" was valid and consistent and found the permanent sedentary restriction to be reasonable (Rx 2). Dr. Fernandez further agreed with Dr. Weisman's adoption of the FCE findings and Dr. Fernandez wrote, "I also believe that it is reasonable..."

Dr. Fernandez further explained why he agrees with Dr. Weisman and the FCE that permanent sedentary work restrictions are reasonable:

> *"A sedentary use restriction is actually reasonable given the fact that she has lost the middle, ring and small fingertips. This is not 'tips' in the sense of just the very ends of the fingers, but she lost the entire distal phalanx and bone of those fingers, which includes the flexor tendons attached to those fingers. That means that she is missing half of the tendons to reach the fingers to flexion. This is objectifiable and her losses in motion and her losses in strength. This would make it difficult for her to grip particularly on a more frequent basis, in particularly with more force such as machinery or tools. The sedentary restriction is very objectifiable in nature."*
>
> *"Yes, I believe her condition has reached maximum medical improvement. I do not believe that further time will yield better functional outcome...released at maximum medical improvement with a sedentary use restriction as outlined in the functional capacity evaluation."*

On November 4, 2016, Petitioner's treating physician Dr. Wiesman wrote a "Follow-Up" note. Dr. Wiesman indicated, **"This is a work-related injury resulting in severe permanent disability of the right hand, which is her dominant hand."** Dr. Wiesman noted that because her rehab was "significantly delayed", her recovery was "severely diminished." Dr. Wiesman reviewed the October 21, 2016 FCE which "shows that she is compliant and showed excellent effort **and is only capable of sedentary work only**." Dr. Wiesman noted, "Her current position is defined as a medium PDC level, therefore, she will certainly need these permanent restrictions when returning back to her job. The patient should also have a disability index in order to receive compensation for the fact that she has significant and traumatic injury resulting in loss of wages and potential earnings." Dr. Wiesman further opined Petitioner "has reached maximum medical intervention. She is discharged from care with her permanent sedentary work restrictions."

Petitioner testified that on November 6, 2016, she presented to her place-of-injury employer, CCS, with the appropriate return to work order/work restriction and was advised by her supervisor, Valdek Obal, the employer could not accommodate her work restrictions.

On January 19, 2018, Petitioner made a formal demand for vocational rehabilitation services (Px 5).

Following Petitioner's demand for vocational rehabilitation services, on March 1, 2018, Respondent sent letters to Petitioner in English and Spanish advising Petitioner Respondent could accommodate the sedentary work restrictions and Petitioner should report to her supervisor, Valdek Obal (Px 6).

Petitioner returned to work at CCS on March 12, 2018. Petitioner testified that as of Arbitration, she continues to work for this employer within the permanent sedentary restriction. Petitioner testified she primarily uses her left hand to perform assembly work. She complained of difficulty with some activities, including lifting over 40-pounds, pushing a cart, picking up small metal pieces, and sweeping.

Petitioner also testified to difficulties with certain activities of daily living as a mother of four. Specifically, turning a doorknob, carrying her children, cooking, and any other activity that requires gripping of the right hand.

CONCLUSIONS OF LAW

The Arbitrator found Petitioner to be a very credible witness. There was no evidence in the record to suggest or indicate otherwise. The Arbitrator finds and concludes Dr. Weisman was highly credible and accordingly adopts his opinions and findings in his treating medical records. The Arbitrator finds and concludes the FCE was also highly credible and accordingly adopts its findings and conclusions. The Arbitrator notes that the FCE was apparently performed by a physician, Dr. Natalie Martinez, or she at least wrote the report and/or supervised the evaluation. The Arbitrator finds and concludes Dr. Fernandez to be very credible and accordingly adopts his opinions. The Arbitrator finds and concludes Dr. Vender offered only incomplete and premature opinions and offered no supplemental opinions regarding the FCE, or the opinions of Dr. Weisman and Dr. Fernandez regarding Petitioner's permanent sedentary work restrictions. Therefore, the Arbitrator gives Dr. Vender's opinions little weight, adopting only his opinion finding accident-causation.

With respect to Issue F, whether Petitioner's current claimed condition of ill-being is related to the work incident:

While causal connection was in dispute, the treating and examining physicians all opined the conditions of Petitioner's right-hand and finger injuries were causally related to the stipulated work accident, as noted above. The Arbitrator notes there was no rebuttal evidence. The Arbitrator therefore finds and concludes Petitioner's current condition of ill-being as relates to her right-hand and fingers is causally related to the stipulated work incident of April 22, 2016.

With respect to Issue J, Respondent's liability for medical services, the Arbitrator concludes as follows:

The Arbitrator finds and concludes the evidence in the record supports the finds that Petitioner's incurred medical treatment was reasonable and necessary. Specifically, Respondent's examining physician Dr. Fernandez opined, **"Based on the review of the records it would appear that her treatment to date has been reasonable and necessary and work related...These injuries were fairly significant and required about a year of recovery."**

Petitioner introduced into evidence two medical bills. All other medical bills were paid. Petitioner Exhibit 1(a) was an ambulance bill from the Village of Bellwood for date of incident services. Respondent represented that this bill would be placed in line for payment, promptly, after Arbitration, pursuant to Sections 8(a) and 8.2.

Petitioner Exhibit 1(b) was for medical charges for date of incident services through Elmhurst Emergency Medical Services. As-billed, the amount of the bill is $1,487.00. Respondent represented on the Record that the bill would be promptly placed in line for payment, pursuant to Sections 8(a) and 8.2. The Arbitrator concludes Respondent has liability for these two bills.

With respect to Issue K, temporary benefits, including temporary total and maintenance benefits:

Respondent suspended temporary total disability benefits after Dr. Vender's September 23, 2016 Section 12 Examination. The ostensible basis was Dr. Vender's assessment

of maximum medical improvement. However, there is no evidence Petitioner was offered work in 2016 or 2017.

Dr. Vender expressed some uncertainty about Petitioner's precise work restrictions. Dr. Vender noted it was "difficult to predict whether she may have difficulties returning to her previous work." Again, the Arbitrator places little weight on this report and does not adopt his opinion regarding return to work.

Petitioner subsequently underwent a FCE and on November 4, 2016, was released to permanent sedentary restrictions by Dr. Weisman as found in the FCE.

Petitioner testified she presented to the borrowing employer, CCS, on November 6, 2016 for employment, identified her prior supervisor, who was the same supervisor, and advised her no work was available.

While the record does not contain evidence Petitioner thereupon immediately demanded vocational services, Respondent had an obligation, under Section 8(a), and Rule 9110.10, to offer work or undertake a vocational assessment of Petitioner. There is no evidence either was done. However, once Petitioner made a formal demand for vocational services in January 2018, Respondent soon thereafter offered Petitioner a job. Petitioner then returned to work on March 12, 2018. Petitioner is working within her permanent sedentary restrictions. Petitioner is performing assembly work with primarily her left hand.

Based on the totality of the evidence, the Arbitrator finds and concludes Respondent is liable for temporary total disability benefits for the period April 23, 2016 through September 23, 2016 [benefit termination date] and again from September 24 through November 4, 2016, a continuous period of 27-6/7 weeks. Petitioner testified as to having four dependents, and the corresponding temporary total disability rate is $330.00.

Petitioner is further entitled to temporary total disability benefits for the period November 5, 2016 through March 11, 2018, a period of 65-5/7 weeks. The benefit rate is $330.00.

With respect to Issue L, the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator has analyzed the five factors as required pursuant to Section 8.1b of the Act.

i) **The reported level of impairment:** Neither party submitted an impairment rating and, therefore, the Arbitrator gives this factor no weight.

ii) **The occupation of the injured employee**: Petitioner worked as a machine operator of a punch press machine. The Arbitrator gives this factor some weight.

iii)**The age of the employee at the time of the injury**: Petitioner was 33 years old at the time of her injury. Petitioner's young age is very relevant. The permanent residuals of her injury will remain for future decades. The Arbitrator gives this factor significant weight.

iv) **The employee's future earning capacity:** Petitioner's present future earning capacity was apparently not affected by this injury. However, her work and job future is at risk, and uncertain, and based on her permanent sedentary restriction and other factors, it is reasonable to infer Petitioner will face a diminished future earnings capacity. See further discussion below. The Arbitrator gives this factor significant weight.

v) **Evidence of disability:** Petitioner testified credibly as to how the residuals of this injury affect her in her everyday life. Petitioner testified she was 34 years of age, unmarried, with four dependent children at the time of the accident. Petitioner has a high school education but does not speak, read, or write in the English language. Petitioner testified at trial through a language translator. Petitioner sustained traumatic amputation injuries to the distal phalanx of fingers of her dominant right hand. Petitioner underwent tuft revision amputation surgery of the middle, ring, and small fingers. After a course of occupational therapy and work conditioning, Petitioner underwent a FCE. Petitioner's testimony regarding her pain, physical limitations, and limited function are consistent and fully supported by the medical evidence. The FCE determined Petitioner could only perform at a permanent sedentary work level. Petitioner's treating physician, Dr. Wiesman, adopted the findings of the FCE. Dr. Weisman further opined **"This is a work-related injury resulting in severe permanent disability of the right hand, which is her dominant hand."** Dr. Wiesman noted that because her rehab was "significantly delayed", her recovery was "severely diminished." Dr. Wiesman reviewed the October 21, 2016 FCE which "shows that she is compliant and showed excellent effort **and is only capable of**

sedentary work only." Dr. Wiesman noted, "Her current position is defined as a medium PDC level, therefore, she will certainly need these permanent restrictions when returning back to her job." Dr. Wiesman further opined Petitioner "has reached maximum medical intervention. She is discharged from care with her permanent sedentary work restrictions." **Respondent's IME by Dr. Fernandez also found the FCE's permanent sedentary restrictions to be reasonable and he opined further time will not result in a better functional outcome.** Petitioner resumed employment with Atlas at the borrowing employer, CCS, in March 2018. The borrowing employer, CCS has been accommodating her permanent sedentary restriction. However, although she is being accommodated, Petitioner testified as to difficulty with certain aspects of ongoing assembly work. Specifically, Petitioner testified she is performing her current work duties with the use of only her left hand. Petitioner further testified she experiences difficulties with activities of daily living. Specifically, Petitioner has difficulty turning a doorknob, carrying her children, cooking, and any other activity that requires right hand gripping. This physical impairment has clearly presented a life change for Petitioner who bears the duties and responsibilities of a mother of four children. Petitioner undoubtedly has significant limitations in any future employment, given her skill-set, language abilities, and the permanent sedentary restrictions. While treating physician Dr. Weisman opined to "...the fact that she has significant and traumatic injury resulting in loss of wages and potential earnings" the record contains no specific, direct evidence to support this opinion (and nothing to indicate Petitioner has suffered any loss of actual earnings in her current, accommodated, restricted position); however, the Arbitrator nonetheless draws the reasonable and logical inference that based on her restrictions and her individual characteristics, Petitioner has indeed suffered a likely impairment in her future (but not present) earnings capacity, Given the permanent sedentary restriction and loss of three digits, Petitioner is forever impaired from engaging in two-handed work. Absent Respondent's accommodation of the permanent sedentary restrictions, Petitioner would highly likely be considered an odd-lot permanent total.

The Arbitrator gives this factor very significant weight.

Based on the totality of the evidence, the Arbitrator finds and concludes Petitioner is entitled to have and receive **250** weeks of permanent partial disability benefits at a rate of $330.00 per week, because the injuries herein sustained - beyond the paid statutory amputation

amounts paid - permanent disability to the person as a whole to the extent of **50%** thereof under Section 8(d)2 of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated July 19, 2018

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Halina Wapniarska,

Petitioner,

vs.

NO: 13 WC 9739

19IWCC0163

Leus Cleaning Service,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent and Petitioner herein and notice provided to all parties, the Commission after considering the issues of causal relationship, temporary total disability benefits, medical expenses, permanent partial disability benefits, and penalties and attorneys' fees and being advised of the facts and the law modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As to the nature and extent of the injury, pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

Section 8.1b(b)(i) – level of impairment

Neither party obtained an impairment rating; as such, the Commission assigns no weight to this factor.

Section 8.1b(b)(ii) – occupation of the injured employee

At the time of the February 1, 2013 accident, Petitioner was employed as a cleaner. Petitioner testified she performed cleaning work for Respondent but provided no details. RX9,

T. 19, T. 27; RX7, Dp. 49. In his November 10, 2014 report to Dr. Allen, physical therapist Jim Buskirk noted the following: "I do, in fact, feel that she could work at her prior job doing cleaning as long as she avoids prolonged overhead activity which could exacerbate her cervicalgia. She should not climb for safety reasons regarding her balance, but otherwise, I feel that she could work as long as those restrictions are enforced." PX7. The Commission agrees with the Arbitrator that it is unknown whether the restrictions suggested by Mr. Buskirk would have prevented Petitioner from resuming her job with Respondent. The Commission assigns no weight to this factor.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 53 years-old on the date of accident. The Commission observes Petitioner has a lesser work life expectancy which will require her to manage the effects of her injury for a lesser period of time. The Commission finds this factor weighs in favor of a decreased permanence.

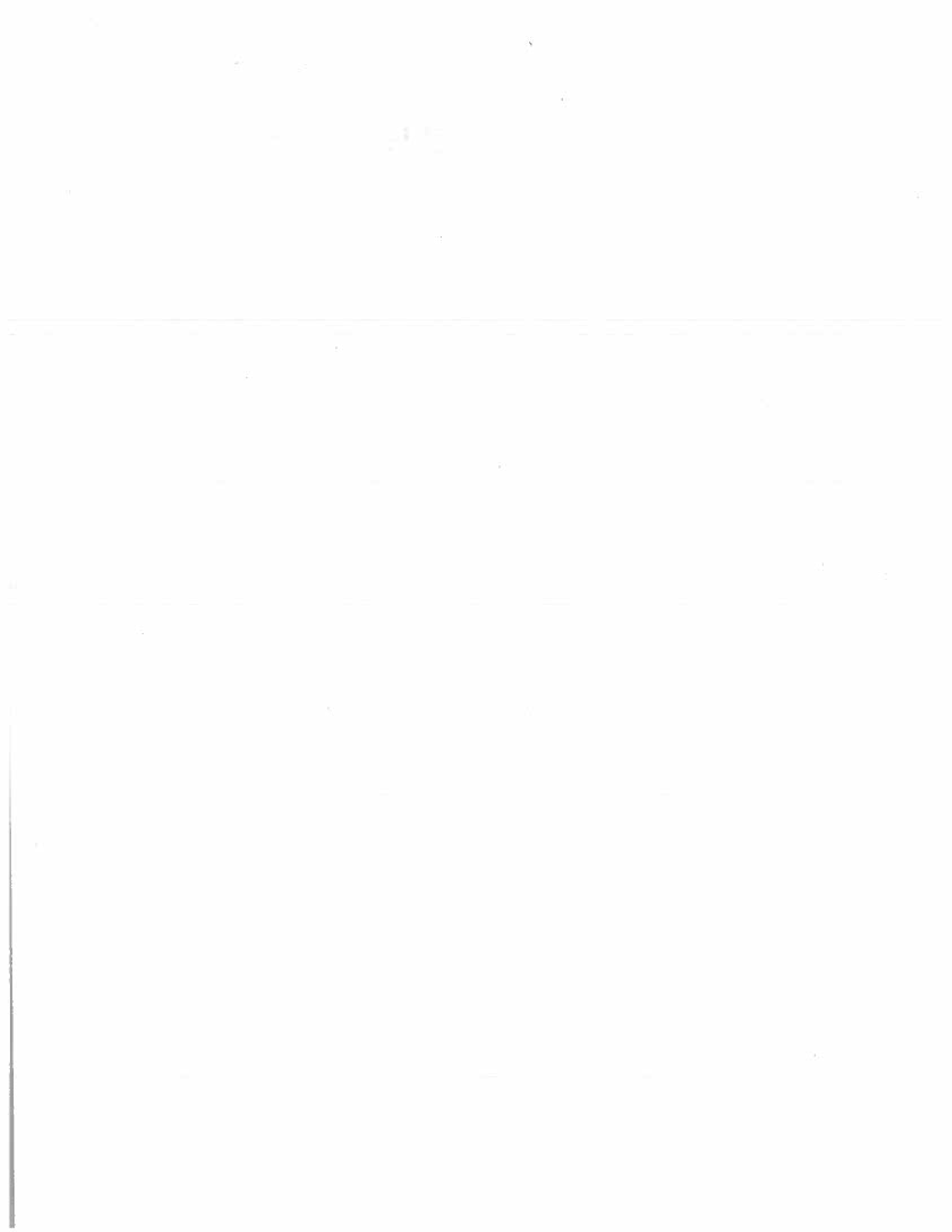
Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner has not worked since the February 1, 2013 accident. Although Petitioner claims she cannot work as a result of her accident, she acknowledged no doctor has told her she is unable to work. RX9, T. 74. On cross examination, Petitioner testified she is currently not working as her symptoms prevent her from working. T. 57. The following colloquy occurred between Respondent's attorney and Petitioner: "Q. And has any doctor provided any medical note or work slip stating that your symptoms prevent you from working? A. No." T. 58. The Commission notes Mr. Buskirk opined Petitioner was capable of resuming cleaning work so long as she avoided climbing and prolonged overhead activity. Thusly, there is no direct evidence Petitioner's earning capacity was impaired. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

According to the medical records, Petitioner initially complained of headache and neck pain at the emergency room of Cook County Stroger Hospital on February 2, 2013. Cervical spine x-rays evidenced no acute findings and mild multilevel intervertebral disc space narrowing. CT scans of the head were preformed on February 3, 2013 and February 8, 2013 both of which found no evidence of acute intracranial hemorrhage or extra-axial fluid collection; the impression was no acute intracranial process. Petitioner was discharged with prescribed medications. PX5. On February 8, 2013, Petitioner also underwent a cervical CT scan ordered by Dr. Bowman; the impression was degenerative changes at the C6-C7 level with left-sided foraminal stenosis. PX1.

Thereafter, Petitioner underwent treatment with Dr. Wojnarski, her primary care physician and Dr. Allen. PX1. At Dr. Allen's referral, Petitioner was evaluated and treated by physical therapist, Mr. James Buskirk. In his November 10, 2014 report Mr. Buskirk noted



Petitioner had been under care for complaints of dizziness, disequilibrium and cervicalgia. Petitioner's balance was better, and she was independent with her gait without assistive devices. Petitioner presented with mild soft tissue restriction in the right upper quadrant and paracervical musculature as compared to the left, though her passive mobility was full. Her active mobility was limited at the terminal motion of rotation to the right. Neurologically she was intact throughout all four extremities for sensation and reflexes. The myotomes were 5/5. Mr. Buskirk noted, "At this point, I feel that she has reached maximum benefits from the therapeutic intervention, and her symptoms have stabilized to where I feel that we can successfully discharge her from our care at this time." Mr. Buskirk further noted, "I do, in fact, feel that she could work at her prior job doing cleaning as long as she avoids prolonged overhead activity which could exacerbate her cervicalgia. She should not climb for safety reasons regarding her balance, but otherwise, I feel that she could work as long as those restrictions are enforced." PX7.

Dr. Allen evaluated Petitioner for a final time on December 2, 2014 at which time Petitioner complained of a chronic headache and subjective symptoms consistent with cervical radiculopathy but with a normal physical examination. Dr. Allen released Petitioner from care, stating "I have little else to offer." PX1. The Commission finds the above weighs in favor of a decreased permanence.

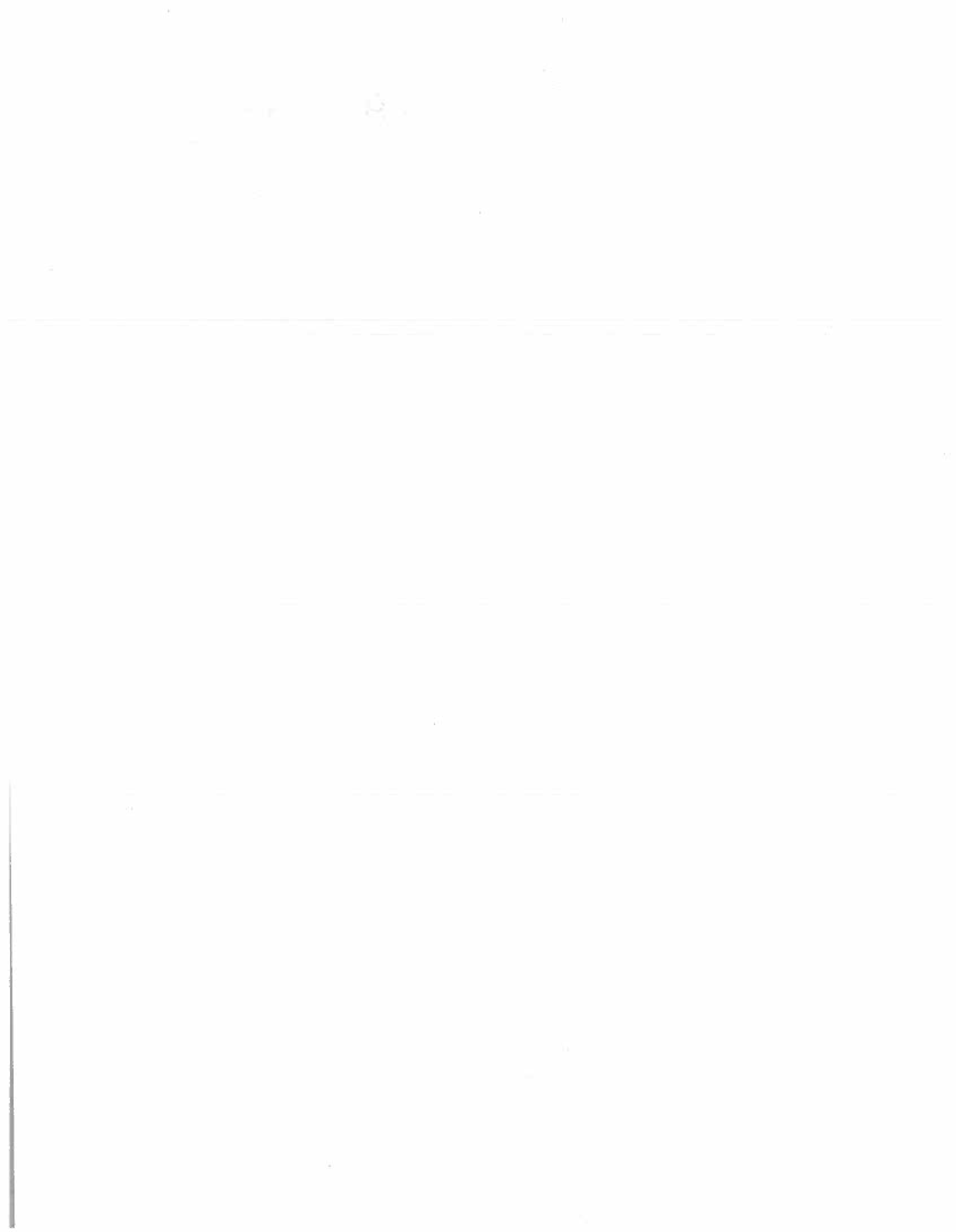
Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained a 5% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's November 27, 2017 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $150.00 per week for a period of 10-6/7 weeks, representing February 14, 2013 through April 30, 2013, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the following medical expenses pursuant to §8(a) of the Act and subject to the Medical Fee Schedule pursuant to §8.2 of the Act: Cook County Stroger Hospital for various dates and amounts of $2,679.00, $2,775.71, $173.00, $1,531.00, $186.00 and $203.00; Dr. Wojnarski in the amount of $2,385.00 and Dr. Allen in the amount of $1,235.00.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $150.00 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 5%.



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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 14 2019
LEC/maw
o01/16/19
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WAPNIARSKA, HALINA
Employee/Petitioner

Case# **13WC009739**

LEUS CLEANING SERVICES
Employer/Respondent

19IWCC0163

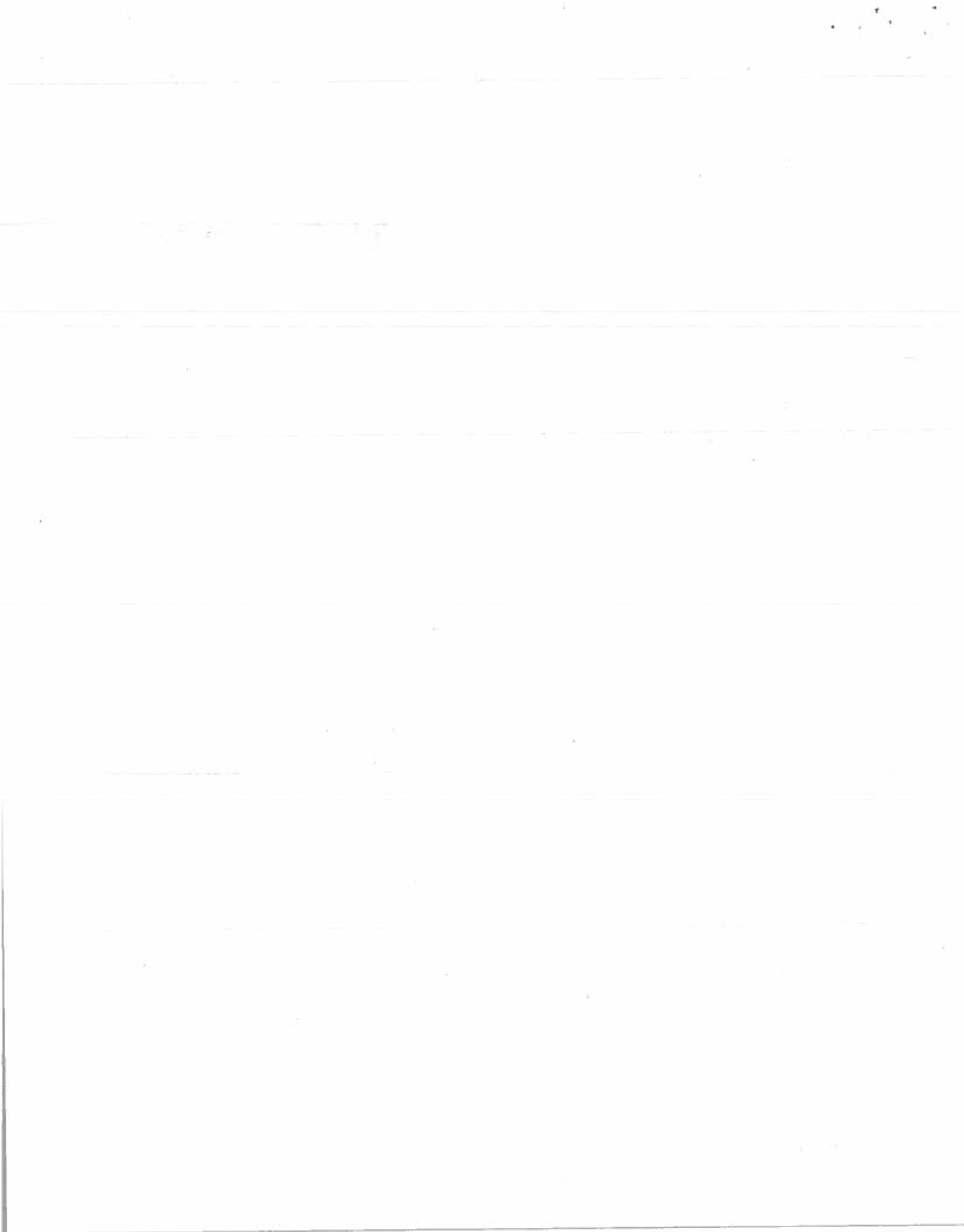
On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% 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:

0786 BRUSTIN & LUNDBLAD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
ALFRED NORMAN
161 N CLARK ST SUITE 800
CHICAGO, IL 60601



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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

HALINA WAPNIARSKI
Employee/Petitioner

Case # **13** WC **9739**

v.

Consolidated cases: **D/N/A**

Leus Cleaning Service
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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2017 and October 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. ☒ 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 **Should sanctions be imposed for failure to comply with a Section 12 Exam?**

FINDINGS

On February 1, 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.

For the reasons stated in the attached decision, the Arbitrator finds Petitioner established causation only as to a mild head injury and neck strain, with those conditions remaining symptomatic as of the hearing.

In the year preceding the injury, Petitioner earned $; the average weekly wage was $**150**.

On the date of accident, Petitioner was **53** years of age, *single* with **0** dependent children.

Petitioner has **in part** received 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

Petitioner was temporarily totally disabled from February 14, 2013 (the date of her first visit to Dr. Wojnarski) through April 30, 2013, a period of 10 6/7 weeks. The Arbitrator awards temporary total disability benefits at the rate of $150/week, based on the stipulated average weekly wage and applicable minimum.

Respondent shall pay the following reasonable and necessary medical expenses, subject to the fee schedule: 1) Stroger Hospital, various dates of service, $2,679.00, $2,775.71, $173.00, $1,531.00, $186.00 and $203.00; 2) Dr. Wojnarski, office visits, $2,385.00; and 3) Dr. Allen, office visits and nerve block, $1,233.00. The Arbitrator declines to award any other claimed medical expenses, for the reasons set forth in the attached decision.

Petitioner is permanently partially disabled to the extent of 10% loss of use of the person as a whole, equivalent to 50 weeks of benefits, under Section 8(d)2 of the Act. The Arbitrator awards permanency at the rate of $150.00/week, based on the stipulated average weekly wage and applicable minimum.

For the reasons stated in the attached decision, the Arbitrator declines to dismiss this case based on Petitioner's failure to attend scheduled Section 12 examinations.

For the reasons stated in the attached decision, the Arbitrator declines to find Respondent liable for penalties and fees.

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

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

11/22/17

Date

NOV 27 2017

Halina Wapniarska v. Leus Cleaning Service
13 WC 9739

19IWCC0163

Procedural History

The procedural history of this case is best described as complicated.

On March 22, 2013, Petitioner filed an Application for Adjustment of Claim alleging multiple injuries stemming from an accident of February 1, 2013.

On November 12, 2014, Arbitrator Steffen conducted a hearing on Respondent's motion to dismiss the claim, based on Petitioner's failure to attend three scheduled Section 12 examinations with Dr. Neri. RX 1-3 (admitted by Arbitrator Steffen over Petitioner's objection). Petitioner testified at this hearing, via a Polish-speaking interpreter. She denied receiving the first two letters (dated April 28 and June 10, 2014, RX 1-2) requesting she appear at Dr. Neri's office, but acknowledged that the address on these letters is the address of the home in Elmwood Park where she resides with her sister. RX 5, pp. 14-16. She acknowledged receiving a third letter, dated August 12, 2014 (RX 3), directing her to appear at Dr. Neri's office at 11 AM on September 8, 2014, but denied ever receiving a travel expense check. RX 5, pp. 16, 23. She testified that, on the morning of September 8th, she met her niece and began traveling to the doctor's office but, while en route, realized she had left her cell phone on a bench at a bus stop. She testified that, at her direction, her niece called Dr. Neri's office to explain the situation and ask whether she could appear twenty minutes late, only to be told that the appointment was being cancelled. She denied canceling the appointment on her own. RX 5, pp. 21-22. Under cross-examination, she acknowledged it was possible her niece informed the doctor's staff she would be thirty minutes late. She denied receiving any communication from an interpreting service, regarding the examination, prior to September 8th. RX 5, pp. 26-27. She acknowledged that some of the relatives with whom she lives speak English. RX 5, p. 27. She denied informing anyone she could not attend the September 8th examination because she had to babysit for a sick child. RX 5, pp. 28-29. In response to questions posed by Arbitrator Steffen, Petitioner's counsel denied receiving RX 1, could not recall whether he received RX 2 but was unable to find any such document in his file and admitted receiving RX 3. RX 5, pp. 36-37. Respondent's counsel informed the Arbitrator it was standard practice for any Section 12 examination request letter to be sent to the claimant's counsel as well as the claimant. The Arbitrator indicated he could have time to produce any additional documents showing that copies were, in fact, sent to Petitioner's counsel. RX 5, pp. 38-41. She continued the case to November 14, 2014. Counsel for both parties appeared before the Arbitrator on said date, with Respondent's counsel indicating he had not been able to secure any documents showing that copies of the letters were sent to Petitioner's counsel. RX 6, pp. 5-6. He went on to state he was seeking dismissal based on lack of progress with the claim as well as Petitioner's failure to submit to examination. Petitioner then testified she remained symptomatic and was still under care with Drs. Wojnarski and Allen. RX 6, pp. 9-13.

On December 8, 2014, Arbitrator Steffen issued an interlocutory order striking Respondent's motion to dismiss as untimely, indicating the motion should be considered in the context of a hearing on the merits. Arb Exh 2.

On January 17, 2017, former Arbitrator Gale conducted a hearing, with Respondent stipulating to employment, accident, notice and wage and disputing causal connection, medical expenses, temporary total disability, permanency and penalties/fees. RX 9, pp. 4-7. After former Arbitrator Gale noted that the Stroger Hospital bills claimed by Petitioner lacked CPT codes, he indicated he would allow bifurcation, so as to permit Petitioner to obtain bills in the proper format. RX 9, pp. 11-13. T. 9/21/17, p. 14.

At the January 17, 2017 hearing, Petitioner testified (via an interpreter) that she began working for Respondent in May 2012. She worked fifteen hours per week and started work at 9 AM. RX 9, p. 28. Her job consisted of cleaning a boutique, Bottega Veneta, located inside the Park Hyatt Hotel complex in Chicago. RX 9, p. 26, 29. Her accident of February 1, 2013 took place while she was walking toward the boutique, taking a route designed by her immediate supervisors, Pawel and Roza. Pawel and Roza told her to use a rear entrance (off of Rush Street) to enter the hotel complex from the street. RX 9, pp. 24-26. She consistently took the designated route during the months preceding February 1, 2013. RX 9, pp. 27-28. On the day of the accident, she was walking underneath a mechanical, garage-type door when she felt excruciating head pain and realized the door had struck her head. RX 9, pp. 28-29. She had never previously encountered a problem with this door. RX 9, p. 29. Her "excruciating headache" radiated toward her neck, arms and spine. She also felt as if she was "having pain inside [her] eyeballs and ears." RX 9, pp. 29-30. She had never experienced pain like this before. RX 9, p. 30. She denied falling after being struck by the door. She managed to perform her usual cleaning inside the boutique and left work at 11 AM, her usual quitting time. She did not feel any better at this point. In addition to her original symptoms, she was experiencing finger stiffness. Her left hand felt worse than her right. She had never previously felt like this. RX 9, p. 31. She did not seek treatment because she thought her symptoms would go away. That evening, at home, her pain increased and she felt like someone was ripping her chest apart. RX 9, p. 31. Her niece gave her some painkillers. The next day she went to the Emergency Room at Stroger Hospital, where she underwent tests. After leaving the hospital, she felt "pretty bad." She was experiencing diarrhea and nausea. RX 9, p. 33. She called Andrzej, who was Pawel's and Roza's supervisor, and told him she would not be able to work on Monday due to the accident. RX 9, p. 33. Later that week, she returned to the Emergency Room because she was still symptomatic. She also saw Dr. Wojnarski, who noted bumps on her head. RX 9, p. 35. At Dr. Wojnarski's recommendation, she started therapy at Universal Healthcare. The therapy consisted of massages and exercises focusing on her arms and back. RX 9, pp. 35-37. She also saw Dr. Allen, who injected the back of her head and recommended therapy at a different facility, Peak Therapy. The therapy at this facility consisted of massages and electrical stimulation. It helped "a little bit." RX 9, p. 37.

Petitioner testified she experiences dizziness, headaches, vision and hearing problems, neck swelling, spinal pain, finger stiffness, forearm pain, left leg pain and difficulty holding a

glass or cup. RX 9, p. 38. After the accident of February 1, 2013, she injured her left leg in a fall at Stroger Hospital. She fell because she was dizzy. Since the accident, she has fallen a few times due to dizziness. She denied experiencing dizziness before the accident. She currently takes medication for dizziness. She also performs prescribed home exercises. RX 9, pp. 40-46.

Petitioner testified she has not worked in any capacity since the February 1, 2013 accident due to her dizziness and other symptoms. RX 9, pp. 48-50.

Under cross-examination, Petitioner testified the accident occurred while she was walking through a loading dock area. No one ever told her that the hotel had other entrances. RX 9, p. 50. She was told to use one particular entrance. RX 9, p. 50. She was aware that the door could go up and down. She also knew you had to push a button to activate the door. RX 9, p. 51. She was not aware of any automatic sensors. RX 9, p. 52. Part of the door is metal. She did not hear the door moving as she walked underneath it. The top of the door was at least two feet higher than the top of the door of the hearing room. RX 9, p. 53. [Arbitrator Gale took judicial notice that the top of the hearing room door is at least six feet, ten inches above the floor. RX 9, p. 54]. She is approximately five feet, three inches tall. RX 9, p. 56. The door was fully open when she started walking underneath it. It came down very quickly. RX 9, p. 57. Before the accident, she never had such excruciating head pain. The treatment she underwent after the accident was due solely to the accident. RX 9, p. 61.

Petitioner acknowledged filing a personal injury claim against Hyatt Hotels due to the accident. She recalled giving a deposition in this claim. At this deposition, she answered questions about other accidents she has had. In 2009, she fell while working at Red Apple Restaurant. She experienced headaches after this fall but they were "not as excruciating" as the headaches she now experiences. RX 9, p. 64. She cannot recall whether she experienced neck pain after the fall at the restaurant. She testified to experiencing bilateral arm, finger and chest pain after the fall at the restaurant. RX 9, p. 65-67. She testified to being struck by a vehicle on May 28, 2015 and landing in such a way that both of her legs were trapped underneath the vehicle. RX 9, p. 68. She saw Dr. Ahmed on January 5, 2017. RX 9, p. 70. She has not worked since the accident of February 1, 2013. RX 9, pp. 72-73. She has not seen any vocational expert or career counselor. RX 9, p. 73. Her doctors have not told her she cannot work. RX 9, p. 74.

On redirect, Petitioner testified her headaches did not disappear after she fell at the Red Apple Restaurant. Her headaches became more acute after the February 1, 2013 accident. RX 9, p. 75. At present, she experiences unbearable headaches every day. Some of her head pain is at the back of her head. Before the February 1, 2013 accident she had head pain but not in the back of her head. RX 9, p. 76. She fell at Stroger Hospital in July 2013 due to dizziness and weakness. The May 2015 automobile accident did not cause her headaches to worsen. RX 9, p. 77.

At this point in the hearing, former Arbitrator Gale continued the case to April 6, 2017. He admitted only one exhibit, i.e., the Request for Hearing form (Arb Exh 1), into evidence at

the January 17, 2017 hearing. RX 9, pp. 77-79. The hearing was not concluded. After Arbitrator Gale departed, the Commission reassigned the case to Arbitrator Mason, with the parties agreeing to begin the hearing anew. T. 9/21/17, pp. 5-7, 13. Arbitrator Mason met with the parties on several occasions prior to September 21, 2017. At the first of these meetings, Respondent's counsel indicated he was now going to place accident in dispute. Petitioner's counsel objected. Arbitrator Mason overruled the objection but allowed Petitioner's counsel additional preparation time. T. 9/21/17, p. 8.

Arbitrator's Findings of Fact Relative to Hearing of September 21, 2017

Petitioner was the sole witness at the re-hearing held on September 21, 2017. She testified through an interpreter.

Petitioner testified she worked for Respondent as of February 1, 2013. T. 9/21/17, p. 23. Her duties involved cleaning a boutique inside a hotel complex at 800 North Michigan Avenue. T. 9/21/17, p. 23. She testified she always took the same route to get to this boutique. Roza, a manager, and Pawel, her immediate supervisor, directed her to take this route. She walked through a garage, entered the hotel and then walked down a hallway toward doors that led to the boutique. T. 9/21/17, pp. 24-25. There was a door inside the hallway that rolled up and down. The door was made of rubber and had a metal frame at the bottom. T. 9/21/17, p. 27. On February 1, 2013, she was walking down the hallway, toward the boutique. The door was open at that time. As she walked through the opening, the door unexpectedly "folded down" and struck the top of her head. T. 9/21/17, p. 27.

Petitioner testified she felt good before the door struck her head. T. 9/21/17, pp. 27-28. Afterward, she felt dizzy and experienced pain in her left shoulder, neck, back and left hand. Later the same day, the fingers of her left hand "stiffened." T. 9/21/17, p. 28.

Petitioner acknowledged that, prior to the February 1, 2013 accident, she occasionally experienced "a little" neck pain and numbness in the fingers of her left hand. T. 9/21/17, p. 28.

Petitioner testified she proceeded to clean the boutique after the accident, despite her symptoms. She felt dizzy but believed she would "survive" for the two hours it took her to clean the store. After she finished her shift, she went home. At about 5 or 6 PM the same day, she began washing a glass when she experienced severe numbness in her fingers, a "big headache," chest pain and dizziness. T. 9/21/17, pp. 29-30.

Petitioner testified she first sought medical treatment on Saturday, February 2, 2013, the day after the accident. She went to the Emergency Room at Stroger Hospital that day. A doctor examined her, maybe administered an injection and gave her medication. T. 9/21/17, p. 30.

The Stroger Hospital Emergency Room records of February 2, 2013 set forth the following history:

"Two days back I was coming out of a building and a door hit my head. I didn't pass out but I have pain on my head radiating to the back of my neck and both arms with numbness since then."

Another history reflects Petitioner reported hitting her head on a metal door "a few days ago." The records reflect these histories were obtained "via interpreter." Petitioner indicated she had previously undergone knee surgery. She complained of finger numbness and substernal chest pain in addition to head and neck pain and arm numbness. Another note reflects she described the neck pain and finger tingling as "chronic." The examining resident described Petitioner as "neurologically intact." He found it likely she had sustained a concussion. He ordered CT scans of the cervical spine and head. The cervical spine CT scan demonstrated mild multi-level degenerative changes and no acute abnormalities. The head CT scan showed no acute intracranial process and "no significant interval change" from a previous scan of November 20, 2012. [No report concerning this previous scan is in evidence.] Petitioner was discharged with medication and directions to seek follow-up care. PX 5.

Petitioner testified she did not report to work the Monday after the accident because she did not feel physically able to do so. T. 9/21/17, pp. 30-31. She called work and talked with Andrzej, who had interacted with her at the time of her hiring. She does not know Andrzej's exact job title but he had supervisory authority over Roza and Pawel. T. 9/21/17, p. 31. They did exactly what Andrzej told them to do. She reported her accident to Andrzej. Specifically, she told him a door had struck her. She also informed him of her Emergency Room visit. She told him a doctor at the hospital had given her a slip directing her to remain off work. She told him she felt dizzy, nauseated and unable to work. He wanted her to come in to work but she declined, again citing the doctor's directive. Andrzej did not offer to pay her hospital bill. T. 9/21/17, pp. 31-32.

Petitioner testified she returned to the accident site on Saturday and told a security employee she wanted to complete a report concerning the accident. The security employee told her to come back on Monday. She went back on Monday but the security employee then told her to come back the following day. She called Andrzej and asked that someone accompany her to act as her translator. Roza met her at the accident site on Tuesday and she made a report, with Roza interpreting for her. T. 9/21/17, pp. 32-33.

Petitioner returned to the Emergency Room at Stroger Hospital on February 7, 2013. On that date, Dr. Papiez indicated that Petitioner reported being "hit by a back door in a hotel on Friday, February 1, 2013." He also noted the previous Emergency Room visit and scans. He noted new complaints of nausea, episodic diarrhea, "swollen eyes" and left eye pain. He indicated that Petitioner described her left hand as more numb than her right. A subsequent history reflects Petitioner described her left hand numbness as "unchanged since previous trauma several years ago." Dr. Papiez prescribed a repeat head CT scan, with contrast, and Ketoralac for pain. The repeat scan "redemonstrated mild diffuse cerebral and cerebellar atrophy with low attenuation involving the peri-ventricular white matter, compatible with

gliosis which is slightly secondary to chronic small vessel ischemia." The radiologist noted no acute abnormalities. PX 5.

Petitioner was discharged from the Emergency Room on February 8, 2013 with prescriptions for Acetaminophen and a topical cream and directions to seek follow-up care at Fantus Clinic within one to two weeks. PX 5.

Petitioner returned to the Emergency Room at Stroger Hospital on February 11, 2013. The evaluating physician, Dr. Grazyna Siwy, noted a history of the work accident and prior Emergency Room visits. She indicated that Petitioner complained of persistent head and neck pain. She also noted that Petitioner "admits to possibility of trying to get disability for [these symptoms] but . . . 'didn't start yet'". She further stated: "initially, pt seems to be distressed but got comfortable during the visit." After examining Petitioner and reviewing the prior CT scan results, she recommended that Petitioner apply warm/cool compresses to the affected areas, continue the previously prescribed medication and start taking Gabapentin. PX 5.

Petitioner testified she saw Dr. Wojnarski on the Thursday after the accident. The doctor examined her and noted her symptoms. He told her she had "bumps" on her head. He referred her to Dr. Allen, a neurologist, and recommended she see "Dr. Jim" and massage her left hand. T. 9/21/17, pp. 33-35.

Dr. Wojnarski's records reflect an initial visit of February 14, 2013. The records are handwritten and difficult to read. The history reflects Petitioner complained of head pain, neck pain and dizziness secondary to being struck by an automatic door "on the way to work" on February 1, 2013. PX 1.

On March 13, 2013, Petitioner underwent an initial physical therapy evaluation at Universal Therapeutic Center. The evaluating therapist described Petitioner as stating she "was injured [at] work and did not have any pre-existing causes." He noted complaints of neck pain radiating to both arms and tingling in both hands. He continued treating Petitioner through May 16, 2013, noting little improvement along the way. PX 3. The bill for the treatment totals $16, 020.00. PX 4.

Petitioner testified she underwent a course of formal therapy at Peak Therapeutics, per Dr. Wojnarski. Before this, however, she saw a Polish therapist whose name she cannot recall. This therapist administered massages, which helped at the outset. During one particular therapy session, she became very weak and therapy was stopped. T. 9/21/17, p. 35.

On March 22, 2013, Petitioner filed an Application for Adjustment of Claim, alleging injuries to her head, neck, back, hands and jaw secondary to an accident of February 1, 2013.

Petitioner returned to Stroger Hospital's Emergency Room on April 9, 2013. Dr. Beeravolu noted a history of the work accident. He noted complaints of worsening left upper extremity weakness since that accident. He indicated that Petitioner also complained of low

back pain and diplopia in both eyes. On examination, he noted decreased sensation and slightly decreased strength in Petitioner's left arm. He restarted the Gabapentin. He referred Petitioner to the hospital's eye clinic and noted she had upcoming appointments at the hospital's sleep clinic, due to possible sleep apnea, and pulmonary clinic. PX 5.

Petitioner first saw Dr. Allen, a neurologist, on April 22, 2013. Dr. Allen wrote to Dr. Wojnarski after seeing Petitioner. In his letter, he indicated he relied on Petitioner's roommate as a translator. He described the mechanics of the February 1, 2013 work accident as follows: "A garage door came down and hit [Petitioner] in the head. She did not fall to the ground and she did not have loss of consciousness."

Dr. Allen indicated that Petitioner complained of a constant bilateral occipital headache, rated 8/10, along with some dizziness and visual distortions. He also noted complaints of neck and back pain.

Dr. Allen noted no abnormalities on examination other than somewhat diminished pinprick in the left face and arm. He recommended a course of Amitriptyline and directed Petitioner to return to him in two to three weeks for re-evaluation and a possible injection. PX 9.

Petitioner underwent an initial physical therapy evaluation at Peak Therapeutics, Ltd. on April 22, 2013. The evaluating therapist, Jim Buskirk, P.T., noted that Petitioner complained of headaches, neck pain and dizziness secondary to hitting her head on a garage door. He also noted that Petitioner was already undergoing therapy at a different facility. After examining Petitioner and performing oculography studies, he diagnosed post-concussive syndrome with headaches/dizziness. Petitioner continued attending therapy at Peak Therapeutics through December 19, 2013. She underwent a re-evaluation on February 3, 2014 and continued therapy thereafter through November 10, 2014, at which point Buskirk found her to have "reached maximum benefit." [See further below]. PX 7. According to the Peak Therapeutics, Ltd. bill, which totals $55,566.00, the therapy consisted of exercises, ultrasound, E-stimulation, massage and "cognitive skills development." PX 8.

On May 8, 2013, Dr. Allen conducted ENG testing. In his report, he noted "left beating nystagmus during head turned right and head hanging right positions." He indicated the results were otherwise unremarkable. PX 9.

Petitioner also underwent an audiologic examination on May 8, 2013, with the examining audiologist noting mild sensorineural hearing loss from 250 – 4,000 Hertz and moderate hearing loss at 8,000 Hertz bilaterally. PX 7.

Petitioner returned to Dr. Allen on May 13, 2013. The doctor wrote to Dr. Wojnarski the same day, indicating Petitioner was still complaining of "pain almost on a daily basis more on the left than the right with some numbness of her left hand." He went on to address causation:

"As you are well aware, [Petitioner] has degenerative arthritis of her hand with a slight bit of ulnar deviation of her fingers. I am not absolutely sure that she does not have rheumatoid arthritis with subsequent osteoarthritis, but this is far outside of the scope of the reason for which we are seeing her, which is that of a recent post-traumatic injury."

Dr. Allen noted that Petitioner was continuing to undergo therapy at Peak Therapeutics for neck and left arm pain as well as balance-related issues. He indicated he injected Petitioner's left nuchal ridge with a combination of Marcaine and Dexamethasone. He recommended that Petitioner continue therapy.

Petitioner underwent a sleep study at Stroger Hospital on July 18-19, 2013. The study demonstrated severe obstructive sleep apnea syndrome. Records in PX 5 reflect that, according to Petitioner's daughter, Petitioner got minimal sleep during the study, became dizzy after leaving the sleep clinic and fell, landing on her right knee and left shoulder. A response team brought Petitioner to the hospital's Emergency Room. The examining physician, Dr. Chhabra, noted bruising of the right knee and minimal tenderness to palpation of the anterior left shoulder. He obtained an EKG, X-rays of the chest, right knee and left shoulder and laboratory work. He described the results of these studies as normal. He released Petitioner from care and directed her to see her personal care physician within one to two weeks. PX 5.

On July 30, 2013, Petitioner saw Dr. Pandey at a Stroger Hospital clinic. Dr. Pandey indicated he relied on a Polish-speaking interpreter in communicating with Petitioner. He also indicated he reviewed Petitioner's "entire chart since 6/4/2010." He noted that Petitioner complained of "left shoulder pain for many years but more since 7/19 when she was injured by a fall in the hall of Cook County." He also noted that Petitioner complained of lumbar and cervical spine pain, "all of which have been at baseline painful since 2009" and bilateral eye pain. He noted a history of left knee surgery in 2009 and a knee injection in 2012.

Dr. Pandey's note of July 30, 2013 sets forth a detailed account of Petitioner's care since May 6, 2011. This account references a fall with loss of consciousness at work on May 24, 2009, at which point Petitioner was "working as a cook's helper."

After conducting his records review and examining Petitioner, Dr. Pandey indicated that Petitioner "seems to have multiple injuries/falls of unclear reasons." He further noted that, despite multiple interventions, Petitioner still complained of "extreme and intractable pain." He recommended that Petitioner be monitored "for secondary gain." He indicated he might consider a "psych referral for depression and possible fibromyalgia." PX 5.

Respondent filed its appearance on July 30, 2013.

On April 28, 2014, Coventry Health Care sent Petitioner a letter directing her to appear at Dr. Neri's office in Hinsdale, Illinois, on May 22, 2014, for purposes of a Section 12

examination. The letter is in English. The last sentence directs Petitioner to bring an interpreter and reflects that a travel reimbursement check is forthcoming. There is no evidence indicating that Coventry sent a copy of the letter to Petitioner's counsel. RX 1.

On June 10 and August 12, 2014, Coventry Health Care sent Petitioner letters directing her to appear at Dr. Neri's Hinsdale office on June 30 and September 8, 2014, respectively, for purposes of a Section 12 examination. These letters are in English. They direct Petitioner to bring an interpreter and allude to a forthcoming reimbursement check. There is no evidence indicating that Coventry sent a copy of either letter to Petitioner's counsel. RX 2-3.

Petitioner returned to Dr. Allen on December 2, 2014. Dr. Allen wrote to Dr. Wojnarski the same day, indicating he relied on Petitioner's niece to translate. He referenced the February 2013 work accident and indicated his previous reference to a motor vehicle accident was erroneous. He noted ongoing complaints of headaches, blurred vision, memory loss, neck swelling and stiffness in the left hand and arm.

On re-examination, Dr. Allen noted a "little giveaway weakness on the left side" along with "good neck movement." He indicated that Petitioner's left extension was "certainly not as good as her flexion."

Based on Petitioner's complaint of chronic headaches, Dr. Allen suggested she keep a headache diary and start taking Topiramate. He noted that "in the past, treatment efforts as regarding [Petitioner] have been somewhat inconsistent, and she has not benefited from most therapies that have been administered . . . including cervical blocks." He noted ongoing symptoms of left cervical radiculopathy and significant arthritic changes in the fingers, "especially the fifth finger of the left hand and the distal interphalangeal joints." He recommended Petitioner take Ibuprofen for this "osteodegenerative process."

Dr. Allen ended his letter by saying he had "little else to offer" Petitioner. PX 9.

On November 10, 2014, Jim Buskirk, P.T. of Peak Therapeutics wrote to Dr. Allen indicating he noted "very subtle left-beating nystagmus spontaneously for two or three beats" on infrared oculography and normal Dix-Hallpike maneuvers bilaterally. He described Petitioner's balance as "now better" and indicated she was "independent with her gait without assistive devices." He noted "mild soft tissue restriction in the right upper quadrant and paracervical musculature as compared to the left."

Buskirk found that Petitioner had "reached maximum benefit from the therapeutic intervention." He indicated Petitioner's symptoms had stabilized to the point where he felt comfortable in discharging her from care. He found Petitioner capable of performing her previous cleaning job "as long as she avoids prolonged overhead activity which could exacerbate her cervicalgia." He indicated Petitioner should avoid climbing, for safety reasons, due to her balance problems. PX 7.

Petitioner returned to Dr. Allen on October 21, 2015. In his handwritten note of that date, the doctor indicated Petitioner was still complaining of near daily pain in her neck and the back of her head. He also noted complaints of dizziness, left arm stiffness and left leg swelling. He indicated Petitioner "doesn't use the crutch as much." [None of the doctor's previous records mention crutch usage.] He recommended a functional capacity evaluation. PX 9. No such evaluation is in evidence.

On October 30, 2015, Petitioner gave a discovery deposition in the personal injury claim she filed in the Circuit Court of Cook County against Park Hyatt and Hyatt Corporation. [Respondent offered the transcript of this deposition (RX 7) into evidence, with no objection from Petitioner.] This claim, numbered 14 L 9782, arises out of the same accident alleged in the instant claim. During this deposition, Petitioner testified to having some memory-related problems. RX 7, pp. 9-10. She testified she was born in Poland. She came to the United States in 2003 and has resided in Elmwood Park, Illinois, with her sister and brother-in-law, since that time. RX 7, pp. 14-15. She denied having any injuries, headaches or problems with her neck, back or left knee while she was in Poland. RX 7, p. 23. Her husband, son and daughter still live in Poland. She has not seen her children since 2003. RX 7, pp. 21-22. Between 2003 or 2004 and 2009, she worked six days per week for "Marek," who operated a cleaning service. RX 7, p. 24. She stopped working for this company after she fell at a restaurant, where she worked on the weekends. She slipped on oil that was on the floor of the restaurant and fell. She lost consciousness when she fell. She injured her head, neck, "entire back" and left knee. She underwent left knee surgery in October 2009 as a result of the fall. RX 7, pp. 22-23, 30-33, 46. She filed a claim against the restaurant as a result of the fall. RX 7, pp. 25, 29. She settled that claim, netting approximately $7,800. RX 7, pp. 29-30. Her head, back and neck pain "decreased" after the fall but she continued taking pain medication "for a few years." RX 7, p. 35. She was no longer taking this medication as of the February 1, 2013 accident. RX 7, pp. 35-36.

Petitioner testified she last worked on February 1, 2013, the day of her claimed work accident. RX 7, p. 16. In addition to her two work injuries, she injured her head, neck, back and left knee when she fell in a hallway at Stroger Hospital on July 19, 2013, after becoming dizzy. RX 7, p. 26. She sustained another accident on May 28, 2015, when a car struck her as she was walking near Fantus Clinic, which is part of Stroger Hospital. She injured multiple body parts, including her right leg, in the car accident. Her right leg was trapped underneath the car, resulting in a "broken bone in the right knee," and necessitating hospitalization. RX 7, p. 27.

Petitioner could not recall whether she had vision problems before the February 1, 2013 accident. She did not recall seeing Dr. Hickey or being told her vision was 20/40 in both eyes. RX 7, p. 41. She had problems with her left arm and left shoulder before the February 1, 2013 accident but was able to perform cleaning work. RX 7, p. 43. She had left hand numbness prior to the February 1, 2013 accident. RX 7, p. 48.

Petitioner testified she began working for Leus Cleaning in approximately May 2012. She cleaned a store "from Monday through Friday, from 9:00 to 11:00." RX 7, p. 49. Her boss

was named "Andrzej." She does not know whether he owned Leus Cleaning. She was paid by check. She received a paycheck every two weeks. RX 7, p. 49. Her supervisor was "Pawel." A manager named "Roza" also worked for Leus Cleaning. Pawel typically supervised her work "telephonically." Pawel only came to the store when something was broken or there was a special assignment. RX 7, p. 51. She saw Roza very rarely. RX 7, p. 51. On her first day of work, she met with two store employees, a man and a woman, outside. These individuals showed her to get to the store from outside. They did not walk her through the front of the store. Instead, they "told [her] to walk around the back" and enter the store via the "garage side," on Rush Street. RX 7, p. 53. After her first day of work, she continued taking the same route each day, coming through the garage. She never saw an employee entrance on Rush Street. The garage door was open most of the time. She never rang a bell in order to gain access. RX 7, pp. 54-55. She does not speak or read English. RX 7, p. 55. She did not wear a uniform to work. RX 7, p. 55. She was not given any key to access the store. RX 7, pp. 55-56.

After looking at a photograph marked as "Exhibit 2," Petitioner testified it "seemed to be" that the photograph showed the garage area where she walked every workday. RX 7, p. 57. She did not however, see the garage door in Exhibit 2. RX 7, p. 58. She has seen the door shown in the photograph marked as "Exhibit 3" but no one ever told her this was an employee entrance. She does not remember ever using this door. RX 7, p. 59. She never paid attention to the sign shown in "Exhibit 3" and "Exhibit 4." RX 7, pp. 59-61. She described the photograph marked as "Exhibit 7" as a better picture of the garage area she walked through. In this area, there were "stairs further up." The stairs led to a ramp. She walked through this area for eight months before the accident. A man who sat in this area saw her do this every workday. RX 7, p. 62. She sometimes saw Pawel and/or Roza taking the same route through this area. RX 7, p. 63. The door that struck her was yellow. It spanned the width of the hallway and had a metal strip mounted to the bottom. The door could roll up to some sort of beam. It was activated by a button. On one side of the door, she would have to use the button to open the door if it was closed. RX 7, p. 69. When she entered the building, she had to pass by a door made of glass before she encountered the rolling door that struck her. The door that struck her had a yellow piece at the top. It looked like the door shown in "Exhibit 11." RX 7, p. 81. The door never struck her prior to the accident. RX 7, p. 82. On the day of the accident, after the door hit her, two men who were typically unloading cargo in the garage, came to her aid. She believes these men worked for the hotel. She saw them every day for eight months but does not know their names. RX 7, pp. 73, 77. Another guy who had been in a nearby room, also approached her. He "seemed scared." The men started asking her questions. She started having an incredible headache and pain in her neck and back. A little later, she decided she felt well enough to get through her two-hour workday so she entered the door to the store and started cleaning. She "started feeling really bad" while she worked but managed. She emptied garbage into a "big gondola" and "slowly somehow made it back home." Once she got home, she felt stronger pain in her head and neck. She also became very dizzy. She rested and was able to eat a little of the dinner her niece made. As she started washing dishes, after the meal, she felt incredible pain in her chest, neck and head. He hand, arm and fingers started hurting. Her right hand started tingling and she became very weak. Her niece, who was nearby, noticed and grabbed her. Her fingers started "stiffening up." RX 7, pp. 72-73.

Petitioner testified she returned to the hotel the following day, a Saturday (RX 7, p. 84) but not for the purpose of working. She went to the hotel to complete an accident report. A male security guard told her she would have to come back on Monday, to talk with a manager. She went back on Monday, using the same route, and talked with a different security guard. She gave this guard her phone number and explained what had happened on Friday. He told her to return the next day to talk with a manager. She then called Andrzej and explained the situation. Andrzej told her he would send Roza to the site to act as an interpreter. She returned to the hotel on Tuesday and met with Roza and a manager. On that day, she saw a man taking photographs of a door. She also saw a person using tools to work on doors that were ahead of the door that struck her. RX 7, pp. 92-93. Through Roza, the manager showed her the doors, told the doors did not do anything to her and told her that, even if she tried to bring a claim, she would not be successful. RX 7, p. 94. The manager was "unpleasant" and spoke loudly. RX 7, pp. 95-96. She went back to the hotel the following day, Wednesday, accompanied by her niece, Barbara. Someone in the security office told them a report ad been sent. RX 7, p. 96.

Petitioner testified she was directly underneath the door when it struck her head. At the last second, she heard some noise or signal but it was "all too late." After the door struck her, it went right back up. RX 7, p. 98. She did not know whether the door ever struck anyone else. She also did not know whether the door was repaired at any time before the February 1, 2013 accident. RX 7, p. 99.

[The transcript, RX 7, reflects the parties agreed to reconvene on another day to complete Petitioner's discovery deposition. It is not clear whether the deposition was ever resumed. The Arbitrator was not provided with any other deposition transcript.]

At the September 21, 2017 hearing, Petitioner testified she never returned to work after the February 1, 2013 accident. She felt unable to work due to her severe headaches and other symptoms. She acknowledged experiencing headaches and dizziness before the accident but testified these symptoms became severe after the accident. T. 9/21/17, pp. 35-36.

Petitioner testified she never received any lost time benefits. Her medical bills remain unpaid. T. 9/21/17, p. 37.

Petitioner acknowledged having an accident at Red Apple Restaurant before the February 1, 2013 accident. She could not recall whether she experienced dizziness before the accident at the restaurant. T. 9/21/17, pp. 37-39.

Petitioner testified she continues to experience severe headaches, swelling of the left side of her neck and stiffness in the fingers of her left hand. She is sometimes afraid those fingers will become paralyzed. She also experiences depression and problems with her hearing and vision. She is afraid to use stairs, take buses and walk on the street. She avoids going out because she is "afraid of falling." T. 9/21/17, p. 39. She had headaches before the February 1,

2013 accident but those headaches were less severe than the ones she experienced afterward. Before the February 1, 2013 accident she was able to work for a cleaning service and could walk everywhere. She is not looking for work "right now" because she is depressed and fears she would be unable to perform tasks such as vacuuming that might be required of her. T. 9/21/17, pp. 39-41.

Under cross-examination, Petitioner acknowledged testifying at the Commission on three prior occasions. T. 9/21/17, p. 42. She recalled being asked about the accident, her symptoms and other issues. At the prior hearings, she testified that Roza and Pawel directed her to take a specific route through the garage. T. 9/21/17, p. 44. She currently experiences headaches and numbness in the fingers of her left hand. She cannot recall exactly what symptoms she complained of at the January 17, 2017 hearing. In addition to the accidents at Red Apple Restaurant and Stroger Hospital, she was involved in a motor vehicle accident in May 2015. She was a pedestrian struck by a vehicle. She was physically stuck underneath the vehicle after the accident. T. 9/21/17, p. 54. She knows she was sent to a physician for purposes of an examination in connection with her February 1, 2013 accident but she does not know who requested this examination. Her niece accompanied her to the examination. Before they arrived at the doctor's office, she (Petitioner) realized she had left her cell phone at a station. Her niece called the doctor's office and explained this. Her niece asked if it would be all right for Petitioner to take the time to go back to the station to retrieve the phone and thus arrive a half hour late at the doctor's office. The doctor's nurse said "no," indicating the doctor had to see other patients. The nurse went on to state the appointment could be rescheduled. She (Petitioner) and her niece then went back to the station to get the phone. T. 9/21/17, pp. 54-56. She has no recollection of any prior testimony she gave concerning other scheduled examinations. T. 9/21/17, p. 57. She is currently off work but not pursuant to any doctor's direction. Her symptoms prevent her from working. T. 9/21/17, pp. 57-58.

No witnesses testified on behalf of Respondent. T. 9/21/17, p. 59.

Over Petitioner's objection, the Arbitrator continued the case to October 24, 2017, to allow Respondent time to subpoena Petitioner's most recent records from Stroger Hospital. T. 9/21/17, pp. 95-96. Proofs were closed on October 24, 2017. Neither party offered any additional exhibits on that date.

Arbitrator's Credibility Assessment

Petitioner was subdued. She testified to having some memory problems.

Respondent offered prior transcripts (RX 7) into evidence, apparently for the purpose of impeaching Petitioner's credibility. The Arbitrator has read those transcripts. For the most part, Petitioner provided the same information each time she described the events giving rise to the February 1, 2013 work accident. Each time she testified, Petitioner identified two supervisors by name and indicated they told her which route to take inside the hotel complex to get to her designated work area, i.e., the boutique. There are some slight variations in

Petitioner's accounts of the exact location and composition of the mechanical door but the Arbitrator does not find this unusual. It was not Petitioner's job to inspect or maintain the door. She merely walked underneath it to get to her workplace.

Respondent maintains Petitioner was not forthright concerning her other accidents and claims. The Arbitrator disagrees. Petitioner never denied falling at the Red Apple Restaurant at some point before the February 1, 2013 accident. Nor did she deny being struck by a vehicle in 2015.

The Arbitrator found credible Petitioner's testimony concerning her designated route to work and the mechanics of the February 1, 2013 accident. Where the Arbitrator had problems with Petitioner, credibility-wise, was with some of her symptom-related testimony (e.g., her claim that she experienced "eyeball pain" after being struck by the door) and her attempt to link her July 2013 fall at Stroger Hospital to the February 2013 accident.

On one occasion, Dr. Allen noted "a little giveaway weakness." He did not otherwise suggest Petitioner was magnifying her symptoms. Dr. Pandey, who saw Petitioner at Stroger Hospital, noted complaints of persistent extreme pain, despite multiple interventions, and recommended Petitioner be monitored for secondary gain. The Arbitrator assigns weight to Dr. Pandey's observations.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on February 1, 2013 arising out of and in the course of her employment?

As noted above, Respondent stipulated to accident at the hearing held before former Arbitrator Gale in January 2017. It was not until after the case was reassigned to Arbitrator Mason that Respondent's counsel indicated he was placing accident in dispute. Respondent's counsel took this position several months before the rehearing, allowing Petitioner time to prepare.

The Arbitrator finds that the accident of February 1, 2013 arose out of and in the course of Petitioner's employment. In so finding, the Arbitrator relies on Petitioner's credible testimony concerning the circumstances of the accident, the histories set forth in the post-accident records from Stroger Hospital and Drs. Wojnarski and Allen and controlling case law.

The "in the course of" element refers to the time, place and circumstances of a work accident. The Arbitrator acknowledges that the accident occurred before Petitioner arrived at the boutique she was scheduled to clean. The boutique was inside a hotel complex. In Christman v. Industrial Commission, 159 Ill.App.3d 479, 482 (3rd Dist. 1987), the Appellate Court held that "the term 'employment' contemplates not only actual work time but a reasonable time before commencing and after concluding actual employment." The evidence in the instant case establishes that the accident took place within a reasonable period before the start

of Petitioner's shift, while Petitioner was en route to her actual work area. Petitioner's location at the time of the accident was reasonable, given her undisputed testimony that Respondent designated her route. The Arbitrator relies on Christman in finding that the accident occurred in the course of Petitioner's employment.

As for the "arising out of" element, the Arbitrator finds that Petitioner's unrebutted testimony establishes she was exposed to a risk, i.e., a malfunctioning door, that was distinctly associated with her employment. There is no evidence suggesting this door was in a public area open to hotel guests. Petitioner encountered the door while taking a route designated by Respondent. "When . . . an injury to an employee takes place in an area that is the usual route to the employer's premises, and the route is associated with a special risk or hazard, the hazard becomes part of the employment." Litchfield Healthcare Center v. Industrial Commission, 349 Ill.App.3d 486, 489 (2004). Also see Springfield Urban League v. IWCC, 2013 Ill. App. LEXIS 388 (4th Dist.).

In finding a compensable accident, the Arbitrator also notes Respondent had the benefit of what amounted to discovery and knew, prior to the rehearing, that Petitioner was going to testify to being injured while walking along a designated route. Respondent could have called witnesses at the rehearing to refute this testimony but did not do so.

Did Petitioner establish causation as to her various claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established causation as to a mild head injury and a neck strain (superimposed on a pre-existing spinal condition) that required Emergency Room care through April 9, 2013 and follow-up care with Drs. Wojnarski and Allen through July 30, 2013, the date of Dr. Pandey's evaluation. The Arbitrator further finds that Petitioner was still experiencing some symptoms secondary to the mild head injury and neck strain as of the September 2017 hearing.

The Arbitrator further finds that Petitioner did not establish causation as to any claimed lower back condition. The initial records from Stroger Hospital and Dr. Wojnarski contain no mention of back complaints. It was not until April 22, 2013, almost three months after the accident, that any medical provider documented low back pain.

The Arbitrator further finds that Petitioner did not establish causation as to any hand or arm condition. The Emergency Room physician who evaluated Petitioner on February 7, 2009 described her hand complaints as "unchanged since a previous trauma of ___," presumably referring to Petitioner's work-related fall at Red Apple restaurant. Dr. Allen, Petitioner's treating neurologist, diagnosed left-sided radiculopathy and left hand arthritis but did not opine that the work accident caused or aggravated either of these conditions.

The Arbitrator further finds that Petitioner failed to establish causation as to any vision or hearing-related condition of ill-being. Petitioner did not offer any credible medical opinion supporting a finding of causation as to either condition.

The Arbitrator further finds that Petitioner failed to establish any connection between the work accident of February 1, 2013 and the need for the sleep study she underwent at Stroger Hospital on July 18-19, 2013. The hospital records reflect that Petitioner underwent this study to determine whether she had sleep apnea. The study showed that she did indeed have a severe form of this condition. Petitioner did not offer any evidence indicating that a blow to the head could result in sleep apnea. The Arbitrator further finds that Petitioner did not establish any connection between the syncopal-type episode she experienced on completion of the sleep study and the work-up she underwent at Stroger Hospital's Emergency Room, for shoulder and knee pain, on July 19, 2013. The records reflect Petitioner "slept minimally" during the study and became weak on leaving the facility where the study was performed. No doctor opined that this weakness stemmed from the February 1, 2013 work accident.

The Arbitrator further finds that Petitioner failed to establish causation, as well as reasonableness and necessity, as to the extensive therapy she underwent at Universal Healthcare and Peak Therapeutics. This therapy was largely passive in nature. For a while, care at the two facilities overlapped. There is no evidence suggesting any of the care had long-lasting beneficial effects. On March 20, 2014, more than a year into the therapy, Dr. Allen informed Dr. Wojnarski that Petitioner remained symptomatic and had derived little improvement. PX 1.

Despite this finding, the Arbitrator gives some weight to therapist Buskirk's comments regarding Petitioner's work status, since Buskirk saw Petitioner over a long period of time and no functional capacity evaluation is in evidence.

Is Petitioner entitled to temporary total disability benefits? Should the claim be dismissed due to Petitioner's failure to attend scheduled Section 12 examinations?

Petitioner claims she was temporarily totally disabled from February 4, 2013 through January 14, 2016. Respondent disputes this claim based on its accident and causation defenses. Arb Exh 1. Respondent also asserts, via its previously filed motion, that the entire claim should be dismissed due to Petitioner's failure to attend three Section 12 examination appointments in 2014.

Petitioner attempts to rely on Dr. Wojnarski, her personal care physician, in asserting she was unable to work for almost three years. Dr. Wojnarski did initially keep Petitioner off work through April 30, 2013 but, following that date, he did not address work status again until late October 2014. His records reflect he did not see Petitioner at all between June 15, 2013 and April 4, 2014. He did not comment on work status on April 4, 2014. On October 29, 2014, he took Petitioner off work through November 15, 2014 but, on November 10, 2014, therapist Buskirk found Petitioner capable of resuming her cleaning job, so long as she avoided climbing and overhead work. There is no evidence indicating Petitioner approached Respondent at that

point. There is also no evidence indicating Petitioner was required to perform climbing or overhead work when she cleaned the boutique.

The Arbitrator finds that Petitioner was temporarily totally disabled from February 14, 2013 (the date of Petitioner's first visit to Dr. Wojnarski) through April 30, 2013, a period of 10 6/7 weeks. The Arbitrator declines to award temporary total disability benefits prior to February 14, 2013, despite Dr. Wojnarski's retroactive finding of disability starting February 1, 2013. There is no evidence indicating the Emergency Room physicians who evaluated Petitioner on February 2, 3, 7 and 11, 2013 imposed work restrictions.

In addressing temporary total disability, the Arbitrator notes that, while Respondent was never able to secure a Section 12 examination, it first requested such an examination in late April 2014, more than a year after Petitioner filed her claim. Respondent offered no reason for this delay. Nor did Respondent provide documentary evidence showing it gave Petitioner's counsel notice of the desired examinations. RX 1-3. At the hearing held before Arbitrator Steffen, Petitioner's counsel admitted receiving the last letter (RX 3), which directed Petitioner to go to Dr. Neri's office on September 8, 2014. Petitioner provided a credible explanation of the circumstances that caused her to run late on that date. Dr. Neri apparently declined to see her at that time and Respondent did not reschedule the appointment. On this record, and given that the Arbitrator is awarding no temporary total disability benefits after April 30, 2013, the Arbitrator declines to grant Respondent's renewed motion to dismiss.

The Arbitrator finds Petitioner's temporary total disability rate to be $150.00, based on the stipulated average weekly wage of $150.00 and the applicable minimum.

<u>Is Petitioner entitled to reasonable and necessary medical expenses?</u>

Based on the foregoing findings as to causation, reasonableness and necessity, the Arbitrator awards the following medical expenses, subject to the fee schedule:

John H. Stroger Jr. Hospital of Cook County (PX 6)	
2/2-3/13, Emergency Room	$ 2,679.00
2/7/13, Emergency Room	$ 2,775.71
	$ 173.00
2/8/13, cervical spine CT scan	$ 1,531.00
2/11/13, Emergency Room	$ 186.00
4/9/13, Emergency Room	$ 203.00
Wieslaw Wojnarski, M.D. (PX 2)	
2/14/13 – 6/15/13, office visits	$ 2,385.00
Neil Allen, M.D. (PX 10)	
4/22/13 – 5/13/13 (office visits and nerve block)	$ 1,233.00

The Arbitrator declines to award any of the other medical expenses claimed by Petitioner.

What is the nature and extent of the injury?

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. This section sets forth five factors to be considered in determining the nature and extent of an injury, with no single factor to be given more weight than any other. The Arbitrator assigns no weight to the first factor, any AMA Guides impairment rating, since neither party submitted such a rating. The Arbitrator also assigns no weight to the second factor, i.e., Petitioner's occupation. Petitioner testified she performed cleaning-related tasks for Respondent but provided no detail as to what those tasks entailed. The Arbitrator is thus unable to ascertain whether the restrictions suggested by therapist Buskirk would have prevented her from resuming her job for Respondent. The Arbitrator assigns some weight to the third factor, Petitioner's age (53) at the time of injury. From a statistical standpoint, Petitioner will not suffer the claimed effects of her injuries for as long as a younger individual. The Arbitrator assigns no weight to the fourth factor, "the employee's future earning capacity." Petitioner claims she was never able to resume working after the accident of February 1, 2013 but she based this claim on her subjective complaints and her unproved assertion that the accident was a cause of her subsequent fall at Stroger Hospital in July 2013. She did not acknowledge that Buskirk found her capable of resuming cleaning work, so long as she avoided climbing and significant overhead work. The Arbitrator assigns some weight to the fifth enumerated factor, i.e., "evidence of disability corroborated by the treating medical records," noting the results of the ENG Dr. Allen performed in May 2013.

The Arbitrator, having considered all of the foregoing, finds that Petitioner established permanency to the extent of 10% loss of use of the person as a whole, equivalent to 50 weeks of benefits under Section 8(d)2 of the Act. The Arbitrator finds Petitioner's permanency rate to be $150.00, based on the stipulated average weekly wage of $150.00 and the applicable minimum.

Is Respondent liable for penalties and fees?

Petitioner placed penalties and fees at issue on September 21, 2017 (Arb Exh 1) but never filed a petition for penalties and fees. T. 9/21/17, p. 10. There is no evidence indicating Petitioner made a specific demand for payment at any point prior to 2017. Given these circumstances, along with the relatively complex causation issues, the Arbitrator is unable to find that Respondent's denial of benefits was objectively unreasonable. The Arbitrator declines to find Respondent liable for penalties and/or fees.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Jarvis,

Petitioner,

vs. NO. 14WC 26114

Knight Hawk Coal, LLC.,

19IWCC0164

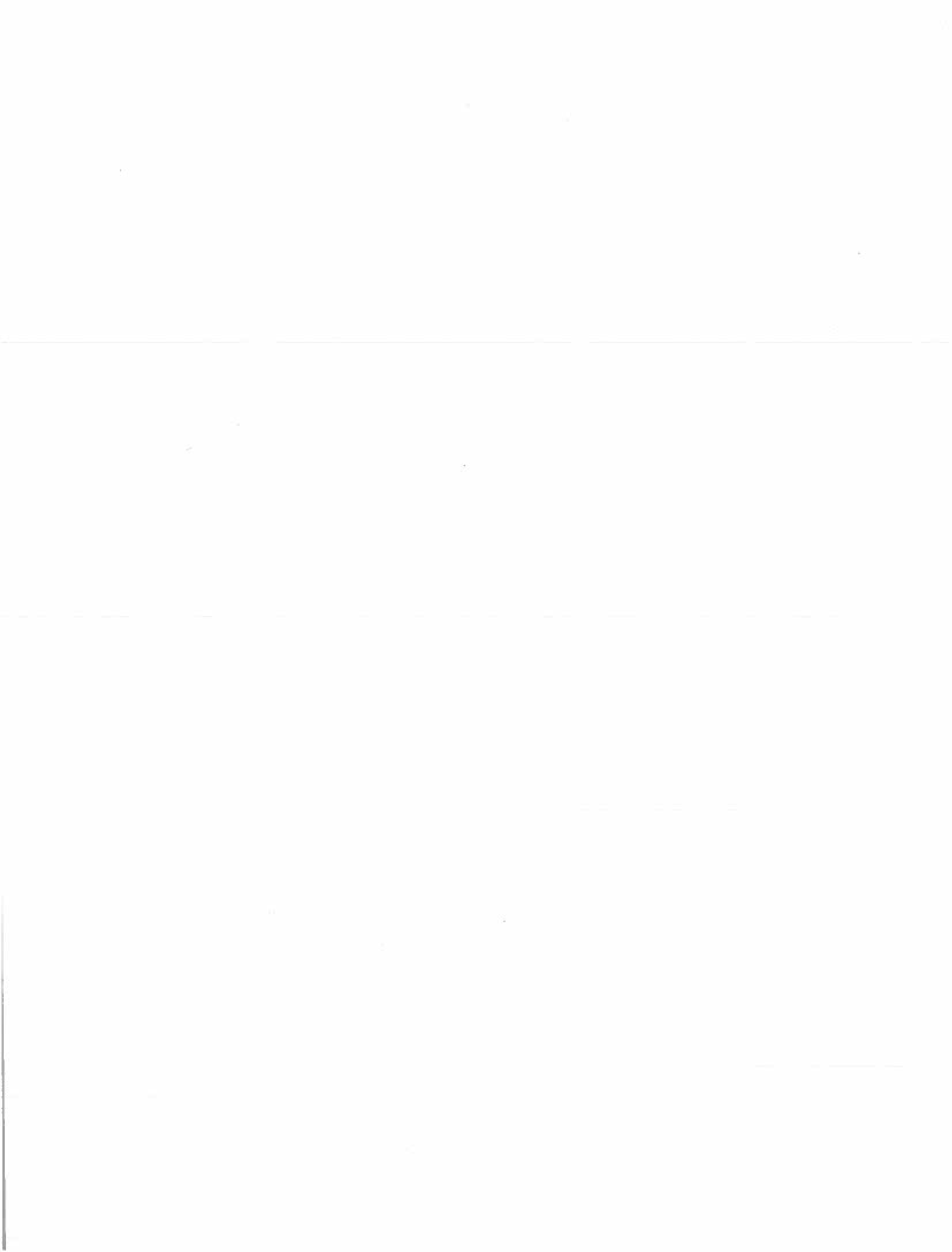
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of notice, occupational disease, legal error, evidentiary error, Section 1(d), Section 1(f) and Section 6(c), permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2018 is hereby affirmed and adopted.

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



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

DATED: MAR 15 2019
SJM/sj
o-3/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JARVIS, PAUL
Employee/Petitioner

Case# **14WC026114**

KNIGHT HAWK COAL COMPANY
Employer/Respondent

19IWCC0164

On 7/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

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

0693 FEIRICH MAGER GREEN RYAN
CHERYL L INTRAVAIA
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

19IWCC0164

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

PAUL JARVIS
Employee/Petitioner

Case # **14** WC **26114**

v.

Consolidated cases: ______

KNIGHT HAWK COAL COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **September 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. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other **Occupational disease, exposure, disablement, Sections 1(d)-(f), 6(c).**

FINDINGS

On **01/03/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date. Petitioner ***did not*** prove that he sustained an occupational disease which arose out of and in the course of employment.

Petitioner failed to prove a current condition of ill-being that *is* causally related to occupational exposure.

In the year preceding the injury, Petitioner earned **$82,985.76**; the average weekly wage was **$1,595.88**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

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

ORDER

The Petitioner has failed to prove that he has an occupational disease which either arose out of or in the course of his employment with the Respondent, or which is causally related to any exposure sustained in such employment with the Respondent.

No benefits are awarded.

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

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

Signature of Arbitrator

July 5, 2018
Date

JUL 6 - 2018

STATEMENT OF FACTS

Petitioner, 67 years old at the time of the hearing, testified that after three years of high school he obtained his GED and joined the Army, where he drove a truck from 1969 to 1971. Thereafter, Petitioner began working as an underground

coal miner, a job he worked for about 40 years. During that time he testified he was regularly exposed to coal dust, silica dust, rock dust, roof bolting glue fumes, and diesel fumes. He last worked as a miner in January 2014 in a position as a repairman for Respondent. He testified that he voluntarily retired in January 2014, and has not worked anywhere else since.

Petitioner testified he started working in the mines in 1974, with Ziegler Coal in Murdock, IL, as a rock duster, involving spraying coal with rock dust powder to prevent explosions, which he described as a very dusty job. After 6 months on the job, he became a general laborer, which involved shoveling coal from the ground to the conveyor belt, as well as shooting air at the face to loosen the coal, both of which generated coal dust. He became a repairman about two years later, which is the position he worked in the rest of his career. As a repairman, he would be involved in examining and fixing any and all mechanical equipment breakdowns, including continuous miners, roof bolting machines and shuttle cars, and this would be done underground. He sometimes would work with roof bolters, and he would also help operate machinery when others were on break.

Petitioner left Ziegler in 1991. He then worked for Eagle Valley for about 4 years as a repairman, then worked in the Sparta mine in 1996 to 1997, which included some roof bolting. This involved some drilling, and this would produce some dust, especially when plugging an auger. Some bolting involved the use of glue pins, some didn't. The pins would break when the bolt would be installed, and this would emit an odor. Petitioner next worked at Big Ridge for two to three months before returning to Eagle Valley as a repairman from 1998 to 2002. He then worked as a repairman back at Ziegler from 2002 to 2004, at Liberty in 2005, then at Pattaki from 2006 to 2008. He then worked as a repairman for Respondent Knight Hawk from 2008 to 2014, with the same described repairman job duties and exposures.

Petitioner testified he first noticed breathing problems when he was doing something that was hard and heavy, and he would have to take it easy. This has stayed the same or has become a bit worse since he left the mine. If he does strenuous activities like carrying groceries or push mowing the yard, he gets out of air and has to sit down and take it easy. Petitioner confirmed that his retirement from the mine was voluntary, and agreed that none of his retirement paperwork stated that he was leaving the mine due to a breathing problem. Petitioner confirmed his participation in the NIOSH chest x-ray program and stated that neither his treating physician (Dr. Morthland), nor his prior physician (Dr. Abedmahmoud), ever advised him to leave the mine due to a pulmonary condition.

Petitioner testified he never really said anything about his breathing difficulties to family physician, Dr. Morthland. Petitioner was not taking any breathing medications and was a life-long non-smoker. His does have other health concerns, including high blood pressure, Addison's disease and diabetes, for which he takes medications. Addison's was diagnosed in 1988, and Petitioner testified he has fatigue if he doesn't take medication for this.

Petitioner's medical records from Dr. Abedmahmoud (Rx6), Dr. Morthland (Rx7), Heartland Regional Medical Center (Rx8) and Herrin Hospital (Rx9) were placed into evidence along with the examination reports and deposition testimonies of Dr. Westerfield (Rx3 and Rx4) and Dr. Paul (Px1, Px2) as well as B-readings and curriculum vitae from Dr. Westerfield, Dr. Meyer, Dr. Paul and Dr. Smith (Rx1, Rx2, Px2) and the B-readings from NIOSH (Rx5).

Petitioner presented to Dr. Abedmahmoud on 1/7/04 for treatment for adrenal insufficiency and hypothyroidism. He was feeling well with an appropriate energy level. On 7/1/04, he returned, again feeling well, and he denied any significant complaints and his lungs. Cardiac sounds were unremarkable. He returned to Dr. Abedmahmoud on 1/3/05 with throbbing headaches, which he reported responded to aspirin and non-steroidal anti-inflammatory (NSAIDs) medications. He was diagnosed with primary hypothyroidism, adrenal insufficiency and headaches with elevated blood

pressure. He returned on 7/27/05, stating he was feeling well with no complaints. His lung and cardiac sounds were unremarkable. (Rx6).

Petitioner presented to Heartland Regional Medical Center on 1/22/06 with epigastric pain. He denied symptoms of chest pain, shortness of breath or cough. A CT of the abdomen showed inflammatory changes in the second part of the duodenum and gallstone pancreatitis was suspected. Petitioner's pulse oximetry was 98% on room air; his lungs were clear to auscultation bilaterally with no rales or rhonchi. A chest x-ray found normal heart size and clear lung fields. An esophagogastroduodenoscopy was performed. The assessment was questionable gallstone pancreatitis with epigastric pain, Addison's disease, hypothyroidism and hypertension. (Rx8).

A second chest x-ray, taken on 1/24/06, revealed no apparent acute chest pathology. (Rx8). Surgery revealed duodenitis, gastritis, and papillary stenosis with no evidence of bile duct stones. (Rx6). A 1/25/06 repeat CT scan of the abdomen noted the pulmonary fields were clear. The film also revealed a large paraduodenal mass that was 8-10 cm in the abdomen. (Rx6; Rx8). Petitioner was discharged on 1/27/06, and follow up care was planned at St. Louis University. (Rx6) Petitioner returned to Heartland Regional Medical Center the next day, experiencing nausea, vomiting and recurrence of his epigastric pain. He was again discharged on 1/30/06, and referred for treatment in St. Louis. (Rx6; Rx8).

A 3/14/06 abdominal CT scan continued to reveal an abnormality in the pancreas and duodenal sweep, while 6/21/06 films indicated Petitioner's lung bases were unremarkable with no focal infiltrate or effusion. A 4-cm mass in the pancreatic head with multiple septa was seen. Dr. Abedmahmoud wrote a 7/24/06 letter stating Petitioner was under his care for adrenal insufficiency and Petitioner was "physically able regarding pulmonary function to work to full capacity." A 7/31/06 CT scan noted decreased size in the pancreatic mass. 2/12/07 repeat testing noted the lung bases appeared clear. Petitioner returned to Dr. Abedmahmoud on 7/17/07 with no specific complaints. His lung sounds were unremarkable. An 8/6/07 CT scan of the abdomen revealed the lung bases were clear and interval resolution of the density seen on the head of the pancreas. (Rx6; Rx8).

A chest x-ray taken as part of a pre-employment physical on 8/20/08 revealed normal sized cardiac silhouette and no evidence of active pulmonary disease. Petitioner returned to Dr. Abedmahmoud on 7/13/09, and his lungs were clear. The diagnoses remained hypertension, adrenal insufficiency and hypothyroidism. Petitioner returned to Dr. Abedmahmoud on 1/12/10 with pain in his left fifth finger, and examination reflected his lung sounds were unremarkable. On 7/13/10, Petitioner followed up with Dr. Abedmahmoud for adrenal insufficiency and hypothyroidism, and had complaints of fatigue and sleeplessness. Again, his lung sounds were unremarkable. On 1/1/12, Petitioner advised Dr. Abedmahmoud that he had been feeling well overall. His blood pressure was fairly well controlled and his lung sounds were unremarkable. His lungs were clear to auscultation bilaterally when he returned on 7/11/12 with complaints of weakness and decreased blood pressure. He was started back on Norvasc. (Rx6).

Petitioner followed up with Dr. Abedmahmoud on 1/2/13, 7/3/13, 12/20/13 and 3/18/14, and each time examination indicated his lung sounds were unremarkable, with no respiratory complaints noted. Petitioner left the mine employment on 1/3/14 (see Arbx2 and Petitioner's testimony). On 3/18/14, Petitioner had some abnormal lab results and his wife stated Petitioner had not been feeling well lately and complained of weakness, dizziness, polyuria and polydipsia. His blood sugar was at 315 and his thyroid functions were abnormal with a high TSH and high T4. His lungs revealed no rales, wheezes or rhonchi. He was diagnosed with Type 2 diabetes, adrenal insufficiency, fatigue/weakness and hypothyroidism. (Rx6).

Petitioner presented as a new patient to Dr. Morthland on 5/13/14. He stated that he felt well but fatigued easily. His history of diabetes, hypertension, hypothyroidism and Addison's disease was noted. His pulse oximetry was 98% on room air. His lungs exam revealed normal excursion with symmetric chest walls, quiet, even and easy respiratory effort with no use of accessory muscles, no chest deformities, normal resonance, no flatness or dullness, non-tender and normal tactile fremitus and on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance. The assessment was Addison's disease, hypothyroid, and generalized weakness. Petitioner returned to Dr. Morthland on 5/28/14, advising that the onset of fatigue was gradual beginning nine months earlier and occurred constantly if he did any physical activity that involved much time. Dr. Morthland noted that Petitioner was a non-smoker and that his lungs revealed normal excursion with symmetric chest walls, quiet, even and easy respiratory effort with no use of accessory muscles, no chest deformities, normal resonance, no flatness or dullness, non-tender and normal tactile fremitus and on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance. The assessment was diabetes, generalized weakness, hypothyroid and Addison's disease. (Rx7).

Pulmonary function testing was performed on 6/2/14. This revealed a moderately impaired FEV1 of 2.44 L (71% predicted), an FVC of 3.72 L (91% predicted) and an FEV1/FVC ratio of 63%. There was a 310 mL and 13% improvement in the FEV1 with bronchodilator. The lung volumes showed no evidence of any hyperinflation with FVC of 3.78 L (92% predicted), a residual volume of 2.39 L (105% predicted) and a total lung capacity of 6.17 L (91% predicted). The RV/TLC was elevated at 114% consistent with air trapping. The uncorrected diffusion capacity was unimpaired/increased at 113% of predicted. There were no previous studies available for comparison. Dr. Morthland's office called Petitioner and informed his wife that Petitioner had some improvement in breathing after bronchodilator and if he would like to have a bronchodilator he could. Petitioner's wife advised that Petitioner was feeling better since stopping blood pressure medicine and they would wait to discuss medications at the next visit. Petitioner had a nuclear exercise stress test performed on 6/4/14. The resting ECG was abnormal due to inferior T wave inversion. The functional capacity was normal and the heart rate response and blood pressure response to exercise were appropriate. Bruce Protocol Myocardial Perfusion Imaging was also performed, and no abnormalities were reported. (Rx6; Rx7; Rx9).

Petitioner returned to Dr. Abedmahmoud on 6/24/14, and the doctor noted that all of Petitioner's testing was on target. His lungs were clear to auscultation. He discussed a different possibility for complaints since Dr. Morthland obtained both breathing and stress testing that both appeared within normal limits. (Rx6). Blood work was scheduled. On 8/28/14, Petitioner presented to Dr. Morthland with complaints of shortness of breath. His chest and lung exam revealed normal excursion with symmetric chest walls, quiet, even and easy respiratory effort with no use of accessory muscles, no chest deformities, normal resonance, no flatness or dullness, non-tender and normal tactile fremitus and on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance. The assessment was fatigue, Addison's disease and hypothyroid. (Rx7). On 12/23/14, Petitioner presented to Dr. Abed with cough and congestion for the previous week. He had no dizziness or weakness, and his lungs were clear to auscultation bilaterally. He was diagnosed with acute bronchitis and medication was prescribed. (Rx6).

On 2/23/15, Petitioner presented to Dr. Morthland. He had good energy level and slept average of 7 hours a night. Petitioner advised that his December labs were normal, but at times he could be up doing something and just did not feel well. He felt as if his blood pressure dropped and complained of his blood pressure getting too low on occasion and feeling fatigue. On exam, his chest and lungs revealed normal excursion with symmetric chest walls, quiet, even and easy respiratory effort with no use of accessory muscles. Dr. Morthland recommended cutting Petitioner's Lisinopril into 1/4 tablets on the days he felt dizzy and weak. Petitioner returned to Dr. Morthland on 5/13/15 and stated that he had been feeling pretty good since he was not taking the Lisinopril/HCTZ due to hypotensive episodes. His lungs revealed no cough, shortness of breath or wheezing. He had quiet, even and easy respiratory effort with no use of accessory

muscles. Petitioner advised that his blood pressure dropped too low after mowing the yard or doing any physical activity and he did not take his blood pressure medicine. Dr. Morthland noted Petitioner's pressure was elevated but stated that was due to him taking hydrocortisone. He advised Petitioner to take ½ additional hydrocortisone on the days that his pressures dropped too low. (Rx7).

Petitioner returned to Dr. Abedmahmoud on 6/23/15 for follow up on adrenal insufficiency, hypothyroidism, hypertension and hyperglycemia. His lungs were clear to auscultation. He was advised on how to take his medications during hypotensive episodes and times of stress. (Rx6). Petitioner returned to Dr. Morthland on 8/6/15, stating his symptoms of weakness were mild and improving. He did not have chest pain, claudication, near syncope, syncope, paresthesias or edema. Dr. Morthland found that Petitioner, overall was doing well, and sometimes if he did too much he could tell and he would just sit down to rest. (Rx7). On 12/21/15, Petitioner presented to Dr. Abedmahmoud. He was doing well and was generally healthy with no change in strength or exercise tolerance. Petitioner's lungs were clear with no rales, rhonchi or wheezes. Petitioner advised of no syncope, orthopnea, dyspnea, wheezing, hemoptysis or cough. (Rx6). Petitioner returned to Dr. Morthland on 1/5/16 for a hypothyroidism check-up, and the report mainly addresses his blood pressure, noting his pressure would drop with activity. His chest and lung exam was normal. The assessment was stable hypotension. (Rx7).

B-reader Dr. Smith's 6/11/14 review of Petitioner's x-rays, at the request of his counsel, indicated a CWP profusion rate of 1/0, with no chest wall plaques or calcifications. His impression was simple CWP with small opacities, primary p, secondary p, upper, mid and lower zones bilaterally, profusion 1/0. (Px2). Dr. Paul interpreted this x-ray as having fibronodular lesions throughout both lung fields compatible with CWP. (Px1). These opinions were obtained at the request of the Petitioner.

B-reader Dr. Meyer reviewed two separate chest x-rays of the Petitioner on behalf of the Respondent. His 10/14/14 review of 6/11/14 films indicated no radiographic findings of CWP. His 3/5/15 review of 2/3/15 films also indicated normal findings without evidence of CWP. (Rx1). The Respondent obtained this opinion, along with that of Dr. Westerfield, who also opined that chest films showed no signs of CWP.

Respondent's Exhibit 5 constituted a number of prior chest x-rays obtained from Petitioner as part of the NIOSH program between 1975 and 2006. None of these reflected B-reader determination of the existence of CWP. (Rx5).

Dr. Paul examined Petitioner on 12/16/14. (Px1). He was informed that Petitioner was 61 years old and worked in the coal mines underground from March 1974 to January 2014 other than one year. Petitioner reported getting short of breath walking about 4 flights of stairs and approximately one mile, but he did not have any significant coughing, wheezing or other shortness of breath. He was a life-long non-smoker. Chest examination revealed normal inspiratory and expiratory effort with no chest wall deformities and no dullness to percussion. Pulmonary function testing revealed an FEV1 of 2.57 (75% predicted) and an FVC of 3.40 (74% predicted). The FEV1/FVC ratio was 76% which was 101% of predicted. Methacholine challenge revealed an FEV of 2.49 (72% predicted), an FVC of 3.29 (71% predicted) and an FEV1/FVC ratio of 76 which was 101% of predicted. Diffusing capacity was 72% predicted. Dr. Paul interpreted the testing as indicating a mild obstruction at the baseline with a 13% fall in the FEV1 after Methacholine suggesting mild underlying bronchitis. Dr. Paul diagnosed simple coal worker's pneumoconiosis and mild obstructive airway disease. (Px1).

At the Respondent's request, Dr. Westerfield examined Petitioner on 2/3/15. (Rx3). Dr. Westerfield reviewed the reports of Drs. Paul, Smith and Meyer, as well as Petitioner's medical records from Dr. Abedmahmoud, Dr. Morthland, Heartland Regional Hospital, Herrin Hospital and NIOSH (National Institute for Occupational Safety and

Health). Dr. Westerfield had a chest x-ray taken and his review indicated no evidence of CWP. (Rx3). Dr. Meyer subsequently reviewed the 2/3/15 chest x-ray and concurred it reflected no evidence of CWP. (Rx1).

Dr. Westerfield's pulmonary function testing revealed an FEV1 of 2.47 (72% predicted), an FVC of 3.43 (78% predicted) and an FEV1/FVC ratio of 72% (92% of predicted). Post-bronchodilator testing revealed an FEV1 of 2.73 (80% predicted), FVC of 3.78 (87% predicted and FEV1/FVC ratio of 72% (92% predicted). The testing took into account Petitioner's age (65) and height (8.25 inches). Diffusing capacity was 84% of predicted. The arterial blood gas testing revealed a pCO2 of 42.0 and pO2 of 91. After review of the chest x-ray, exam findings, data results and the medical records, Dr. Westerfield opined that Petitioner did not have simple or complicated CWP, but did have reversibility on the pulmonary function testing consistent with asthma. He indicated that asthma is a disease of the general population, and was not caused by or due to coal dust inhalation. He stated that Petitioner did not have any pulmonary impairment or respiratory disability and had normal pulmonary function testing and excellent arterial blood gas. In his review of Dr. Paul's testing, Dr. Westerfield explained that Paul's testing was based on a different height, and if the correct height were used, that testing would also have been in the normal range. Dr. Westerfield opined that Petitioner's breathing capacity would allow him to return to his previous position in the coal mine or other employment with equal energy requirements. (Rx1).

Dr. Paul was deposed on 1/25/16. (PX1). He testified he was the medical director of St. John's respiratory therapy and clinical assistant professor of medicine at SIU Medical School where he taught internal medicine and pulmonary. He was a practicing physician at the Central Illinois Allergy and Respiratory Clinic which had six doctors specializing in allergy and pulmonary disease and they took care of patients with respiratory diseases, critical care, allergy diseases and some internal medicine problems. Dr. Paul wrote a book concerning asthma. He stated he had 5,000 patients in his census and performed chest x-rays and read them when it was necessary, indicating he would read 15-20 chest x-rays a day, possibly 5,000 per year, and interpreted pulmonary function testing at the same frequency. Dr. Paul treated coal miners for coal mine induced lung disease back in the '70s, and examined coal miners for Federal black lung claims as well as state black lung claims. (Px1).

Dr. Paul's 12/16/14 examination of Petitioner indicated no significant coughing or wheezing, noting the report's indication of no shortness of breath should be deleted, as the Petitioner reported shortness of breath with four flights of stairs or a mile of walking. He explained that Petitioner's primary Addison's disease involved adrenal failure, which was treated with hydrocortisone and fludrocortisone. Petitioner was not taking any pulmonary medications. He was taking Synthroid for hypothyroidism, Lisinopril and Hydrochlorothiazide for hypertension and Celebrex for symptomatic arthralgia. Physical examination of the chest was normal. Pulmonary function testing revealed a mild decrease in the forced vital capacity and mild decrease in FEV1, a moderate decrease in the fatigue expiratory flow rate and a borderline low carbon monoxide diffusing capacity. Dr. Paul opined that Petitioner had CWP due to being in the coal dust environment in the mines. He found that Petitioner had an obstructive airway disease caused by coal dust exposure, and further opined that Petitioner had chronic bronchitis which caused his obstructive airways disease. He testified that chronic bronchitis can exist despite negative pulmonary function testing. Dr. Paul noted a 13 percent fall after eight breaths of methacholine, which suggested Petitioner had some mild reactive airways disease, not in the asthmatic range, but in the range you would find in someone with bronchitis. He testified that the cause of the bronchitis "had to be coal dust." (Px1).

Dr. Paul testified that, with all three of these diagnoses, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He believed Petitioner had clinically and physiologically significant pulmonary impairment, as well as radiographically apparent CWP, caused by exposure to coal dust. As a result, he opined that Petitioner was totally disabled from working as a coal miner due to CWP, obstructive airways

disease and chronic bronchitis. Dr. Paul stated that if, hypothetically, Petitioner's treating physician diagnosed reactive airways disease based on post-bronchodilator testing that showed an increase in the FEV1 of 13% and 310 milliliters he would not have any reason to disagree. Any coal dust in Petitioner's lungs will remain there for his lifetime. A person can have CWP despite a negative x-ray reading, and the only way to diagnose this would be biopsy or autopsy. (Px1).

On cross examination, Dr. Paul stated that he has examined approximately 250 coal miners on behalf of Petitioner's counsel in the last five years, and had reviewed about twice as many chest x-rays during that time for the attorney's law firm. However, he testified that he found the majority of x-rays read for this law firm did not reflect CWP. Dr. Paul agreed he did not review any of Petitioner's medical records. Dr. Paul defined chronic bronchitis as involving someone that was coughing for at least two months, for two years in a row, and agreed that Petitioner did not report any significant coughing. Dr. Paul stated that his definition of "clinical" impairment would involve somebody that had symptomatology when he was doing activities of daily living, such as walking or going up stairs, while "physiological" impairment would involve someone who had decreased pulmonary function studies and/or a positive methacholine stimulation test that showed some reactive airways disease. (Px1).

In opining that Petitioner was permanently disabled from coal mining, Dr. Paul agreed he was not saying that Petitioner was totally disabled due to pulmonary impairment, he was saying that he returning to work in a coal mine could make his CWP and/or bronchitis worse. He agreed Petitioner's pulmonary impairment would be classified as mild. Petitioner did not report any difficulties performing his job at the mine. Dr. Paul did not obtain chest x-rays when he examined Petitioner, he reviewed films the Petitioner brought in from another source. He agreed he is not a board-certified radiologist or a "B-reader." His review of the chest x-rays noted fibronodular lesions throughout both lung fields compatible with CWP. Dr. Paul does not use the ILO classification system to diagnose black lung disease." Id. When asked if he had to classify Mr. Jarvis' chest film under the ILO classification system. While he opined that the presence of CWP nodules in Petitioner's lungs is at least moderate, he testified that "mild" or moderate" is irrelevant, as you either have CWP or you don't: ". . .how much it bothers you depends on how long you have it and how long you live." Dr. Paul agreed that CT scans gave a better interpretation of lung disease than a chest x-ray for the most part. He did not look at any CT scans for Petitioner. Dr. Paul agreed that, physically, but for the CWP diagnosis, Petitioner's other pulmonary conditions would not prevent him from physically performing his regular job at the coal mine. Dr. Paul opined that Petitioner's pulmonary function studies showed no evidence of asthma. (Px1).

Dr. Westerfield was deposed on 3/4/16. (Rx4). Dr. Westerfield is board certified in pulmonary medicine and has been a B-reader since 1991. He explained that a B-reader is required to pass an examination given by NIOSH, involving the review of x-rays, and re-certify every four years with another test, which he last did in 2015. Dr. Westerfield had two practices: sleep disorders and an occupational lung disease practice where he did independent medical evaluations for any type of respiratory injury related to work, including black lung, asbestos, occupational asthma, or anything inhaled in the workplace that may injure them. He also reviewed records and interpreted chest x-rays. Dr. Westerfield performed independent medical examinations for the federal Department of Labor and the State of Kentucky, for defense and plaintiffs' attorneys and also for some insurance companies. (Rx4).

Dr. Westerfield reviewed Petitioner's prior medical records and examined him on 2/3/15 at the Respondent's request. Dr. Westerfield reviewed Petitioner's 6/11/14 chest films. Petitioner's respiratory history was remarkable for being negative in that he had not been treated for respiratory disease and he never smoked cigarettes. He was treated for hypertension and adrenal insufficiency, and Dr. Westerfield indicated that neither of those conditions caused or created pulmonary symptoms. Petitioner was not taking any medication for lung disease. His work history was significant for working 38 years in the coal mining industry, all underground, with the last year worked being 2014. Dr. Westerfield's examination of Petitioner was "quite normal", with a normal chest x-ray, no evidence of cyanosis or clubbing, and some

slight edema in the right lower extremity. On exam, the doctor was looking for pulmonary abnormalities, like wheeze and rhonchi, which were airways sounds, or rales, which were the very fine alveolar sounds. He also looked for the absence of breath sounds or decreased breath sounds. None of those were present. In addition to the physical examination, Dr. Westerfield obtained a chest x-ray, electrocardiogram and pulmonary function studies, which included spirometry, lung volume measurements, diffusing capacity and arterial blood gases. (Rx4).

Dr. Westerfield personally reviewed the chest x-ray, and opined that it was completely negative, with nothing to suggest CWP. There were no pleural abnormalities. He testified: "There are not any abnormalities at all, but there are certainly none that would represent (CWP)." Dr. Westerfield also reviewed the Petitioner's prior NIOSH chest x-rays, which were interpreted as negative by the NIOSH readers. The readers from NIOSH used the same ILO – International Labor Organization - classification system used by Dr. Westerfield. (Rx4).

Dr. Westerfield explained that spirometry is a measure of lung mechanics, the ability to take air in and blow it out. He testified this is particularly important with work-related issues, because you have to be able to move the air faster while working, so the mechanics of the lungs needed to be adequate to move that air in an exertional capacity. Petitioner provided full effort during his testing. Dr. Westerfield noted a height discrepancy between Dr. Paul's testing and his own with Dr. Paul noting a height of 70 inches and Dr. Westerfield noting a height of 68.25 inches. He explained that this is relevant because if you took the same values – absolute values – a person who is taller would have a lower predicted value, because height was considered as well as the age and the sex, for selecting the predicted values. If the height varies, the higher height would have a lower predicted. Dr. Westerfield testified that Dr. Paul's test result values were really exactly the same as Dr. Westerfield's values, but the predicted values were different due to the height discrepancy. He testified that a height measurement in his office is taken without shoes on. (Rx4).

Pulmonary function testing indicated the forced vital capacity (FVC) was 78 percent predicted pre-bronchodilator and it improved to 87% predicted. The FEV1 was 72 percent predicted and improved to 80 percent predicted, so Mr. Jarvis normalized with the inhaled bronchodilator. Dr. Westerfield testified that the significance of the bronchodilator improvement suggested an element of bronchospasm which showed some reversibility to the lung function, which indicated he had some asthma. For pulmonary function testing, the predicted normal ranged from 80 percent to 120 percent of predicted. Dr. Westerfield explained that diffusion capacity measured the ability of the body to take oxygen out of the air through the lungs and put it in the bloodstream; the oxygen diffused across into the bloodstream. All three diffusing capacities reviewed were normal because the predicted normal for diffusion capacity was 70 percent and above, not 80 percent, due to more error in the diffusing capacity measurement. Lung volumes looked at total lung capacity and residual value, which was the amount of air that was left in the lungs after all the air was blown out. Petitioner's total lung capacity, which was the TLC measurement, was slightly reduced at 75 percent. The arterial blood gas testing revealed the endpoint of what the lungs did, i.e. the amount of oxygen the lungs took in and the amount of carbon dioxide they put out. Petitioner had excellent arterial blood gases and his pO2 of 91 was very good. (Rx4).

Based on the pulmonary function, arterial blood gas and spirometry testing, Dr. Westerfield found no evidence of any pulmonary condition. He noted that Dr. Pineda's flow rates improved and the FEV1 did improve with the bronchodilator. He also noted that Dr. Paul did not do a post-bronchodilator study, but did a methacholine challenge test, which does not assess for CWP, but rather for things like occupational asthma. The bronchodilator testing showed a possibility of asthma in Petitioner. Dr. Westerfield testified that asthma is not caused by coal dust exposure. (Rx4).

Dr. Westerfield found no evidence of shortness of breath or chronic bronchitis when he examined Petitioner. He provided the same general basis for diagnosing chronic bronchitis as Dr. Paul, and opined that Petitioner did not have any cough so he could not have chronic bronchitis. Acute bronchitis is something everyone experiences. After his review

of all the reports, the records, the chest x-rays and the testing. Dr. Westerfield opined that Petitioner did not suffer from either simple or complicated CWP. Petitioner did not have a pulmonary condition based given all the normal pulmonary function studies. Given his improvement with the inhaled bronchodilator, he opined that Petitioner could have an element of asthma, but noted there was no clinical history of asthma and he had not been treated for asthma. He further opined that even if the Petitioner did have asthma, it was not due to coal dust because coal dust does not cause asthma. Dr. Westerfield found that Petitioner had no pulmonary impairment and thus had the pulmonary capability to work as a coal miner or other jobs involving the same physical exertion requirements. (Rx4).

On cross examination, Dr. Westerfield agreed that Petitioner's 38-year history of underground coal mining was sufficient to cause a mining-related lung disease. He testified that it did not make any difference if opacities in Petitioner's lungs were round or irregular, sized between one-half millimeter or one millimeter, or in certain lung zones in terms of looking for CWP. The only question is whether there were sufficient opacities consistent with CWP. He testified that the great majority of coal mine workers do not get CWP – "only a few percent actually get pneumoconiosis." He agreed that coal dust could likely be seen in the lungs of anyone who has worked in a coal mine. He agreed its possible for a person to have CWP despite a normal chest x-ray, including Petitioner. He agreed it's possible that someone could have latent CWP that could manifest itself after leaving employment in the mines. (Rx4).

Dr. Westerfield agreed that Petitioner had some reversibility with bronchodilator that suggested he might have some asthma, and this reversibility was even more pronounced with Dr. Pineda's testing. However, he again testified that any reactive airways disease, including asthma and bronchospasm, was not caused by coal dust. Dr. Westerfield agreed there were other things in a mine, i.e., irritants like fumes from roof bolting or diesel fumes, that could bother a sensitive person. He testified that a lot of things in the workplace that can contribute to bronchitis: "People are sensitive to things that they inhale and they can develop chronic bronchitis from those things." A lot of times when they leave that environment, the symptoms improve. (Rx4).

Dr. Westerfield agreed that he Petitioner had a mild obstructive ventilatory defect that converted to normal following bronchodilator administration which brought the FEV1 up to 80 percent, which was the same result in Dr. Pineda's testing. Again, Petitioner did not say anything about asthma, but his medical records revealed no treatment for asthma. He agreed Petitioner underwent pulmonary function testing with Dr. Pineda for purposes of treatment. Dr. Westerfield agreed that antibiotics that had been prescribed to Petitioner in the medical records can be used to treat pulmonary conditions, as well as urinary tract infections, skin infections, sinusitis or ear infections: "there are a number of things." (Rx4).

On re-direct exam, Dr. Westerfield reiterated there was no evidence of emphysema, COPD or bronchitis in Petitioner. He further stated there was no evidence of industrial or occupational bronchitis. Petitioner had no irritant condition - if he had, it would have manifested at the time of his examination. Dr. Westerfield stated that the FEV1/FVC ratio was 72 which was ninety-two percent of predicted and was within the range of normal. Short of pathological evaluation, the number one test used to evaluate someone for CWP is chest x-ray. Functional impairment is best measured by pulmonary function testing. On re-cross, Dr. Westerfield admitted that COPD, emphysema, and chronic bronchitis all manifest themselves as an objective ventilatory defect, but clarified that only asthma demonstrated a reversible airway obstruction. (Rx4).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID THE PETITIONER SUSTAIN AN OCCUPATIONAL DISEASE DUE TO EXPOSURE THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT WITH THE RESPONDENT, and (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE OCCUPATIONAL EXPOSURE, THE ARBITRATOR FINDS AS FOLLOWS:

"The term 'Occupational Disease' means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence. An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists; . . ." 820 ILCS 310/1(d).

Section 1(d) also states as follows: "The employer liable for the compensation in this Act provided shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease claimed upon regardless of the length of time of such last exposure, except, in cases of silicosis or asbestosis, the only employer liable shall be the last employer in whose employment the employee was last exposed during a period of 60 days or more after the effective date of this Act, to the hazard of such occupational disease, and, in such cases, an exposure during a period of less than 60 days, after the effective date of this Act, shall not be deemed a last exposure. If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment."

Sections 1(e) and 1(f) state:

"(e) "Disablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body, or the event of becoming disabled from earning full wages at the work in which the employee was engaged when last exposed to the hazards of the occupational disease by the employer from whom he or she claims compensation, or equal wages in other suitable employment; and "disability" means the state of being so incapacitated.

(f) No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease, except in cases of occupational disease caused by beryllіosis or by the inhalation of silica dust or asbestos dust and, in such cases, within 3 years after the last day of the last exposure to the hazards of such disease and except in the case of occupational disease caused by exposure to radiological materials or equipment, and in such case, within 25 years after the last day of last exposure to the hazards of such disease."

According to the Request for Hearing form (Arbx1), Petitioner's last date of exposure was on 1/3/14. His claim was filed on 8/1/14 (Arbx2). Pursuant to 820 ILCS 310/6(c), Petitioner's claim is applicable to any disease caused by coal

dust exposure. In the case at bar, the medical evidence included diagnoses of coal workers' pneumoconiosis, obstructive airways disease in due to chronic bronchitis, mild obstructive airways disease due to asthma along with complaints of shortness of breath and fatigue.

1. *Coal Workers' Pneumoconiosis (CWP)*

As both Dr. Paul and Dr. Westerfield have testified to, CWP can be diagnosed pathologically or radiographically. There is no pathological evidence in this case, as it would involve a biopsy or autopsy.

Chest x-rays of the Petitioner dated 1/15/75, 2/6/81, 1/13/89, 8/28/02 and 8/3/06 were reviewed by NIOSH B-readers, and all were interpreted as negative for CWP. (Rx5).

While the evidence indicates that a higher percentage of coal mine workers are determined to have contracted CWP via autopsy pathological evaluation, Dr. Westerfield testified that a small percentage of mine workers actually contract CWP. Based on this evidence, it is clear that the simple fact of an employee working in a coal mine does not mean that the employee will have CWP.

Petitioner's medical records revealed a chest x-ray dated 1/22/06 that found clear lung fields. A chest x-ray taken 1/24/06 revealed no apparent acute chest pathology. A CT scan of the abdomen dated 1/25/06 noted the pulmonary fields were clear. A CT scan of the abdomen dated 6/21/06 found Petitioner's lung bases were unremarkable with no focal infiltrate or effusion. (Rx8). A CT scan of the abdomen dated 2/12/07 indicated the lung bases appeared clear. (Rx6; Rx8). An 8/20/08 chest x-ray revealed well-expanded lungs that were clear bilaterally with no evidence of active pulmonary disease. (Rx9). There is no evidence that any of the radiologists reviewing these films, nor any of Petitioner's treating physicians, ever diagnosed him with CWP or referred him for consultation regarding CWP.

As noted above, Petitioner's 6/11/14 chest x-ray was reviewed by Dr. Smith, Dr. Paul, Dr. Westerfield and Dr. Meyer. Dr. Smith is a B-reader and board-certified radiologist; Dr. Paul is neither and does not use NIOSH's ILO system for pneumoconiosis classification. Both Dr. Smith and Dr. Paul found the film positive for coal workers' pneumoconiosis with Dr. Smith classifying the film as 1/0, p/p, all lung zones, and Dr. Paul classifying the film as reflecting moderate pneumoconiosis. (Px1 & 2). Dr. Westerfield and Dr. Meyer, both B-readers, with Dr. Meyer also board certified in radiology, determined that the films were negative for CWP. (Rx1 & 2).

A chest x-ray dated 2/3/15 was reviewed by Dr. Westerfield and Dr. Meyer, and both interpreted the film as negative for CWP. (Rx1; Rx3).

While there is conflict with the 6/11/14 readings, the remainder of the chest x-rays, taken both before and after that date, failed to reveal any diagnosis of CWP and none of Petitioner's treating physicians diagnosed the disease. Therefore, the Arbitrator is unable to determine that the preponderance of the radiological and medical evidence supports a finding of coal workers' pneumoconiosis. These cases are very difficult for an Arbitrator to make findings for given the discrepancies of positive and negative findings of different doctors reviewing the exact same films. However, the burden remains the Petitioner's to show that it is more likely than not that he has CWP. The Petitioner in this case has failed to do so by the greater weight of the evidence. To determine that the Petitioner has CWP simply based on his coal mining experience would be very speculative. Here, the greater weight of the evidence indicates the Petitioner does not have radiographic evidence of CWP.

2. *Obstructive airways disease caused by chronic bronchitis.*

Dr. Paul defined chronic bronchitis as somebody that was coughing for at least two months two years in a row. A similar definition was provided by Dr. Westerfield who stated that most pulmonary doctors would accept the definition as daily mucus production associated with coughing for three consecutive months of the year for two years. Dr. Westerfield further explained that acute bronchitis was something everyone experienced. Acute bronchitis involves an irritation of the bronchial tubes following an upper respiratory infection. His example was if you had a cold and you were coughing up mucus, you may have acute bronchitis.

Dr. Paul opined that Petitioner had an obstructive airways disease caused by coal dust exposure, and that Petitioner's chronic bronchitis caused his obstructive airways disease. However, Dr. Paul acknowledged that Petitioner did not report significant coughing. Further, there was no mention of any mucus production in Dr. Paul's report. Petitioner advised Dr. Westerfield that he did not have any cough. Based on this information, Dr. Westerfield found Petitioner could not have chronic bronchitis.

Dr. Westerfield's conclusion was consistent with Petitioner's medical records that denied cough on 1/22/06, 5/13/15 and 12/21/15. (Rx6; Rx7; Rx8). In the span of 12 years of medical records submitted into evidence, only one instance of coughing was reported by Petitioner on 12/23/14, which was almost a year after he retired from the mine. (Rx6). Dr. Abedmahmoud diagnosed Petitioner with acute bronchitis and prescribed Augmentin and Robitussin at that time. The medical records fail to provide any evidence of Petitioner's coughing and/or mucus production at a level as described by either physician as reflective of chronic bronchitis. The preponderance of the medical opinion evidence, comprised of both expert and treating physicians, fails to support a finding of obstructive airways disease caused by chronic bronchitis.

3. *Obstructive airways diseases caused by asthma.*

Dr. Paul, who wrote a book on asthma, found that based on his own testing, Petitioner did not asthma. (Px1). Dr. Paul stated that if Petitioner's treating physician diagnosed reactive airways disease based on post-bronchodilator testing that showed an increase in the FEV1 of 13% and 310 milliliters he would not have any reason to disagree. (Px1). Dr. Pineda's pulmonary function testing taken on 6/2/14 revealed a 310 mL and 13% improvement in the FEV1 with bronchodilator. (Rx6; Rx7; Rx9). Dr. Westerfield noted that Dr. Pineda's flow rates improved and the FEV1 did improve with the bronchodilator. Dr. Westerfield explained that the significance of the bronchodilator improvement suggested an element of bronchospasm and revealed there was some reversibility to the lung function which indicated Petitioner had some asthma. (Rx4).

There is conflict as to whether Petitioner had an obstructive airways disease caused by asthma. However, regardless of such finding, Dr. Westerfield testified that asthma was not caused by coal dust exposure. Petitioner's counsel indicated he agreed with this conclusion during Westerfield's deposition. There was no evidence submitted with a contrary conclusion. Petitioner's counsel did raise the issue of whether such asthma condition could have been aggravated by coal mine exposure. Again, however, the existence of asthma in the first place, based on the evidence ion the record, is tenuous at best. Therefore, the Arbitrator finds that the preponderance of the evidence failed to support a finding that Petitioner's obstructive airway disease caused by asthma, even if properly diagnosed, arose out of and in the course of his employment.

4. *Petitioner's symptoms of shortness of breath and fatigue.*

At the hearing, Petitioner complained of difficulty getting air and fatigue when he performed strenuous activity. Petitioner's medical records listed the cause as Petitioner's hypotension, i.e., drop in blood pressure, when exerting himself. This condition was treated by Petitioner's physicians with blood pressure medicine and steroids. On 7/24/06, Dr. Abedmahmoud indicated Petitioner was able to work to full capacity regarding his pulmonary function. Nothing was noted in this report about a lung problem or respiratory issues, so the Arbitrator believes there likely is some potential relationship between Petitioner's pulmonary function and his other co-morbidities, including renal insufficiency, or Addison's Disease. It would not make much sense for him to mention Petitioner's pulmonary function status at that point in time if this were not the case. There also were indications of complaints of fatigue that also appear related to Petitioner's Addison's Disease going back to 2010. None of Petitioner's treating physicians opined that Petitioner's shortness of breath, fatigue or hypotension stemmed from his coal mining exposures, or from any pulmonary or respiratory condition in general. Therefore, the preponderance of the evidence fails to support a finding that Petitioner's symptoms of shortness of breath and fatigue or his hypotension were caused by coal dust exposure.

5. *Conclusion*

The preponderance of the evidence fails to support a conclusion that Petitioner has the existence of any occupational disease arising out of and in the course of his employment as a result of his occupational exposure, either with Respondent or his prior mining employers. Therefore, the preponderance of the evidence fails to support a conclusion that Petitioner has any occupational disease.

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF DISABLEMENT; WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT; and WITH RESPECT TO ISSUE (O), DID THE PETITIONER TIMELY FILE HIS CLAIM WITH REGARD TO THE STATUTE OF LIMITATIONS / SECTION 6(C), THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings that the Petitioner failed to prove he has any causally related occupational disease, these issues are moot.

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

Based on the Arbitrator's findings that the Petitioner failed to prove he has any causally related occupational disease, this issue is moot.

WITH RESPECT TO ISSUE (O), SECTIONS 1(F) and 6(C) OF THE ACT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings that the Petitioner failed to prove he has any causally related occupational disease, these issues are moot.

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

Cory E. Trip,

Petitioner,

19IWCC0165

vs.

NO: 15WC035400

Steelcad Industrial Services,and Illinois State Treasurer as
Ex Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent IWBF herein and notice given to all parties, the Commission, after considering the issue(s) of accident, employment, causal connection, medical expenses, notice, Respondent-Employer's insured status, permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2018 is hereby affirmed and adopted.

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

obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent-Employer 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 either 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: MAR 15 2019
SJM/sj
o-3/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRIP, CORY E
Employee/Petitioner

Case# **15WC035400**

STEELCAD INDUSTRIAL SERVICES/STATE TREASURER AND EX OFFICIO OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

19IWCC0165

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

If the Commission reviews this award, interest of 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:

4852 FISHER KERKHOVER COFFEY ET AL
JASON D GREMMELS
1300 1/2 SWANWICK PO BOX 191
CHESTER, IL 62233

0000 STEELCAD INDUSTRIAL SERVICES
1270 JAMESTOWN RD
CUTLER, IL 62238

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

19IWCC0165

- [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

Cory E. Tripp
Employee/Petitioner

Case # 15 WC 35400

v.

Consolidated cases: n/a

Steelcad Industrial Services/State Treasurer and ex officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 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. [ ] 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. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Respondent's Insured Status

19IWCC0165

FINDINGS

On October 23, 2013, Respondents were operating under and subject to the provisions of the Act.

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

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, it was stipulated that Petitioner earned $n/a; and the Arbitrator determined that the average weekly wage was $350.00.

On the date of accident, Petitioner was 30 years of age, married with 3 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

Respondents are entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent, Injured Workers' Benefit Fund, shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 3, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent, Injured Workers' Benefit Fund, shall pay Petitioner permanent partial disability benefits of $330.00 per week for 16.7 weeks because the injury sustained caused the 10% loss of use of the left foot, as provided in Section 8(e) of the Act.

Petitioner's Petition for Penalties and Attorneys' Fees is denied.

The Illinois State Treasurer, ex officio custodian of the Injured Workers' Benefit Fund, was named as a Co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

June 3, 2018
Date

JUN 6 – 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 25, 2013. According to the Application, Petitioner sustained an injury to his left foot when a steel I beam landed on it. Petitioner subsequently filed an Amended Application which was identical to the Application he initially filed, but alleged a date of accident of October 23, 2013. In both Applications, the named Respondents were Steelcad Industrial Services and the State Treasurer and ex officio Custodian of the Injured Workers' Benefit Fund (Arbitrator's Exhibit 2).

At trial, no one appeared on behalf of Steelcad Industrial Services (hereinafter referred to as "Steelcad"). A representative from the Attorney General's office appeared on behalf of the Injured Workers' Benefit Fund (hereinafter referred to as "IWBF").

At trial, the IWBF disputed liability on the basis of employee/employer relationship, accident, notice and causal relationship. In regard to the average weekly wage, Petitioner alleged an average weekly wage of $516.92, which Respondent disputed. Petitioner also claimed Respondent was liable for various medical bills he incurred as a result of the accident as well as penalties and attorneys' fees. Petitioner did not claim that he was entitled to payment of temporary total disability benefits because the Respondent, Steelcad, continued to pay him his regular wages during the period he was off work. Finally, the IWBF disputed Steelcad's non-insured status (Arbitrator's Exhibit 1).

At trial, Petitioner testified he was employed by Steelcad as a sand blaster. Petitioner stated he was hired by Tim Fulkerson, the brother of Michael Fulkerson, the owner of Steelcad. Petitioner said he was always paid by a check which was left adjacent to a time clock at Steelcad's main building. Petitioner would usually work approximately 6:00 AM to 4:30 or 5:00 PM based upon what work was scheduled by Respondent. Petitioner stated he did have the option of working for other employers but chose not to do so. Steelcad provided the tools that Petitioner used while at work. Petitioner also tendered into evidence some pay stubs from Steelcad which identified Petitioner as an "employee" and included the usual withholding for federal/state income taxes, Social Security and Medicare. Petitioner also tendered into evidence copies of W-2 forms from Steelcad for 2013 and 2014 which also indicated withholding for federal/state income taxes, Social Security and Medicare (Petitioner's Exhibit 4).

In regard to the average weekly wage, Petitioner testified he was paid $14.00 per hour and usually worked 40 to 45 hours per week. The paycheck stubs tendered by Petitioner were for six two week pay periods. The paycheck stubs were not a complete record of Petitioner's earnings from Steelcad. Petitioner stated that they were the only pay stubs he could locate.

Only one of the pay stubs was for a two week period that preceded the date of accident. It was for September 29, 2013, through October 12, 2013. It indicated Petitioner worked a total of 50 hours and had a base hourly pay of $9.00 with incentive pay which increased it to $14.00 per hour. The other pay stubs were for various periods of time that occurred after the accident, but showed Petitioner working from 69 hours to 80 hours for two week pay periods (Petitioner's Exhibit 4).

At trial, Petitioner testified he had worked off and on for Steelcad for about one to one and one-half years prior to the accident. However, the paycheck stub for the period of September 29, 2013, through October 12, 2013, indicated that his current and year to date hours/earnings were identical (Petitioner's Exhibit 4).

The original Application was filed with the Commission on October 30, 2015, and the Amended Application was filed with the Commission on June 6, 2016. To date, no one has filed an entry of appearance on behalf of Steelcad and no one appeared on behalf of Steelcad in the case was on the arbitration docket or set for trial. Petitioner's counsel previously served a subpoena on Michael Fulkerson directing him to appear with proof of workers' compensation insurance for the date of October 23, 2013, on February 21, 2018, at the Commission's office in Collinsville. Fulkerson did not appear (Petitioner's Exhibit 5).

In regard to the accident of October 23, 2013, Petitioner testified that he had just finished sand blasting some I beams. One of the I beams fell off of a stack and struck Petitioner's left foot. Petitioner said he reported the accident to Respondent shortly after it occurred.

Petitioner initially sought medical treatment at Sparta Community Hospital on October 23, 2013. X-rays of Petitioner's left foot taken on that date were negative, but a CT scan performed on October 25, 2013, revealed an avulsion fracture of the base of the second metatarsal (Petitioner's Exhibit 2).

Petitioner was subsequently treated by Dr. Tony Chien, an orthopedic surgeon, who evaluated Petitioner on October 25, 2013. Dr. Chien agreed Petitioner had sustained a fracture of the base of the second metatarsal. He applied a cast and prescribed pain medication. When Dr. Chien remove the cast on December 13, 2013, he ordered physical therapy and authorized Petitioner to return to work with restrictions (Petitioner's Exhibit 1).

Dr. Chien continued to treat Petitioner and released him to return to work without restrictions on February 21, 2014. When he saw Petitioner on March 19, 2014, Petitioner was able to ambulate without a problem, but still had some pain in the ankle/foot joint (Petitioner's Exhibit 1).

Petitioner testified Steelcad paid him his wages for the time he was off work, but did not pay the medical bills. Petitioner worked light duty for Steelcad for approximately one to one and one-half months and continued to work for Steelcad until the business closed.

At trial, Petitioner testified he still has left foot symptoms, especially if he has to stand for long periods of time. He continues to take over-the-counter medication as needed for pain.

Conclusions of Law

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

The Arbitrator concludes that the Respondent, Steelcad, was operating under and subject to the Illinois Workers' Compensation Act and that there was an employee/employer relationship between Petitioner and Respondent, Steelcad.

In support of this conclusion the Arbitrator notes the following:

The evidence was clear that Respondent, Steelcad, was operating under and subject to the Illinois Workers' Compensation Act.

The IWBF took the position that Petitioner was not an employee, but an independent contractor. That position was not supported by the uncontroverted testimony of Petitioner. Petitioner testified he was an employee, worked hours scheduled by Steelcad, and Steelcad furnished the tools that he used. Further, Petitioner's pay stubs and W-2 forms indicated Petitioner was an employee and the usual federal/state income taxes, Social Security and Medicare were withheld.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner gave notice of the accident to the Respondent, Steelcad, within the time period prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that he informed the Respondent, Steelcad, of the accident on the date it occurred was unrebutted.

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 his left foot/ankle is causally related to the accident of October 23, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the accident and the left foot symptoms he experienced thereafter was unrebutted.

In regard to disputed issue (G) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner had an average weekly wage of $350.00.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he made $14.00 an hour and generally worked 40 to 45 hours per week. $14.00 an hour for 40 hours would computer to an average weekly wage of $560.00.

There was a minimal amount of documentary evidence in regard to Petitioner's wages. Several paycheck stubs were introduced into evidence; however, only one of them was for a two week period that preceded the date of accident. It indicated Petitioner had worked 50 hours for the two week period commencing September 29, 2013, through October 12, 2013.

It was also unclear as to exactly when Petitioner started working for the Respondent, Steelcad. Petitioner testified he had worked for Steelcad approximately one to one and one-half years prior to the accident of October 23, 2013; however, the aforementioned paystub indicated Petitioner had just begun to work for the Respondent, Steelcad, on September 29, 2013, as the year to date earnings were the same as the current pay period.

Given the fact that the only evidence of what Petitioner earned prior to the date of accident was his testimony and the one paystub, the Arbitrator concludes Petitioner is entitled to an average weekly wage of $350.00. This determination is based upon Petitioner having worked 50 hours per two week period or 25 hours per week at $14.00 per hour.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that the Respondent, IWBF, is liable for payment of the medical bills incurred therewith.

The Respondent, IWBF, shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 3 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the left foot.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner was employed as a sandblaster at the time of the accident. The exact nature of a sandblaster's job duties was not described in any great detail. The Arbitrator gives this factor minimal weight.

Petitioner was 30 years old at the time of the accident and 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.

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

Petitioner sustained an avulsion fracture of the base of the second metatarsal of the left foot. The fracture required casting and a period of physical therapy. Petitioner still has complaints consistent with the injuries he sustained. The Arbitrator gives this factor significant weight.

In regard to disputed issue (M) the Arbitrator makes the following conclusion of law:

There is no basis to assess either penalties or attorneys' fees because the IWBF is a party to this case.

In regard to disputed issue (O) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Respondent, Steelcad, did not have workers' compensation insurance at the time of the accident of October 23, 2013.

In support of this conclusion the Arbitrator notes the following:

No one has filed an entry of appearance or appeared on behalf of the Respondent, Steelcad.

The reason there was no dispute in regard to temporary total disability benefits was that the Respondent, Steelcad, continued to pay Petitioner his wages while he was disabled.

All of Petitioner's medical bills for treatment he received as result of the accident remain unpaid.

Respondent, Steelcad's owner, Michael Fulkerson, was subpoenaed to appear with proof of Steelcad having workers' compensation insurance for the date of the accident, October 13, 2013, at the Commission office in Collinsville on February 21, 2018, but failed to do so.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF ROCK ISLAND	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Koffi Gadegbesso,

Petitioner,

vs. NO. 13WC 42269

Farmland Foods,

Respondent.

19IWCC0166

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

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

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.

19IWCC0166

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: MAR 15 2019
SJM/sj
o-3/7/2019
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GADEGBESSO, KOFFI
Employee/Petitioner

Case# **13WC042269**

FARMLAND FOOD
Employer/Respondent

19IWCC0166

On 3/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5271 LEADERS LAW CENTER LLC
OWOLABI ALABA
684 W BOUGHTON RD SUITE 203
CHICAGO, IL 60603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

19IWCC0166

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Koffi Gadegbesso
Employee/Petitioner

v.

Farmland Foods
Employer/Respondent

Case # 13 WC 42269

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Rock Island**, on **April 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. [ ] 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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other Prospective Medical

FINDINGS

On 11/6/13, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $32,136.00, the average weekly wage was $462.00.

On the date of accident, Petitioner was 35 years of age, *married* with 2 dependent children.

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

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

Respondent shall be given a credit for statutory permanent partial disability benefits paid.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $2,560.00, as set forth in Petitioner's exhibit 21, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for prospective medical care as recommended by Dr. Ricketts, and Dr. Anane-Sefah, including those related to prosthetics, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 12/15/14, of $198.67/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.

Respondent shall pay to Petitioner penalties of $1,280.00, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

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

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

Michael K. Nowak, Arbitrator

1/18/18
Date

ICArbDec p. 2

MAR 5 - 2018

FINDINGS OF FACT

Petitioner came to the United States from Togo, Africa in 2005. At the time of hearing he was 35 years of age, married and had two children under the age of 18.

Petitioner began working for Respondent in 2012. On 11/06/13 while working for Respondent as a bacon press operator, Petitioner was working with a bacon press which was new to the facility and one on which he had not previously worked. During the operation of the machine, a pork belly became miss fed. In an effort to clear the machine, Petitioner opened the gate on the bacon press, as he had been trained on the old bacon press, and reached in to straighten the pork belly. As he did so, the bacon press cycled, crushing Petitioner's right hand and fingers.

After the accident Petitioner was taken to OSF in Galesburg, IL. Due to the severity of the crush injury Petitioner was immediately transferred to OSF in Peoria. X-rays demonstrated a transversely oriented fracture through the mid shafts of the proximal phalanges of the index and 3rd digits with minimal comminution.

Petitioner was evaluated by Dr. Jason M. Anane-Sefah, M.D. Dr. Anane-Sefah found Petitioner had exposed bone of the proximal phalanx. Petitioner had absent capillary refill distally in the index and long fingers. Capillary refill was brisk and less than two seconds in the ring and small fingers, as well as the thumb. Dr. Anane-Sefah noted Petitioner appeared to have complete lacerations of the FDP and FDS as well as the extensor tendons of both of the index and long fingers. Both the index and long fingers were cool to touch. The thumb, ring and small fingers were warm to the touch. There were only as small amount of soft tissues holding these fingers on. Sensation was completely absent to light touch on both radial and ulnar borders of the index and long fingers.

Dr. Anane-Sefah and Petitioner explored the possibility of irrigation and debridement and open reduction-internal fixation of the right index and long proximal phalanx bones, repair of tendons, arteries, nerves and veins. However, after reviewing the risks, goals, benefits, and alternatives, to the attempted repair of the fingers it was determined that Petitioner's injuries would necessitate amputation of the fingers.

The procedure consisted of irrigation, debridement, and exploration right index and long fingers with index and long finger complete amputation. After the surgical amputation, Petitioner was discharged on 11/8/13.

On 11/13/13, Petitioner followed up with Dr. Anane-Sefah. Inspection of the right hand showed some moderate swelling at the radial border of the hand. There was no erythema, no fluctuance, and no drainage. The fingers were amputated near the level of MCP joints. The suture was in place. Wounds were well approximated. Petitioner could flex and extend across the IP joint of the thumb with moderate stiffness. X-rays showed amputation of the right index and long fingers across the proximal phalanges. Dr. Anane-Sefah's impression was status post revision amputation of right index and long fingers from severe crush injury and open fractures of the index and long fingers.

On 11/20/13, Petitioner returned to Dr. Anane-Sefah for a follow up. Petitioner was still having pain the right hand posteriorly and on the radial aspect of the hand. He denied numbness or tingling in the hand or fingers. He was to have therapy initiated the following day. Petitioner had already obtained a splint.

On 01/09/14, Petitioner returned to Dr. Anane-Sefah for follow up. Petitioner told Dr. Anane-Sefah his hand was getting better; his range of motion was improving and he was in therapy. He complained of some pain overlying the index and long MCP joints. He was to meet Dr. Jefferey Weinzweig in Chicago for consultation. Physical examination revealed the absence of the index and long fingers at the bases. He was able to flex and extend the ring and the small fingers, and was nearly able to make a full composite grip and extend the fingers. Petitioner had no hypersensitivity within skin. Petitioner had some mild swelling about the radial border of the hand near the amputation sites. Capillary refill was brisk at less than 2 seconds distally in the thumb, ring and small fingers. He had mild to moderate stiffness within the wrist. Petitioner also complained of occasional nightmares about the injury.

On 01/23/14, Petitioner followed up with Dr. Anane-Sefah complaining of cramping and pain in the hand. He admitted those symptoms were improving. Petitioner told Dr. Anane-Sefah he was still somewhat upset and had some nightmares about the injury. Dr. Anane-Sefah's physical examination charts noted Petitioner had only mild swelling about the radial border of the hand. Capillary refill was brisk at less than 2 seconds. He had some sensitivity about the amputations sites with light touch, but Petitioner had no skin shininess and hair changes. Petitioner was able to flex and extend the small and the ring fingers. Dr. Anane-Sefah noted this was a marked improved from his previous examinations. Dr. Anane-Sefah noted Petitioner could continue to work with his therapy, and could return to sedentary work with no exposure to cold, office work and no use of the right hand. He could start work 4 hours per day and that could be gradually increased. Dr. Anane-Sefah recommended psychotherapy for Petitioner's occasional nightmares.

On 02/05/14, as Petitioner continued to have nightmares and re-live his traumatic injury, he presented for psychological therapy with Dr. Francy Ricketts, Ph.D. at the Adolescent Child and Couple Psychology in Rock Island, Illinois. (Px # 10). Petitioner complained "I can hear the noise of the machine." *Id.* Dr. Ricketts sent a letter to Respondent Farmland Foods dated 02/05/14 and noted Petitioner entered therapy with her on that date. Dr. Ricketts explained Petitioner met the criteria for the diagnoses of post-traumatic stress disorder and that that she was unable to provide a return to work date for Petitioner. Dr. Ricketts was emphatic that Petitioner was unable to return to work at that time due to the severity of his symptoms noting he experiences daily symptoms of re-living his work accident, and persistent avoidance of sights and sounds associated with the accident. It was also noted that the doctor felt Petitioner would be a danger to himself and a danger to other workers at that time.

Petitioner returned to Dr. Ricketts to 02/13/17 complaining of headaches and loneliness. Dr. Ricketts taught Petitioner psychological exercises including breathing and physical strategies for reducing anxiety. Petitioner completed a Wellness Assessment and noted he was "feeling sad or blue, trouble sleeping and having difficulty at home." On 02/20/14, Petitioner returned to Dr. Ricketts for follow up. He complained "I can hear myself screaming. See the blood." Petitioner told Dr. Ricketts that he did not trust his concentration well enough to drive very far. On 03/03/14, Petitioner returned to Dr. Ricketts complaining of more nightmares. He was bothered that he could hear himself scream and saw himself looking at the crushed fingers.

On 03/19/14, Petitioner returned to Dr. Anane-Sefah. He indicated his right hand was getting better, but he still had some weakness with his grip. He stated his therapy was helping a great deal. Px #14, p. 7). On physical examination, Petitioner was able to bring the small and ring fingers down completely in the palm and

extend the fingers. Petitioner had some weakness with flexion through the FDP of the ring finger. Petitioner and Dr. Anane-Sefah discussed possible referral for a toe to finger transplant, but Petitioner did not wish to do that. Dr. Anane-Sefah then noted Petitioner could return to office work and return for follow up in 8 weeks.

On 03/24/14, Petitioner returned to Dr. Francy Ricketts for follow on psychological therapy for his nightmares. Petitioner complained: "when I close my eyes, I see pictures. hear my screaming." Petitioner noted he was driving better. He felt his physical therapy was helping. Petitioner complained of headache and could not sleep at night. Dr. Ricketts wrote to Respondent, restating Petitioner was unable to return to work at that time due to the severity of his symptoms. Dr. Ricketts explained that the Petitioner "experiences daily symptoms of re-experiencing his work accident, persistent avoidance of sights and sounds associated with the work accident arousal." The doctor concluded by stating that Petitioner would be a danger to himself and other workers at that time.

On 04/02/14, Petitioner told Dr. Ricketts he had problem with noise, stating "noise is a trigger" to his anxiety. Petitioner complained to Dr. Ricketts that he was not sleeping at all. On 04/24/14, Petitioner told Dr. Ricketts he was sleeping better, at least 4hours. His pain was improving. He was self-conscious about his disfigurement. Petitioner was afraid of industrial machines.

On 05/12/14, Petitioner returned to Dr. Anane-Sefah for follow-up. Petitioner still had numbness in the index and long fingers at the stumps. He was not back to work yet. He denied fever or night sweats. Petitioner was interested in prostheses or guards for the amputated fingers. Physical examination showed Petitioner's swelling had now resolved. There was no hyper sensitivity in the skin at the amputation sites. He had no tenderness. He had good fluid range of motion. Dr. Anane-Sefah imposed some work indicating Petitioner might return to work with no lifting over 5pounds with the right hand, no repetitive grip, or exposure to cold as his hand was sensitive to cold and noted Petitioner had almost achieved an MMI. Dr. Anane-Sefah recommended disability rating. *Id.*

On 05/15/14, Petitioner returned to Dr. Ricketts complaining his anxiety was often triggered by sounds and worries. He reported his heart pounding. He continued to follow up with Dr. Ricketts. He indicated he had to put his amputated fingers in his pocket as his prosthetic was delayed. Petitioner complained that noise bothers him, even that to which he was exposed from watching movies.

On 08/06/14, Petitioner returned to Dr. Anane-Sefah. Petitioner was still waiting for prosthetic approval. He indicated Respondent would not pay for his disability evaluation. Physical examination remained unchanged from the previous visit. Restrictions on job duties were maintained. However, Dr. Anane-Sefah felt Petitioner might not be able to write as the amputated finger was his dominant extremity. Dr. Anane-Sefah maintained Petitioner would benefit from an FCE if he was not going to have disability evaluation and placement.

Dr. Rickett's billing records reflect that at least by 08/06/14 Respondent was refusing to pay the charges incurred in their office. The note stated "because in litigation-No claims paid. Will not cover counseling. Will not respond to appeal because all claims stand as denied." (Px #21)

On 08/28/14, Petitioner returned to Dr. Ricketts for follow up. He complained: "I cannot stay home. I think too much." Petitioner told Dr. Ricketts that he planned to look for work.

On 10/20/14, Dr. Ricketts wrote the third letter to Respondent. (Px #10, p. 39). She noted Petitioner had come to the realization he would never return to Farmland plant without experiencing significant post-traumatic stress disorder symptoms and had decided to look for another employment. *Id*. Dr. Ricketts wrote Petitioner continued to re-experience the industrial injury. "The sounds of machines are particularly activating. He continues to re-experience his own screaming. The shame he feels from the loss of his fingers has lessened somewhat. He does not always hide his hand." Dr. Ricketts noted Petitioner was industrious and determined to support his family. *Id*. Petitioner eventually stopped seeing Dr. Ricketts due to Respondent's failure to pay.

On 04/08/15, Petitioner returned to Dr. Anane-Sefah stating his hand was "getting better and better." (Px #14. p. 4). He stated sometimes, "I get this shooting sensation in my hand." Petitioner complained of weakness in the amputated hand, especially gripping objects and lifting objects, secondary to loss of the index and long fingers. He complained he was unable to have disability rating because Farmland Foods did not authorize it. He said he was trying to do as much as he could with the hand. (Px #14, p. 4). Dr. Anane-Sefah inspected the amputated fingers. The right hand still had some swelling about the amputation sites and the loss of index and long fingers at the level of the MCP joints. He was able to flex and extend the small and the ring fingers. Petitioner had weakness with grip. Capillary refill was brisk at less than two seconds distally. Petitioner had some slight hypersensitivity distally overlying the amputation sites. Dr. Anane-Sefah's impression was Petitioner was quite limited with the loss of the index and long fingers. Again, Dr. Anane-Sefah believe Petitioner would benefit from disability rating. A note in Dr. Anane-Sefah's record confirmed that Respondent denied Dr. Anane-Sefah's referral to Dr. Lisa Snyder's office for disability rating. "The Adjuster stated she didn't need a disability rating." (Px #14. p. 20).

Petitioner attended the therapy recommended by Dr. Anane-Sefah at the Rock Valley Therapy from 11/21/13 to 03/21/14. During the therapy sessions, Petitioner engaged in learning how to grip, grasp, and perform object manipulation with the injured hand.

Dr. Peter Orris M.D. testified by way of deposition. He has been the Director of Occupational Health Services Institute. University of Illinois at Chicago School of Public Health since 1999. Dr. Orris examined Petitioner on 06/17/15. At the time of this consultation, Petitioner was working full-time, full duty at N.I.S. Davenport, where he was engaged in plugging cables into different ports. (Px #2, p. 1). Petitioner noted the job opportunities he had in the past were limited as he cannot lift, push or pull heavy objects, hold and manipulate tools or small objects or do repetitive tasks. Petitioner still experiences pain in his second and middle fingers when he accidentally bumps up against an object, pain and restriction of the 4th finger extension movement when he does repetitive or grips tightly on a repetitive basis. His 4th finger gets stuck when he bends his finger, and the problems were more pronounced three months up to the time of the evaluation. (Px #2, p. 1).

Additionally, Dr. Orris noted Petitioner was still sensitive to cold exposure which causes stiffness and extreme sensitivity of the tips of the right index and middle fingers. (Px #2. p. 2). "When he grips objects, he gets cramps. A prosthetic was custom made for him, but does not allow finger flexion or gripping. As a result, he uses it to hide his disfigurement, but does not function well with it and cannot use it at work." *Id*.

At home his activities of daily living have been compromised. (Px #2. p. 2). He cannot cut with a knife, hold change in his right hand when he goes shopping, pinch objects, carry plates with one hand, or grip heavy

objects. He has learned to write and keyboard with his right hand, but the process is slow and tedious and he fatigues with repetition. *Id.*

Dr. Orris noted that Petitioner has been affected psychologically by this trauma. (Px #2, p. 2). (Px #11, p.12, lines 6-13). Loud noises remind him of the loud machine that amputated his hand. Id. When he is alone, he plays the incident in his head over and over and has had recurrent nightmares of the event. Though his nightmares have improved somewhat, Petitioner continues to experience a hypervigilant state (partially asleep and partially awake state). Petitioner's new job has provided him with a platform for social interactions with his new colleagues, but he knows that he cannot return to manual labor. *Id.*

Dr. Orris conducted a physical examination which revealed the amputations which were well healed with adequate soft tissue contours and normal appearing vascularity. (Px #2, p. 1). Range of motion was 30 degrees of flexion and 90 of extension at metacarpo-carpal joint of the middle finger and 0 degrees of flexion and 90 of extension at metacarpo-carpal joint of the index finger. There was no triggering of right 4th finger noted. Petitioner had sensitivity to touch on finger stumps. Motor function was 5/5 for all other muscles tested, but could not be tested for amputated digits. *Id.*

Having also reviewed Petitioner's medical records and within a reasonable degree of medical certainty. Dr. Orris assessed Petitioner as follows: "36-year-old man, suffered traumatic amputation to the index and middle fingers of his dominant hand at the level of MCP joints and additionally complains right finger's ring getting stuck in a flexed position. Petitioner suffered Post Traumatic Stress Syndrome caused by this amputation." (Px #2, p. 3).

Applying the Sixth Edition of AMA Guide Dr. Orris assessed Petitioner with an impairment rating of 40% of the entire hand, and 22% of a whole person. And combining Petitioner's post-traumatic syndrome, physical and psychological impairments into account, Dr. Orris assessed Petitioner with 27% (22% +5%) whole person impairment and noted that Table 15-1, 16-29 % (WPI) impairment range was considered in the "severe" category.

James Radke performed a vocational evaluation of Petitioner and issued a report. After interviewing the Petitioner and reviewing the medical reports, Radke noted Petitioner only had 7 years of schooling while in Africa. (Px #3, p.1). Petitioner took some English classes when he moved to United States and obtained a welding certificate. Petitioner is certified in MIG welding. Petitioner is unable to perform his prior welding work due to his inability to effectively grasp and handle objects of anything more than negligible weight. *Id.* James Radke opined that Petitioner is a multiply impaired individual, not only does he have limitations regarding his manipulative abilities and strength with his dominant hand, but also some mental health limitations regarding his traumatic amputations. Petitioner no longer has the dexterity to perform his previous manual work. Petitioner strength is reduced and his hand speed and manipulation is also limited by the loss of 2 very important digits. Mr. Radke opined that Petitioner cannot use his transferable work skills due to his physical disabilities. Thus, Mr. Radke concluded Petitioner would function at the unskilled level. He further opined that in addition to physical impairments, Petitioner also has mental health issues regarding his injury. Petitioner is particularly frightened of any re-injury to his hand area. He does not want to be around machinery where he could re-injure his hand. (Px # 3, p. 3). As Petitioner possesses limited education and is no longer able

to perform his prior occupations, Mr. Radke believed Petitioner's potential wages in the greater Quad Cities area were $9.23/hour as an entry wage and $10.50 as the median wage. (Px # 3, p. 4).

On 02/26/14 Dr. James Williams on behalf of Respondent examined Petitioner pursuant to section 12 of the Act. After his physical examination, Petitioner's interview and review of his medical records, Dr. Williams found Petitioner to be status post revision amputation of his right index and middle fingers. (Px # 8, p. 3). Dr. Williams believed the injury was directly related to his work and that all treatment had been reasonable and necessary and related to his work injury. (Px # 8, p. 10). He believed Petitioner had significant apprehension to return to work and Dr. Williams felt it would be hard to return to the workplace. "He is symptom focused. He is very focused on the fact that he has nightmares about going back to the job. I think it will be difficult to return him to any type of work at Smithfield Foods." At the time Petitioner presented for the exam, Dr. Williams felt Petitioner was not at maximum medical improvement. He believed Petitioner would have a definite functional impairment as he has lost the index and middle fingers of his right hand. *Id.* Dr. Williams wrote he found Petitioner to be honest and forth coming. *Id.*

On 03/07/17, Dr. Francy Ricketts, Ph.D. testified by deposition. She provides therapeutic services to people with traumatic injuries. (Px #17, p. 5). She testified that following his traumatic injuries on 11/06/13, Petitioner saw her 14 times for psychological therapeutic services. *Id.* Petitioner reported to Dr. Ricketts that after his injuries he couldn't sleep, had nightmares, he couldn't concentrate, and he kept reliving the accident. (Px #17, p. 6-7). Dr. Ricketts testified that she made Petitioner complete the PCLC form to determine his psychological reaction to the accident of 11/06/13. (Px #17, p. 8). Dr. Ricketts testified that the PCLC form is frequently used by the Department of Veterans Affairs to determine whether a person is suffering from post-traumatic stress disorder (PTSD). She testified based on the interview she conducted of Petitioner and the information Petitioner provided on the PCLC, Petitioner scored 48, and under the Veterans Administration's system, a score of 36 or higher is indicative of PTSD. (Px #17, p. 9). Dr. Ricketts testified she made the judgment, based upon her interviews and discussions with Petitioner during the psychological testing, that Petitioner's concentration was impaired and therefore he should not be in a workplace where there was dangerous equipment. (Px #17, p. 10). Dr. Ricketts was aware Petitioner had been released for some kind of work by his surgeon, but she determined that Petitioner's psychological symptoms were so severe that he shouldn't be in a plant with dangerous equipment. *Id.* Dr. Ricketts re-stated Petitioner met the criteria of post-traumatic disorder. (Px #17, p. 11). Because Petitioner's anxiety was so severe, Dr. Ricketts referred Petitioner to Dr. Randy Doyle, a psychiatrist, for psychoactive medication but he had problems connecting with Dr. Doyle. *Id.* Dr. Ricketts testified that Petitioner's missed appointments were indicative of how severe his symptoms were. "I presumed those were symptoms that life was not going well for him." (Px #17, p. 16). Dr. Ricketts testified that the very act of re-living his traumatic accident was the primary symptom of posttraumatic stress disorder. "Feeling jumpy, feeling detached from the world, feeling the he has no future." (Px #17, p. 17, 26). Dr. Ricketts testified that as time went by, Petitioner's worry appeared to increase and his depression worsen. (Px #17, p. 121). Dr. Ricketts testified that sudden noise from movies triggered his PTSD. "It was a sudden noise, a loud noise, and Koffi would go into anxiety and panic attacks, which does not make for good infant care." (Px #17, p. 25). Dr. Ricketts testified Petitioner felt defeated and lonely after his traumatic accident. (Px #17, p. 30). He was terrified by trucks and industrial machines. (Px #17, p. 31). He also had a sense of shame. She testified:

> Koffi has been doing that all along, putting one hand over the other, you know, to cover up the compression glove and cover up his injury. Hands are very important to each and every one of us. So, he was feeling shame, even though, the industrial accident, you know, was not his fault and did not take on the blame for that accident, but he still felt shame about the accident.

(Px #17, p. 20). Dr. Ricketts felt Petitioner was an ambitious, hardworking young man. (Px #17, p. 33). His accident made him feel letdown being unable to provide financially for his family. *Id.* She testified that Petitioner was adamant he would never return to Farmland plant because of his fear that the plant will trigger his anxiety. (Px #17, p. 34 - 35). Dr. Ricketts opined that Petitioner suffered from a post-traumatic stress disorder, inclusive of depression and anxiety because of the 11/06/13 accident. (Px #17, p. 36 - 37). Dr. Ricketts opined the PTSD Petitioner experiences is likely permanent. (Px #17, p. 38). Dr. Ricketts was also of the opinion that Petitioner had not received adequate treatments as of the last time she saw him. Dr. Ricketts testified she felt Petitioner was a responsible person who wanted his bills paid. Because the psychological bills were not being paid, Petitioner walked away from the treatments he required. (Px #17, p. 41). When asked whether Petitioner was symptom magnifying or malingering Dr. Ricketts responded: "On the contrary, Koffi was more likely to minimize his symptoms rather than maximize his symptoms. He also stated and demonstrated early in therapy that he wanted to work, that he missed being able to be productive rather than desired to avoid work." (Px #17, p. 53).

Dr. Jason Anane-Sefah, M.D. testified by deposition on 03/21/17. Dr. Anane-Sefah testified consistently with his medical charts on the Petitioner. He said Petitioner came under his care on 11/7/13 after sustaining severe injury to his right hand working with a bacon press. (Px #16, p. 10). Dr. Anane-Sefah determined that Petitioner's traumatic injuries were so severe, that he ordered the transfer from Galesburg to Peoria. (Px #16, p. 8). Dr. Anane-Sefah stated Petitioner had near amputations of his index and long fingers on the right hand with crushing-type injury and segmental traumatic injury to both of the fingers and open fractures of the index and long finger proximal phalanx. (Px #16, p. 8). Dr. Anane-Sefah opined that Petitioner's disability and disfigurement from the amputations of his index and long finger were permanent. (Px #16, p. 12). After the elected surgical procedure, Dr. Anane-Sefah felt Petitioner was unable to immediately return to work. *Id.* Petitioner was followed with post-surgical care and held off work. (Px #16, p. 15). As to his referral to Dr. Lisa Snyder for disability rating, Dr. Anane-Sefah testified that a note dated 05/15/16 was dictated in his chart indicating Respondent denied the referral he made. (Px #16, p. 23 - 24). Dr. Anane-Sefah testified that on 05/12/14 he returned Petitioner to work with some restrictions. (Px #16, p. 24). Restrictions included no lifting over zero to five pounds with the right hand, no repetitive grip, or exposure to cold, and only sedentary work. *Id.* Dr. Anane-Sefah testified prosthetics overall were medically necessary for patients with similar injuries as the Petitioner and that if the prosthetic benefitted the Petitioner, he would permanently need it. (Px #16, p. 26, 28). Dr. Anane-Sefah testified that the prosthetic would also function to hide Petitioner's disfigurement. Dr. Anane-Sefah concluded that Petitioner would permanently have weakness with his grip. (Px #16, p. 30). Dr. Anane-Sefah testified Petitioner was quite limited with the loss of these fingers as he lacked the ability to really pinch object s effectively and was limited in ability to grip well. (Px #16, p. 31).

As of the date of hearing Petitioner continued to use his prosthetic and wished to return to Dr. Ricketts once when Respondent begins paying the bills.

CONCLUSIONS

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

Although Respondent disputed causal connection at the hearing, the totality of the evidence in this record indicates that both Petitioner's physical injuries to his hand and his PTSD, as well as the disabilities which flow therefrom are causally related to the accident. The Arbitrator so finds.

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

It appears from the record that all medical expenses, with the exception of those incurred for treatment provided by Dr. Ricketts, have been paid by Respondent. Petitioner submitted bills for the treatment provided by Dr. Ricketts of $2,560.00. The evidence in the record indicates these charges were reasonable necessary and related to the accident. No evidence to the contrary was offered into evidence. The Arbitrator finds Respondent is responsible for payment of these charges. The record further indicates that Petitioner would benefit from continued treatment by Dr. Ricketts and may require periodic visits with Dr. Anane-Seefah. In addition, Petitioner's prosthetic will need maintenance, up keep and periodic replacement. The Arbitrator finds Petitioner is entitled to and Respondent shall pay for this prospective medical treatment.

Respondent shall pay reasonable and necessary medical services of $2,560.00, as set forth in Petitioner's exhibit 21, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall further authorize and pay for prospective medical care as recommended by Dr. Ricketts, and Dr. Anane-Sefah, including those related to prosthetics, as provided in Sections 8(a) and 8.2 of the Act.

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

Section 8(d)1 of the Act 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.

In this case the accident resulted in Petitioner becoming incapacitated from pursuing his usual and customary line of employment. On 12/15/14 Petitioner began working for NIS. He now works for the Isle of Capri hotel in the housekeeping department. As of the date of hearing he was earning $9.25 per hour. The evidence in the record shows that if he were able to continue in his usual and customary employment with Respondent he would be earning $16.70 per hour. The hourly wage differential is $7.45. (16.70 – 9.25 = 7.45) The weekly differential is $298.00 (7.45 x 40 hours = 298.00) Petitioner is therefore entitled to benefits of $198.67 per week pursuant to section 8(d)1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 12/15/14, of $198.67/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.

Issue (M) **Should penalties or fees be imposed upon Respondent?**

Section 19 (l) of the Act provides:

> In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.
>
> A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l) (West 2006).

Section 19(l) penalties are in the nature of a late fee and the imposition of such penalties "is mandatory when an employer or insurance carrier is late in making a payment but cannot provide adequate justification for its delay." *See McMahan v. Industrial Commission*, 183 Ill.2d 499, 515 (1998); *Central Rug & Carpet v. Industrial Commission*, 361 Ill.App.3d 684, 691 (1st Dist. 2005). In this case the unrefuted evidence shows that Dr. Rickett's billing records reflect that as of 08/06/14 Respondent was refusing to pay the charges incurred in their office. The note stated "because in litigation-No claims paid. Will not cover counseling. Will not respond to appeal because all claims stand as denied." (Px #21). As of 04/06/17, the date of hearing, Dr. Ricketts bills in the amount of $2,560.00 remained unpaid. Respondent delayed payment of these benefits approximately 32 months. Respondent offered no justifiable explanation for the delay in payment.

The standard for an award of penalties under Section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides, in pertinent part, "In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation. Then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305 /19(k). (West 2006).

Generally speaking, an employer's reasonable and good faith challenge to liability ordinarily will not subject it to penalties under the Act. *Board of Education of City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 20,

25, 442 N.E.2d 883, 885, 66 Ill. Dec. 322 (1982); *Complete Vending Services, Inc. v. Industrial Comm'n*, 305 Ill. App. 3d 1047, 1050, 714 N.E.2d 30, 32-33, 239 Ill. Dec. 472 (1999).

For instance, when the employer acts in reliance upon a responsible medical opinion or when there are conflicting medical opinions, penalties ordinarily are not imposed. *Avon Products, Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 302, 412 N.E.2d 468, 470, 45 Ill. Dec. 117 (1980). Whether an employer's conduct justifies the imposition of penalties is a factual question for the Commission, and the Commission's determination on the matter will not be disturbed on review unless it is against the manifest weight of the evidence. *Board of Education*, 93 Ill. 2d at 25, 442 N.E.2d at 885. In this instance, the Arbitrator concludes penalties are appropriate

Attorney's fees and penalties are appropriate in this case because there was no legitimate dispute. Although the request for hearing form indicates Respondent disputed the issue of causation no legitimate basis for this claimed dispute was put forward at the hearing. Respondent had no legitimate reason to delay payment of these benefits. The Arbitrator finds Respondent's conduct in refusing to pay these medical bills was unreasonable and vexatious.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to Section 19(l) penalties in the amount of $10,000.00 for late payment of medical bills from 08/06/14 through 04/06/17. At the rate of $30.00 per day for this period Respondent owes the statutory maximum of $10,000. Further, pursuant to Section 19(k), the Arbitrator awards $1,280, which is equal to 50% of the unreasonably delayed medical benefits.

Issue (N): Is Respondent due any credit?

Respondent paid statutory permanent partial disability benefits as a result of the amputation of Petitioner's index and long fingers. However the Arbitrator is unable to determine the total amount paid in PPD. Respondent's exhibit contains codes for the payments made and the Arbitrator cannot determine with certainty what payments reflect PPD versus TTD or other benefits. The Arbitrator finds Respondent is entitled to credit for PPD benefits paid, but simply cannot determine the amount of that credit from the records admitted into evidence.

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

Keith Haun,

Petitioner,

19IWCC0167

vs.

NO: 17 WC 8803

Altorfer, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical, prospective medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 27, 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.

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 $15,000.00. 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: MAR 15 2019
O3/7/19
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

19IWCC0167

HAUN, KEITH
Employee/Petitioner

Case# **17WC008803**

ALTORFER INC
Employer/Respondent

On 8/27/2018, 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 2.18% 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:

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

2904 HENNESSY & ROACH PC
EMILIE MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

19IWCC0167

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Keith Haun
Employee/Petitioner

v.

Altorfer, Inc.
Employer/Respondent

Case # **17 WC 08803**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **July 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. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **10/31/2016**, 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 ***partially*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**64,563.20**; the average weekly wage was $**1,241.60**.

On the date of accident, Petitioner was **55** 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 $.

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

ORDER

- *Petitioner's current condition of ill-being with respect to the right knee is causally related to the accident of 10/31/2016.*
- *Petitioner's current condition of ill being with respect to his lumbar spine is not causally related to the accident pf 10/31/2016.*
- *Respondent shall pay reasonable and necessary medical services related to treatment of the right knee, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act.*
- *Prospective medical treatment is allowed with respect to the right knee: it is denied with respect to the lower back.*
- *Respondent shall be given a credit for all monies paid for medical benefits under Section 8(j) of the Act.*

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

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

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

19IWCC0167

Signature of Arbitrator

Aug. 20, 2018
Date

ICArbDec19(b)

AUG 2 7 2018

FINDINGS OF FACT

Petitioner has been employed with Respondent for 32 years. At the time of his accident on October 31, 2016, Petitioner was working as an assembler. Petitioner previously worked for Respondent as a welder/fabricator. As an assembler Petitioner is responsible for assembling generators. (T. 12-13)

Petitioner testified that prior to October 31, 2016 he sustained several injuries while working for Respondent. Petitioner testified that he sustained injuries in 1994 to his low back, 2008 to his right shoulder, and 2012 to his right knee. (T. 17)

Petitioner testified he underwent four prior surgeries, including a lumbar laminectomy in 1994, lumbar fusion in 2001, a right knee arthroscopy in 2012, and cervical surgery in 2015. (T. 18-19) Petitioner testified that from 2012 to October 31, 2016 he did not have any problems with his right knee or back or weakness in his in his legs. (T. 20-22)

There is no dispute that Petitioner sustained a compensable work injury on October 31, 2016. Petitioner's testimony and an Incident Investigation Report completed by Respondent confirm that on October 31, 2016 Petitioner was working on a generator when he fell off. Petitioner testified that as he was stepping out of the generator with his right leg when it missed the fender and he fell to the floor, causing him to do the splits. Petitioner testified that as he fell, his left leg was caught in the machine. (T. 23) Photographs taken of Petitioner's left calf following the accident confirm bruising to the left calf. (P's Ex. 7)

Petitioner testified that he noticed immediate pain and swelling in his legs after his accident, as well as giving out in his right leg. (T. 27) Petitioner testified that following his accident he asked for approval to seek medical treatment, but was denied by Respondent. (T. 29) Petitioner testified he eventually decided to seek treatment on his own through his primary care physician. It is noted that Petitioner had group health insurance provided by Respondent. (T. 31)

Petitioner first sought treatment for his knee with Dr. Vijaya Jujjavarapu on December 15, 2016 at Unity Point Proctor Medical Group Family Associates of Bartonville. Petitioner reported discomfort on weight bearing and right knee pain and was diagnosed with a right knee sprain and instructed in knee strengthening exercises.

Petitioner returned to Dr. Jujjavarapu next on January 19, 2017. Based on Petitioner's reports of catching in his knee, Dr. Jujjavarapu referred him for an orthopedic consultation.

Petitioner was evaluated for the first time at Midwest Orthopaedic Center on April 13, 2017 by Dr. Luke Luetkemeyer. Petitioner reported right hip and right knee pain. Dr. Luetkemeyer diagnosed Petitioner with localized primary osteoarthritis of the right knee and administered a corticosteroid injection. (Px's Ex. 2)

After failing to improve with the injection, Dr. Luetkemeyer ordered an MRI of Petitioner's right knee. The MRI was completed on May 4, 2017 and showed moderate chondral fissures at the patella apex, as well as the patellar facet, and moderate arthritic changes and fissuring in the posterolateral formal condyle and posterior lateral tibia plateau, but no acute tearing.

Upon reviewing the MRI on May 11, 2017, Dr. Luetkemeyer, confirmed it showed more degenerative type fraying, as opposed to acute findings and recommended Euflexxa injections to treat Petitioner's arthritis. Dr. Luetkemeyer also noted that based on Petitioner's complaints, his problems could be coming from the back. (P's 2)

Petitioner underwent a total of three Euflexxa injections in May and returned to Dr. Luetkemeyer on July 13, 2017. Based on Petitioner's complaints of persistent right leg weakness, Dr. Luetkemeyer administered another corticosteroid injection into Petitioner's knee. Dr. Luetkemeyer also discussed the option of surgery with Petitioner and possible referral to Dr. Michael Merkley; however, he noted surgery would only be considered if injections did not work.

Petitioner was then submitted for a Section 12 examination at Respondent's request with Dr. John Kolb. Dr. Kolb examined Petitioner on August 22, 2017. Dr. Kolb opined that while Petitioner temporarily aggravated his underlying arthritic condition in his right knee as a result of his October 31, 2016 accident, the temporary aggravation caused by the work accident had resolved and the current condition of his knee was not related to his accident. Dr. Kolb also testified he thought some of Petitioner's symptoms may be coming from his low back. As a result, Petitioner's ongoing treatment was denied. (R's 1, pg. 19-22)

Petitioner was then evaluated by Dr. Merkley on October 16, 2017. It is noted that Dr. Merkley performed Petitioner's prior right knee surgery in 2012. After examining Petitioner and reviewing his MRI, Mr. Merkley diagnosed him with chronic right knee pain and possible chronic partial ACL tear. To rule out the possibility of an ACL tear, Dr. Merkley ordered KT 2000 testing. Pending Petitioner's testing, he was provided a playmaker brace. Petitioner's KT 2000 testing was completed on November 1, 2017 and showed only 2 mm maximal side-to-side difference. (P's 2)

On November 13, 2017, Petitioner returned to Dr. Merkley to review the results of his testing. After noting the testing results, Dr. Merkley referred Petitioner for physical therapy. Petitioner said that the brace helped him but that the knee continued to feel weak. (P's 2)

After reporting some improvement with physical therapy, Petitioner returned to Dr. Merkley on January 29, 2018. At that time Dr. Merkley recommended an updated MRI to further assess Petitioner's ACL, but noted Petitioner's effusion has resolved. He did diagnose the condition as a partial ACL tear in the right knee (P's 2)

The MRI was completed on February 2, 2018 and again ruled out an ACL tear. (P's 2)

Petitioner last saw Dr. Merkley on February 7, 2018. In his report, Dr. Merkley confirmed that Petitioner's repeat MRI did not show any meniscal pathology or ACL pathology and that he did not recommend any surgical intervention, but noted if Petitioner's pain persists, a diagnostic arthroscopy could be considered. However, he also noted there was a low likelihood of any positive yield from surgery. (P's 2)

Dr. Merkley testified by way of a deposition. He said his initial examination of the Petitioner along with his review of the MRI done on May 4, 2017 led to his diagnosis of a partial tear of the ACL. (PX 5 at 27, 28) He acknowledged that the MRI revealed that the ACL was not grossly torn. Dr. Merkley testified that as of January 29, 2018, Petitioner's effusion had resolved and that his remaining diagnoses for Petitioner as of February 7, 2018 were chronic recalcitrant right knee pain and partial anterior cruciate ligament tear of the right knee. He was asked to explain why he felt that the Petitioner had a partially torn ligament considering that the two MRI's were negative. He explained that one could have a tear of the ACL which would not show up on an MRI. He said his diagnosis was based on the slight knee laxity found on the KT 200 test, along with the Petitioner's complaint of pain and findings of effusion. (Id at 49) Dr. Merkley also testified that in his opinion Petitioner's current condition is related to his work accident. As it relates to Petitioner's need for surgery, Dr. Merkley testified that surgery for Petitioner would be completely diagnostic in nature to either confirm or deny the existence of an ACL tear. However, Petitioner confirmed he has not seen Dr. Merkley since February 7, 2018. Dr. Merkley also testified that without surgery Petitioner would be at MMI for his right knee. (Id at 56)

After completing his treatment with Dr. Merkley, Petitioner began treating for his low back with Dr. Patrick O'Leary. Dr. O'Leary first saw Petitioner on March 6, 2018. Like Dr. Merkley, Petitioner treated with Dr. O'Leary prior to his October 31, 2016 accident. As of March 6, 2018, Dr. O'Leary diagnosed Petitioner with lumbar disc disease, lumbar spondylolisthesis and prior back surgery and ordered an MRI. (P's 2)

The MRI was completed on March 9, 2018 and revealed findings consistent with a L4-5 left hemilaminectomy with trace retrolisthesis and listhesed disc gently encroaching upon left ventral dural sac and left L5 nerve root contacting foraminal left L4 nerve root; L5-S1 right hemilaminectomy/hemilaminotomy with trace disc bulge; L3-4 trace anteriorlesthesis with listhesed disc gently encroaching upon left ventral dural sac, mild spinal stenosis, mild foraminal stenosis gently encroaching upon left L4 nerve root; T11-12 shallow disc bulge with trace retrolisthesis; and very slender filum terminal lipoma. (P's 2)

Upon reviewing the MRI with Petitioner on March 13, 2018, Dr. O'Leary noted Petitioner's prior lumbar fusion with an auto-fusion at L5-S1, infection, left-sided laminectomy at L5-S1 with foraminal stenosis at L4-5, and a prior laminectomy on the left at L4-5, likely explained his symptoms of leg heaviness and weakness and recommended epidural steroid injections. (P's 2)

Petitioner's injections were administered by Dr. Adam Colen. Dr. Colen first attempted a left L4 transforaminal epidural steroid injection under fluoroscopic guidance; however, it was unable to be completed due to the severity of Petitioner's stenosis. A L3 left intraneural injection was then administered. (P's 2)

Petitioner underwent a second injection with Dr. Colen on April 11, 2018 and then returned to Dr. O'Leary on May 1, 2018. As of May 1, 2018, Petitioner reported that the first injection had given him a little bit of relief, but the second one really did not help much at all. Petitioner also reported to Dr. O'Leary a new onset of acute back pain after another injury at work. Petitioner reported he was holding a roof down as he was moving with the crane, and the crane operator stopped and the end he was on kind of raised up and then it jolted him and had an acute onset of pain. In lieu of additional injections, Dr. O'Leary referred Petitioner for physical therapy. While Petitioner testified he was unable to attend physical therapy due to Respondent's denial, records from Midwest Orthopaedic Center confirm Petitioner was scheduled for an initial physical therapy evaluation on May 10, 2018, but elected to cancel it. (P's 2)

As it relates to causation concerning Petitioner's back, Dr. O'Leary was not deposed. However, he noted in his May 1, 2018 report that Petitioner has a "pretty significant degenerative condition" in his low back, which could have been aggravated by the mechanisms of injury he described at work, particularly falling off the generator. (P's 2)

Petitioner last saw Dr. O'Leary on July 3, 2018. At that time, Dr. O'Leary noted Petitioner was having increasing pain on his left side, going down the lateral aspect of the knee to the lateral calf. Dr. O'Leary recommended one more epidural steroid injection on the left at L4-5 to see if this may help alleviate Petitioner's symptoms. (P's 2) Petitioner testified that injection was completed in July.

After testifying, Dr. Kolb authored a supplemental report related to the issue of Petitioner's low back treatment. Like Dr. O'Leary, Dr. Kolb noted Petitioner has an extensive history of lumbar surgery. Dr. Kolb opined that the current condition of Petitioner's back is not causally related to his October 31, 2016 accident and, even if he sustained a temporary aggravation to his low back as a result of his accident, that aggravation would have resolved within six weeks of the injury. (R's 2)

CONCLUSIONS OF LAW

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

The parties agree Petitioner sustained a work injury on October 31, 2016. The question to be answered is whether the current condition of Petitioner's right knee and back are related to his accident. For the reasons stated below, the Arbitrator feels the Petitioner's right knee condition for which he has received treatment is causally related to his accident while his lumbar condition for which he treated beginning in March 2018 is not.

It is undisputed that Petitioner had significant degenerative problems with his lower back. While Dr. O'Leary notes in his records that it's likely that Petitioner sustained an aggravation related to his low back related to his work accident, Petitioner never reported any pain in his back as a result of his accident and the symptoms Petitioner initially experienced on his right side have moved to his left. Moreover, Petitioner's medical records and imagining studies confirm, as noted by Dr. O'Leary, that the arthritic condition of Petitioner's back is significant. His initial treatment following this accident with Dr. Jujjavarapu only involved care of the right knee. (PX 3) He did not seek treatment for the lower back until early March 2018 which was approximately 17 months after his accident. As noted above, he met with Dr. O'Leary, who ordered an MRI. Four days after receiving and reviewing the test, Dr. O'Leary wrote that the Petitioner's symptoms were likely caused by his old pathology at L4-5 and L5-S1. (PX 2) In his supplemental report, Dr. Kolb notes that any aggravation of Petitioner's back related to his accident should have resolved within six weeks of the time of the injury and that Petitioner's current condition is solely related to his advanced underling anthric condition.

The Arbitrator finds that the condition of Petitioner's back for which began seeking treatment on March 6, 2018 is not causally related to his injury. The Arbitrator relies on the delay in Petitioner's treatment for his back, as well as his extensive history of prior lumbar surgeries, evidence of degenerative condition, and the opinions of Dr. Kolb.

On the other hand, the Petitioner began treating for his right knee as soon as he obtained authorization from his employer. His initial treatment notes in December 2016 and January 2017 show objective findings of swelling from the patella laterally which is the same area where he described pain. He continued to have mild to moderate effusion when first seen at Midwest Orthopedics in April 2017. Conservative treatment did not provide any lasting relief, so he was referred back to Dr. Merkley in October. He continued with complaints of posterior and lateral pain. Dr. Merkley noted slight instability and suggested a partial tear of the ACL even though he noted the negative MRI done in May of the same year.

Dr. Merkley testified Petitioner's accident resulted in synovitis effusion to his right knee, as well as a possible ACL tear. Dr. Merkley testified that while Petitioner's synovitis resolved as of January 29, 2018, he continued to experience instability in his right knee as of his last visit on February 7, 2018.

Dr. Kolb testified that based on his examination of Petitioner and review of his records, Petitioner sustained a contusion/strain of the right knee because of his accident that caused a temporarily aggravation of his underlying right knee arthritic condition, but that his residual complaints of instability in his right knee are related to his underlying degenerative conditions. Dr. Kolb notes that for a permanent aggravation to have occurred there should be evidence on MRI consistent with specific trauma; which there is not.

The Arbitrator finds that Petitioner's right knee condition is causally related to his accident. The Arbitrator relies upon the opinions of Dr. Merkley, as well as the timeline of consistent symptoms and exam findings since treatment began in December 2017. The ongoing treatment and consistent findings rebut the opinion of Dr. Kolb that the accident only produced a temporary aggravation.

J. Where 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 is liable for Petitioner's reasonable, necessary and related medical expenses incurred in connection with his right knee treatment, pursuant to the fee schedule. Respondent shall also receive a credit for any amounts paid toward Petitioner's medical expenses under Section 8(j) of the Act.

K. Is Petitioner entitled to prospective medical care?

In light of the Arbitrator's findings on causation, prospective medical care is approved insofar as Dr. Merkley is concerned. The Arbitrator does however note that as of the date of his deposition, April 27, 2018, Dr. Merkley had not prescribed any further care to the Petitioner's right knee. With respect to the low back, prospective care is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Geraldine Jackson as Executor of the estate of James Jackson,
Petitioner,

19IWCC0168

vs.

NO: 08 WC 9203

Monterey Coal Company,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 13, 2017, is hereby affirmed and adopted.

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

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

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

DATED: MAR 15 2019
o3/7/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0168

JACKSON, GERALDINE AS EXECUTOR OF THE ESTATE OF JACKSON, JAMES
Employee/Petitioner

Case# 08WC009203

14WC021043

MONTEREY COAL COMPANY
Employer/Respondent

On 7/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Geraldine Jackson, as executor of the Estate of James Jackson
Employee/Petitioner

Case # 08 WC 09203

v.

Consolidated cases: 14 WC 21043

Monterey Coal Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **2/22/2017**, city of **Quincy** on **4/5/2017 and** city of **Springfield** on **5/25/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/31/07**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, the employee, James Jackson, ***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 last date of exposure, the employee, James Jackson, earned $**82,776.00**; the average weekly wage was $**1,591.85**.

On the date of last exposure, the employee, James Jackson, was **58** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner failed to prove that James Jackson suffered from an occupational disease, including coal workers' pneumoconiosis, that arose out of and in the course of James Jackson's employment with Respondent. Petitioner's claim for compensation is denied. No benefits are awarded.

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

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

[signature]
Signature of Arbitrator

July 9, 2017
Date

JUL 13 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner has two claims on file against Respondent: 08 WC 09203 and 14 WC 21043. The "08" claim was originally filed by James Jackson. He subsequently passed away and Petitioner intervened in the case. She also filed a separate claim for benefits which is the subject of case number 14 WC 21043. The two cases were consolidated for hearing and the parties/attorneys understood separate decisions would issue.

The Arbitrator finds:

The records from Dr. Chopra are contained in Petitioner's Exhibit 4. In looking at those records from April 5, 2007 through the last note of June 16, 2011, there are 30 office visits in which shortness of breath is mentioned. In 28 of those office notes, it states that James Jackson denied any shortness of breath. The two office visits where Mr. Jackson complained of shortness of breath were on 2/03/10 and 12/17/10. On both occasions Mr. Jackson was suffering from cold symptoms. There is no mention of occupational lung disease in any of Dr. Chopra's records. (PX 4)

Within Dr. Chopra's records is a letter from the Department of Health and Human Services. The letter notes that chest x-ray films taken on 5/08/07 as authorized under the Federal Mine Safety and Health Act of 1977were reported to show an abnormal heart size or cardiomegaly. The attached note from Dr. John Parker reflects a mild progressive increase in heart size from 1970 – 2007 as x-rays from 1970, 1974, 1992, 2002, 2006 and 2007 were being compared to identify any significant changes or progression of disease due to the abnormality of Petitioner's heart shape and/or size of cardiomegaly. (PX4; RX 6)

Petitioner's last day at Respondent's coal mine was December 31, 2007.

On February 2, 2008 Dr. Henry Smith, a B-reader, reviewed chest x-ray films taken on 1/07/08 and found evidence of CWP in a 1/0 profusion. (PX 2)

On February 22, 2008 James Jackson signed his Application for Adjustment of Claim in this matter. (AX 3)

Dr. Glennon Paul examined James Jackson on one occasion, June 11, 2008. He then issued a written report. Dr. Paul took a history from Mr. Jackson which included his working in the coal mines for 37 years, 32 of which were underground and five of which were above ground. Petitioner reported shortness of breath when walking for one mile and when going up two flights of stairs. He denied any coughing or wheezing. His symptoms had reportedly been present for about five years. By history, Petitioner had smoked ½ pack of cigarettes for two years, had undergone a triple bypass procedure, and suffered from diabetes mellitus, gastroesophageal reflux disease and hypercholesteremia. an employment history. At the time of the examination, Mr. Jackson was not under any treatment for a lung condition or breathing problem and was not on any medication for a breathing problem. (PX 1, dep. ex. 2)

Dr. Paul's physical examination of Petitioner's chest was normal. In reviewing the chest x-ray films brought to him, the doctor indicated that he saw fibronodular lesions. With regard to the pulmonary function study done, Dr. Paul indicated it showed a moderate restrictive lung disease which he felt was related to coal workers' pneumoconiosis. Dr. Paul also noted an abnormal carbon monoxide diffusing capacity. Dr. Paul indicated that

with regard to a restriction you really look at the total lung capacity measurement because it is more sensitive than the FVC and the FEV1. The total lung capacity was 60% of predicted. The FEV1 was 58% of predicted and the FVC was 53% of predicted. Dr. Paul indicated that Mr. Jackson was 71" inches tall and weighed 241 pounds. Dr. Paul wrote that he believed Petitioner had coal worker's [sic] pneumoconiosis with restrictive lung disease along with his other medical conditions as noted earlier in his report. (PX 1, dep. ex. 2)

On April 15, 2008 Mr. Jackson was examined by Dr. William Pyle with regard to his abnormal lower extremity Doppler studies which had shown moderate or more peripheral vascular disease. Mr. Jackson's main complaints centered on nocturnal cramps, especially in his feet. He denied any cramps while walking or going up and down stairs. Mr. Jackson reported extensive walking in the past as he had worked as a mine examiner but, since retiring, he didn't walk very much. Mrs. Jackson told the doctor that her husband had walked from the parking lot to the office (a relatively long distance) without having to stop or complain about his legs. On occasion, when going up stairs he would notice a heaviness in his legs. Dr. Pyle discussed lifestyle adjustments, including a walking program, with the Jacksons. (PX 4)

In looking at the record of Mr. Jackson's last visit with Dr. Chopra's on June 16, 2011, the different conditions listed under past medical history do not contain anything to suggest a lung problem. The medications listed do not reflect that any inhaler had been prescribed. The list of conditions included benign hypertension, Alzheimer's disease, neuropathy in diabetes, and diabetes mellitus. There is no mention of any lung condition or disease. The records back in 2007 routinely mention diabetes mellitus, hypertension, and hyperlipidemia. The note from 8/16/07 reflects cardiomegaly, secondary to coronary artery disease. It reflects coronary artery bypass surgery in 2002. The medical records between 4/05/07 and 6/16/11 do not reflect any diagnosis of any lung condition or disease (PX4).

Petitioner underwent a pulmonary function report at Evansville Pulmonary Associates on December 15, 2011 under the guidance of Dr. William Houser. According to the report, Mr. Jackson had moderate restrictive ventilator defect as indicated by a finding of a severely reduced forced vital capacity (FVC). Continued bronchodilator therapy was recommended. (PX 8)

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Dr. Tuteur evaluated Jackson on May 24, 2012. As part of the history Dr. Tuteur obtained, Jackson was not taking any medication for a breathing problem. Dr. Tuteur noted that Jackson was 5'11" tall and 245 pounds, approximately 60 pounds overweight. Because of the extra energy consumption required to do a task at the overweight status, one would expect there to be breathlessness where there would not be if he was at a normal weight. On his physical examination of the chest, Dr. Tuteur noted the expiratory duration was borderline between normal and too low. Dr. Tuteur reviewed the x-ray films taken on that day and found no evidence of coal workers' pneumoconiosis or any occupational lung disease. The pulmonary function study revealed a normal total lung capacity of 84% of predicted. The study revealed a mildly reduced FEV1, reflective of a mild obstructive abnormality. There was no restrictive abnormality. The diffusing capacity was normal at 85% of predicted. The arterial blood gas study was normal both at rest and with exercise. The oxygen saturation level was normal at 98%. With exercise, the level remained stable and normal. An electrocardiogram was also performed. The doctor noted that Jackson's heart rate was irregularly irregular. The electrocardiogram revealed atrial fibrillation with a relatively slow ventricular response. The doctor noted the electrocardiogram results would explain shortness of breath or exercise intolerance. With regard to Jackson's heart, Dr. Tuteur noted left ventricular dysfunction associated with concentric left ventricular hypertrophy and dilatation and diastolic dysfunction and atrial fibrillation. Dr. Tuteur noted coronary artery disease, hypertension, overweight status, diabetes and hyperlipidemia. These issues explain the mild obstructive ventilatory defect noted on the pulmonary function study. Dr. Tuteur found no evidence to support a diagnosis of coal workers' pneumoconiosis or any occupational lung disease. Dr. Tuteur noted that Jackson's shortness of breath and symptomatology including dizziness was not a function of lung problem but a heart problem. The symptoms were actually less than would be expected based upon the cardiac dysfunction. In comparing his pulmonary function study to Dr. Paul's, Dr. Tuteur indicated that the differences do not happen in the presence of coal workers' pneumoconiosis. The earlier physiologic abnormality in part resolved lending further support to the contribution from the heart problem. Dr. Tuteur noted that Jackson's pulmonary impairment was not due to a primary pulmonary disease but is secondary to his cardiac dysfunction. The doctor noted that the cardiac dysfunction was the explanation for the breathlessness. The doctor noted that the predicted pulmonary function values with age go down. (RX 1)

Petitioner was admitted to Kettering Hospital on June 22, 2012 when Mr. Jackson was seen because of a syncopal episode. Mr. Jackson was found to have atrial fibrillation and they proceeded with a pacemaker implantation. On page 2 of the records it indicates under problem list black lung disease noted by Krista Gilliam, RN. That diagnosis continues throughout the Kettering records without any indication that the condition was actually diagnosed by any doctor. Petitioner was discharged on June 23, 2012. (PX 5)

On August 19, 2012 Dr. Ralph Shipley, a B-reader read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 2)

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On December 19, 2012 Dr. Michael Alexander, a B-reader, also reviewed the films taken on 5/24/12 and felt that they showed CWP in a 1/1 profusion (PX3).

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On February 15, 2013 Dr. Christopher A. Meyer, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 4)

On February 24, 2013 Dr. Robert D. Tarver, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 3)

On February 28, 2013 Dr. Danielle M. Seaman, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 5)

Mr. Jackson was admitted to Kettering Hospital on April 23, 2013 for a procedure in the cath lab. He was discharged on April 25, 2013. (PX 7)

Petitioner returned to Kettering Hospital between July and August of 2013. The records reflect a number of chest x-ray films taken in the course of Mr. Jackson's care and treatment at Kettering Hospital. Chest x-ray films taken on 10/25/12 were read to show mild congestive change and no pneumothorax. There is no mention of any occupational lung disease or black lung. Subsequent chest films were taken on 11/15/12 revealing a small pneumothorax and moderate cardiomegaly with central pulmonary vascular prominence. There is no suggestion of any occupational lung disease or black lung. The initial medical records from Kettering Hospital do not reflect that Jackson was on any type of breathing medication. It would appear that the records first reflect that he was using an inhaler when he was at the hospital on November 30, 2012. The inhaler had not been mentioned when he was at the hospital two weeks before with a discharge date of 11/17/12. This would be almost five years after he last worked as a coal miner. (PX 6)

James Jackson was diagnosed with Non-Hodgkin's Lymphoma while at Kettering Hospital in July of 2013. When seen on July 3, 2013 his complaints included hypotension, fatigue and pain throughout his right side. Earlier that morning Mr. Jackson had experienced trouble supporting himself with the right side of his body. The discharge summary reveals the diagnoses to be Stage IV diffuse B-cell lymphoma, hypercalcemia secondary to malignancy, acute renal failure, diabetes mellitus, hypertension, atrial fibrillation, CAD status post myocardial infarction, congestive heart failure with an ejection fraction of 30-35%, and Alzheimer's Disease. Kettering Hospital records reflect a PET scan was done on 7/11/13 revealing bilateral pleural effusions which were concerning for malignancy, as well as at least two pulmonary nodules for which malignancy cannot be excluded. A chest x-ray was done on 7/17/13 showing an enlarged heart. There was also noted to be an accentuation of the bronchovascular markings suggesting some pulmonary venous congestion. There was no mention of any black lung or occupational lung disease on either interpretation. (PX6)

Mr. Jackson was admitted to Kettering Hospital on September 23, 2013 for a procedure in the cath lab. He was discharged on September 26, 2013. (PX 7)

Mr. Jackson underwent a transesphogeal ECHO at Kettering on January 31, 2014. (PX 7)

James Jackson was admitted to Heartland Hospice Services on April 6, 2014 for Non-Hodgkins Lymphoma. James Jackson passed away on May 19, 2014. (PX 9)

On June 7, 2014 Geraldine Jackson signed her Application for Adjustment of Claim in case #14 WC 21043 alleging her husband, James Jackson, died, in whole or in part, due to coal mine dust. (AX 4)

The Arbitration Hearing

Petitioner's claims were presented for arbitration on February 22, 2017. Both cases were consolidated for purposes of the hearing with separate decisions to be issued. Separate Request for Hearing forms were submitted at trial. Mr. Jackson's claim was also amended to indicate Geraldine Jackson was the petitioner, as executor of Mr. Jackson's estate. Petitioner, Geraldine Jackson, was the sole witness testifying at the hearing.

Petitioner, Geraldine Jackson as the executor of her husband's estate, testified that James Jackson's date of birth was 2/14/1949. He passed away on May 19, 2014. She testified that she is the executor of his estate. They were married 26 years. Mrs. Jackson testified that her husband began working with Respondent in December of 1970 and his last day of work was December 31, 2007, when the mine closed. According to Mrs. Jackson, her husband never worked elsewhere following the Respondent's mine closing in December of 2007, including never working for another coal company.

Geraldine Jackson testified that her husband had worked all of his years with Respondent at the #1 Mine in Carlinville, underground. She indicated his job classification as of December of 2007 was an examiner.

Geraldine Jackson testified that she noticed dust from the mine on her husband's clothes when she went to wash them. With regard to physical complaints or problems, she testified that there was coughing. She stated that her husband would get dizzy sometimes and even fell at the mine. She testified that this happened during the time that they were married. She testified that she did witness her husband having shortness of breath. He could not do a lot of stuff. He got to the point where his breathing was really bad and he had a CPAP machine at night. This was when he was still working at the mine. She noticed his problems getting progressively worse. She indicated that her husband had an inhaler, which he used a lot. James Jackson had seen Dr. Chopra as his family doctor for many years until they moved to Ohio in 2011.

Mrs. Jackson testified that, at some point, James Jackson received a pacemaker, probably in 2013. At that point, he was having trouble breathing and catching his breath. Not even a year later, they had to replace the pacemaker with a defibrillator. In 2012, James Jackson was diagnosed with cancer. He was having breathing problems. They discovered a mass that they thought was on his kidney but it was on his lung. This was a lymphoma. They tried to do surgery but it was already too advanced. They could not do chemotherapy because of his reaction to it. There was some radiation treatment. James Jackson had high blood pressure and diabetes and was taking medication for both. In addition to the pacemaker and defibrillator, he had open heart surgery back in 2002. He also had an enlarged heart.

Mrs. Jackson testified that besides the breathing difficulties and cancer, Mr. Jackson also had high blood pressure and diabetes. She agreed that he had an enlarged heart. Mrs. Jackson testified that her husband was an occasional smoker. He would maybe smoke one or two cigarettes a week. He had not smoked since they had married, this would be approximately 30 years.

Proofs were closed on February 22, 2017.

On/about March 28, 2017 Petitioner's attorney, Mr. Wissore, filed a Notice of Motion and Order in both cases regarding a Motion to Consolidate Evidence. A hearing on this motion was held in Quincy on April 5, 2017. At that time proofs were re-opened for consideration of Petitioner's Motion to Consolidate Evidence. A hearing on the Motion was held in Springfield on May 25, 2017. At that time the Arbitrator denied the Motion and entered a written Order. Proofs were again closed.

The Arbitrator concludes:

Petitioner has failed to prove by a preponderance of the evidence that James Jackson sustained an occupational disease arising out of and in the course of his employment. The Arbitrator finds the B-readings of Drs. Shipley, Tarver, Meyer, and Seaman to be more persuasive. Six B-readers reviewed the same chest x-ray dated May 24, 2012. Four of the B-readers found it to be negative for CWP while two of them found it to be positive for CWP. While all B-readers were experienced, the Arbitrator finds the fact that four out of the six read the same x-ray as being negative quite compelling.

In comparing the evaluations by Dr. Paul and Dr. Tuteur, the Arbitrator notes that Dr. Tuteur's evaluation was more thorough. It included an arterial blood gas study done both at rest and with exercise, which was always normal. An oxygen saturation level was measured before and during exercise and was normal. In view of the heart issues, Dr. Tuteur also had an electrocardiogram performed. Dr. Tuteur noted a mild obstructive abnormality from his pulmonary function study, but testified that this was not due to any pulmonary disease, but was secondary to Mr. Jackson's cardiac dysfunction. There was no evidence of any restrictive abnormality as the total lung capacity was within the normal range. Additionally, the carbon monoxide diffusing capacity was normal. Both of those numbers were abnormal at the time of Dr. Paul's evaluation. Dr. Tuteur noted that these differences do not take place in the presence of coal workers' pneumoconiosis. He thought the explanation was from the heart problems. A little over a month after Dr. Tuteur saw Petitioner, Petitioner underwent surgery at which time a pacemaker was installed. Dr. Paul did not really address the extent of Mr. Jackson's heart problems. The Arbitrator does note that Dr. Tuteur evaluated Mr. Jackson almost exactly four years after Dr. Paul did. Dr. Tuteur concluded that there was no evidence to support a diagnosis of coal workers' pneumoconiosis or any occupational lung disease. That particular opinion is corroborated by the B-readings of four different board-certified radiologists, Dr. Shipley, Dr. Tarver, Dr. Meyer and Dr. Seaman. Further, the records of Dr. Chopra do not suggest that Jackson was having any problems with breathing or had any type of lung condition or disease. At virtually every office visit over a four year period of time (4/05/07 to 6/16/11), the note indicates that Mr. Jackson denied shortness of breath. The only exceptions were two occasions on which he had a cold. The records support the fact that Mr. Jackson was having significant heart problems. He had the coronary bypass surgery in 2002. The letter from the Department of Health and Human Services noted progressive increase in heart size through the most recent films taken in May of 2007.

While Mr. Jackson's medical records at Kettering Hospital do note black lung disease under "past medical history," no evidence was presented as to how these entries came about. Their inclusion in that section, without more, do not in and of themselves establish that Mr. Jackson had CWP.

Based upon the evidence in the record, the Arbitrator finds that Petitioner has failed to prove that James Jackson developed an occupational disease from any exposures he had working for Respondent. The claim for compensation is denied.

All other issues are moot. Petitioner's claim for benefits is denied.

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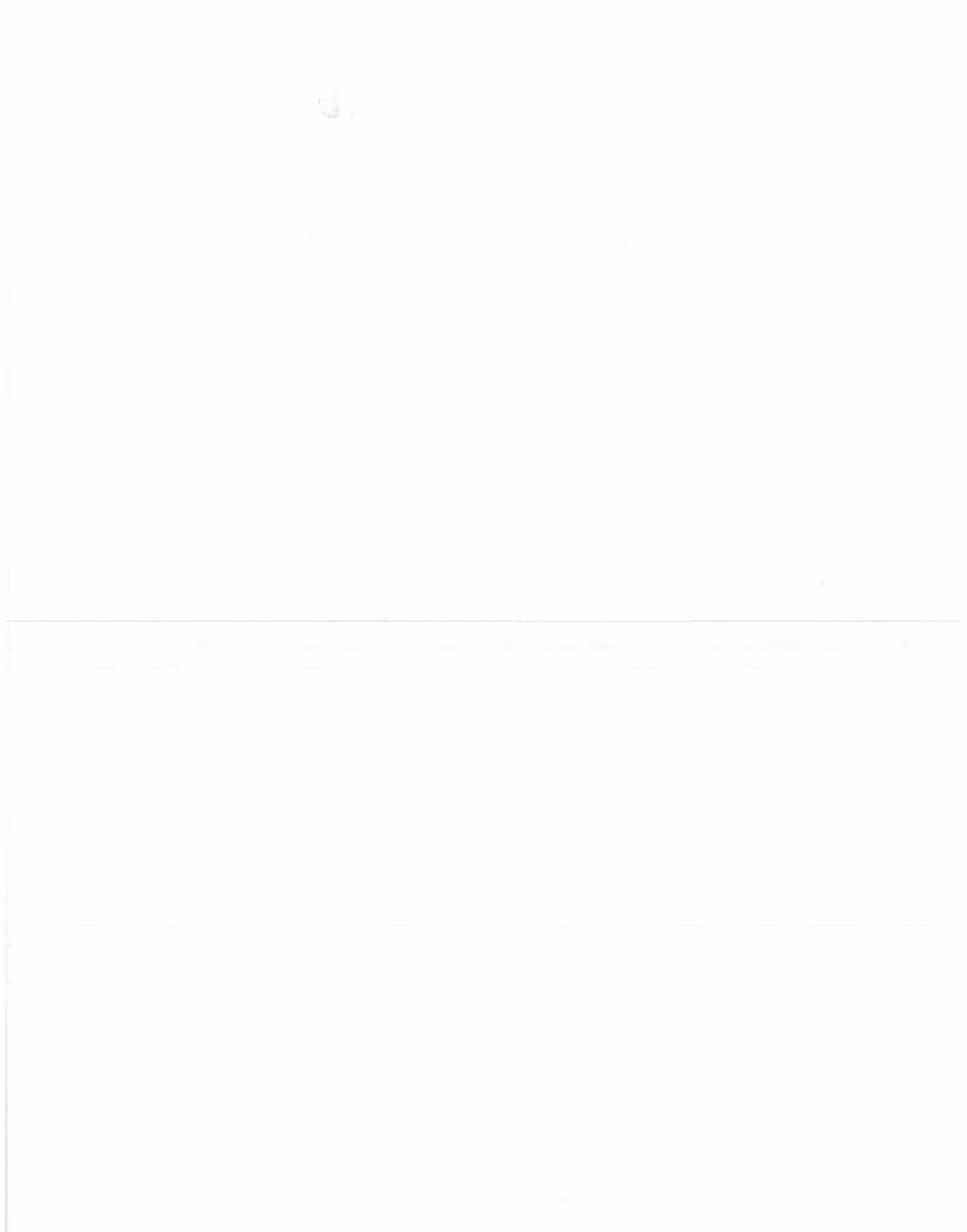

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

[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

Geraldine Jackson as Executor of the estate of James Jackson,
Petitioner,

19IWCC0169

vs. NO: 14 WC 21043

Monterey Coal Company,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 13, 2017, is hereby affirmed and adopted.

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

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

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

DATED: MAR 15 2019
o3/7/18
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0169

JACKSON, GERALDINE AS EXECUTOR OF THE ESTATE OF JACKSON, JAMES
Employee/Petitioner

Case# **14WC021043**

08WC009203

MONTEREY COAL COMPANY
Employer/Respondent

On 7/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62703

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

Geraldine Jackson, widow of James Jackson,
Employee/Petitioner

Case # 14WC 21043

v.

Consolidated cases: 08 WC 9203

Monterey Coal Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield** on **2/22/2017**, city of **Quincy on 4/5/2017**, and City of **Springfield on 5/25/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/19/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, the Employee *was not* exposed to an occupational disease that arose out of and in the course of employment.

Timely notice of this last exposure *was* given to Respondent.

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

In the year preceding the last date of exposure, the Employee earned $**82,776.00**; the average weekly wage was $**1,591.85**.

On the date of last exposure, the Employee was **58** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

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

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

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

Signature of Arbitrator

July 9, 2017
Date

JUL 1 3 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner has two claims on file against Respondent: 08 WC 09203 and 14 WC 21043. The "08" claim was originally filed by James Jackson. He subsequently passed away and Petitioner intervened in the case. She also filed a separate claim for benefits which is the subject of this case. The two cases were consolidated for hearing and the parties/attorneys understood separate decisions would issue.

The Arbitrator finds:

The records from Dr. Chopra are contained in Petitioner's Exhibit 4. In looking at those records from April 5, 2007 through the last note of June 16, 2011, there are 30 office visits in which shortness of breath is mentioned. In 28 of those office notes, it states that James Jackson denied any shortness of breath. The two office visits where Mr. Jackson complained of shortness of breath were on 2/03/10 and 12/17/10. On both occasions Mr. Jackson was suffering from cold symptoms. There is no mention of occupational lung disease in any of Dr. Chopra's records. (PX 4)

Within Dr. Chopra's records is a letter from the Department of Health and Human Services. The letter notes that chest x-ray films taken on 5/08/07 as authorized under the Federal Mine Safety and Health Act of 1977were reported to show an abnormal heart size or cardiomegaly. The attached note from Dr. John Parker reflects a mild progressive increase in heart size from 1970 – 2007 as x-rays from 1970, 1974, 1992, 2002, 2006 and 2007 were being compared to identify any significant changes or progression of disease due to the abnormality of Petitioner's heart shape and/or size of cardiomegaly. (PX4; RX 6)

Petitioner's last day at Respondent's coal mine was December 31, 2007.

On February 2, 2008 Dr. Henry Smith, a B-reader, reviewed chest x-ray films taken on 1/07/08 and found evidence of CWP in a 1/0 profusion. (PX 2)

On February 22, 2008 James Jackson signed his Application for Adjustment of Claim in this matter. (AX 3)

Dr. Glennon Paul examined James Jackson on one occasion, June 11, 2008. He then issued a written report. Dr. Paul took a history from Mr. Jackson which included his working in the coal mines for 37 years, 32 of which were underground and five of which were above ground. Petitioner reported shortness of breath when walking for one mile and when going up two flights of stairs. He denied any coughing or wheezing. His symptoms had reportedly been present for about five years. By history, Petitioner had smoked ½ pack of cigarettes for two years, had undergone a triple bypass procedure, and suffered from diabetes mellitus, gastroesophageal reflux disease and hypercholesteremia. an employment history. At the time of the examination, Jackson was not under any treatment for a lung condition or breathing problem and was not on any medication for a breathing problem. (PX 1, dep. ex. 2)

Dr. Paul's physical examination of Petitioner's chest was normal. In reviewing the chest x-ray films brought to him, the doctor indicated that he saw fibronodular lesions. With regard to the pulmonary function study done, Dr. Paul indicated it showed a moderate restrictive lung disease which he felt was related to coal workers'

pneumoconiosis. Dr. Paul also noted an abnormal carbon monoxide diffusing capacity. Dr. Paul indicated that with regard to a restriction you really look at the total lung capacity measurement because it is more sensitive than the FVC and the FEV1. The total lung capacity was 60% of predicted. The FEV1 was 58% of predicted and the FVC was 53% of predicted. Dr. Paul indicated that Mr. Jackson was 71" inches tall and weighed 241 pounds. Dr. Paul wrote that he believed Petitioner had coal worker's [sic] pneumoconiosis with restrictive lung disease along with his other medical conditions as noted earlier in his report. (PX 1, dep. ex. 2)

On April 15, 2008 Mr. Jackson was examined by Dr. William Pyle with regard to his abnormal lower extremity Doppler studies which had shown moderate or more peripheral vascular disease. Mr. Jackson's main complaints centered on nocturnal cramps, especially in his feet. He denied any cramps while walking or going up and down stairs. Mr. Jackson reported extensive walking in the past as he had worked as a mine examiner but, since retiring, he didn't walk very much. Mrs. Jackson told the doctor that her husband had walked from the parking lot to the office (a relatively long distance) without having to stop or complain about his legs. On occasion, when going up stairs he would notice a heaviness in his legs. Dr. Pyle discussed lifestyle adjustments, including a walking program, with the Jacksons. (PX 4)

In looking at the record of Mr. Jackson's last visit with Dr. Chopra's on June 16, 2011, the different conditions listed under past medical history do not contain anything to suggest a lung problem. The medications listed do not reflect that any inhaler had been prescribed. The list of conditions included benign hypertension, Alzheimer's disease, neuropathy in diabetes, and diabetes mellitus. There is no mention of any lung condition or disease. The records back in 2007 routinely mention diabetes mellitus, hypertension, and hyperlipidemia. The note from 8/16/07 reflects cardiomegaly, secondary to coronary artery disease. It reflects coronary artery bypass surgery in 2002. The medical records between 4/05/07 and 6/16/11 do not reflect any diagnosis of any lung condition or disease (PX4).

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On December 19, 2012 Dr. Michael Alexander, a B-reader, also reviewed the films taken on 5/24/12 and felt that they showed CWP in a 1/1 profusion (PX3).

On January 31, 2013 Dr. Michael Alexander, a B-reader, reviewed the films from 1/07/08 and found them to be positive for CWP in a 1/0 profusion. (PX 3)

On February 15, 2013 Dr. Christopher A. Meyer, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 4)

On February 24, 2013 Dr. Robert D. Tarver, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 3)

On February 28, 2013 Dr. Danielle M. Seman, a B-reader, read the 5/24/12 chest x-ray film and found it negative for coal workers' pneumoconiosis. (RX 5)

Mr. Jackson was admitted to Kettering Hospital on April 23, 2013 for a procedure in the cath lab. He was discharged on April 25, 2013. (PX 7)

Petitioner returned to Kettering Hospital between July and August of 2013. The records reflect a number of chest x-ray films taken in the course of Mr. Jackson's care and treatment at Kettering Hospital. Chest x-ray films taken on 10/25/12 were read to show mild congestive change and no pneumothorax. There is no mention of any occupational lung disease or black lung. Subsequent chest films were taken on 11/15/12 revealing a small pneumothorax and moderate cardiomegaly with central pulmonary vascular prominence. There is no suggestion of any occupational lung disease or black lung. The initial medical records from Kettering Hospital do not reflect that Mr. Jackson was on any type of breathing medication. It would appear that the records first reflect that he was using an inhaler when he was at the hospital on November 30, 2012. The inhaler had not been mentioned when he was at the hospital two weeks before with a discharge date of 11/17/12. This would be almost five years after he last worked as a coal miner. (PX 6)

James Jackson was diagnosed with Non-Hodgkin's Lymphoma while at Kettering Hospital in July of 2013. When seen on July 3, 2013 his complaints included hypotension, fatigue and pain throughout his right side. Earlier that morning Mr. Jackson had experienced trouble supporting himself with the right side of his body. The discharge summary reveals the diagnoses to be Stage IV diffuse B-cell lymphoma, hypercalcemia secondary to malignancy, acute renal failure, diabetes mellitus, hypertension, atrial fibrillation, CAD status post myocardial infarction, congestive heart failure with an ejection fraction of 30-35%, and Alzheimer's Disease. Kettering Hospital records reflect a PET scan was done on 7/11/13 revealing bilateral pleural effusions which were concerning for malignancy, as well as at least two pulmonary nodules for which malignancy cannot be excluded. A chest x-ray was done on 7/17/13 showing an enlarged heart. There was also noted to be an accentuation of the bronchovascular markings suggesting some pulmonary venous congestion. There was no mention of any black lung or occupational lung disease on either interpretation. (PX6).

Mr. Jackson was admitted to Kettering Hospital on September 23, 2013 for a procedure in the cath lab. He was discharged on September 26, 2013. (PX 7)

Mr. Jackson underwent a transesphogeal ECHO at Kettering on January 31, 2014. (PX 7)

James Jackson was admitted to Heartland Hospice Services on April 6, 2014 for Non-Hodgkins Lymphoma. James Jackson passed away on May 19, 2014. According to the Death Certificate, the cause of Mr. Jackson's death was Non-Hodgkin's Lymphoma. (PX 2 and RX 2 of "Additional Exhibits)
(PX 9)

On June 7, 2014 Geraldine Jackson signed her Application for Adjustment of Claim in case #14 WC 21043 alleging her husband, James Jackson, died, in whole or in part, due to coal mine dust. (AX 4)

On September 16, 2015, and at the request of Petitioner's attorney, Dr. Istanbouly performed a records review and then prepared a report. The doctor noted that he reviewed B-readings from Dr. Smith and Dr. Alexander,

Dr. Paul's report from 6/11/08, Dr. Houser's pulmonary function results, Kettering Health Network records, Dr. Chopra's records and Heartland Hospice records. Dr. Istanbouly indicated that he had looked at a pulmonary function study from May of 2012 on the day of the deposition. Dr. Istanbouly testified that all of the chest x-rays revealed findings consistent with coal workers' pneumoconiosis and none of the chest x-rays were read as normal. However, the doctor did not review the B-reading reports from Dr. Shipley, Dr. Tarver, Dr. Meyer or Dr. Seaman. All four of these board certified B-readers felt that the chest x-ray films from 5/24/12 were negative for coal workers' pneumoconiosis. Dr. Istanbouly indicated that the pulmonary function results between 2008 and 2012 met the DOL criteria for disability. Dr. Istanbouly agreed that if the FEV1 and FVC in 2012 were 70% of predicted or above, that would not meet the criteria for disability. The pre-bronchodilator FVC and FEV1 on 5/24/12 were both 71% of predicted. With the bronchodilator, they were slightly increased to 76% and 75% of predicted. Dr. Istanbouly indicated he did not see the rest of the data or the report from Dr. Tuteur from May of 2012. Dr. Istanbouly agreed that if in May of 2012 the arterial blood gas study at rest and with exercise was felt to be normal, that would suggest that Jackson did not have hypoxemia at that time. Dr. Istanbouly also indicated that he did not see a copy of the death certificate. (PX 1 – Additional Exhibits)

Based upon the information he did have, Dr. Istanbouly indicated that James Jackson had a severe case of coal workers' pneumoconiosis. Dr. Istanbouly referred to the 2008 pulmonary function results of Dr. Paul showing a moderate restrictive defect and a moderate reduction of the DLCO. He did not see the pulmonary function results from Dr. Tuteur's evaluation four years later which showed no restrictive defect, with a normal total lung capacity, and a normal DLCO. Dr. Istanbouly indicated that James Jackson's pulmonary diseases including coal workers' pneumoconiosis were a causative factor in his death. He indicated that each one of those diseases hastened Jackson's death. Dr. Istanbouly indicated that Mr. Jackson had chronic hypoxemia. He noted that when you get to the point of needing oxygen, your lung disease is advanced. Dr. Istanbouly agreed that oxygen can be prescribed because of a heart condition. The doctor never saw or treated James Jackson. (PX 1 – Additional Exhibits)

At the request of Respondent, Dr. Tuteur issued a supplement report on September 19, 2016. (RX 2 to RX 1 – Additional Exhibits) He was later deposed. Dr. Tuteur reviewed medical records from Kettering Health Network and Dr. Chopra. He also reviewed Dr. Istanbouly's report and Dr. Istanbouly's deposition. He had a transcript of his own deposition to review as well as the deposition of Dr. Paul. He reviewed the hospice records. He reviewed the pulmonary function data from Dr. Paul's examination and his own examination, as well as the data from 12/15/11 from Dr. Houser. He reviewed the B-readings from Dr. Smith, Dr. Alexander, Dr. Shipley, Dr. Meyer, Dr. Seaman and Dr. Tarver. Finally, he reviewed the medical certificate of death signed by Dr. Okwara. Based upon his review of all of the records just noted, his opinion with regard to a pulmonary problem and a coal mine dust related pulmonary disease did not change from the time of his initial exam of Mr. Jackson (in 2012) (RX 1 – Additional Exhibits, pp. 1 – 6 and supplemental report).

At the outset Dr. Tuteur reaffirmed that at the time he examined Mr. Jackson in May of 2012 he found no evidence of coal workers' pneumoconiosis or any occupational lung disease. He also testified that, based upon all of the information he had reviewed, Mr. Jackson's heart problem worsened thereafter, which is an expected natural history of the disease. Dr. Tuteur testified that when Mr. Jackson underwent a CT scan to evaluate for a spinal disease, it revealed Non-Hodgkin's Lymphoma. This was about a year after Dr. Tuteur had seen Mr. Jackson in May of 2012. The doctor explained that Non-Hodgkin's Lymphoma is a malignant process involving the lymph nodes and blood. It is a systemic problem and untreated or treated can lead to death. The records revealed the Non-Hodgkin's Lymphoma as Stage IV, which is the bad end. The doctor noted that the treatment attempted for the Non-Hodgkin's Lymphoma was not successful in controlling the disease. Some forms of chemotherapy used in the treatment of Non-Hodgkin's Lymphoma can adversely affect the heart. In

this case, the heart was already severely compromised due to his coronary artery disease and its complications. The treatment had to be discontinued. (RX 1 – Additional Exhibits, pp. 6 – 9)

Dr. Tuteur indicated that based upon his evaluation of Jackson and the medical records reviewed, the immediate cause of death was Non-Hodgkin's Lymphoma, widely metastatic, its treatment and complications. The doctor indicated that not too long before Mr. Jackson's death, he was on oxygen. Shortly before death, he had a multiplicity of health problems headed up by the extremely severe cardiomyopathy, as well as the lymphoma and its treatment consequences. One of the sequences of lymphoma is to adversely affect heart muscle function. In this case, his heart failure worsened. His ejection fraction dropped below 30% at times. The most important function of the heart is to pump oxygenated blood to the tissues. Supplemental oxygen was provided to make sure that the blood was filled with as much oxygen as possible to blunt the adverse effect of a pumping deficit. This was treatment for congestive heart failure. Dr. Tuteur found no evidence in the medical records reviewed of any treatment Mr. Jackson was having with regard to any lung problems. With reasonable medical certainty, Dr. Tuteur opined that Mr. Jackson's employment with Respondent did not play a part in his death. He also indicated that coal mine employment with exposures to dust and fumes and vapors did not contribute in any way to Mr. Jackson's death or hasten his death. (RX 1 – Additional Exhibits, pp. 10 - 12) Dr. Tuteur further testified that he found no evidence that Mr. Jackson had CWP or any occupational lung disease. (RX 1 – Additional Exhibits, p. 46)

On cross-examination Dr. Tuteur explained that atrial fibrillation is a dysrhythmia of the heart. When asked "And if a person has a chronic lung disease overlaid on atrial fibrillation, can the chronic lung disease affect the atrial fibrillation?" Dr. Tuteur replied that it could with "extremely severe pulmonary disease." However, he added "That's not the case here." (RX 1 – Additional Exhibits, pp. 15-16) Dr. Tuteur also agreed that Mr. Jackson became hypoxemic in the two years preceding his death; however, it was not on account of a primary lung disease. (RX 1 – AE, pp. 16-17) Dr. Tuteur remained adamant throughout cross-examination that Mr. Jackson did not have a pulmonary disease due to his work for Respondent. He also repeatedly pointed out that the questions he was often being presented with on cross-examination were general in nature and not specific to Mr. Jackson's particular situation. (RX 1 – AE, pp. 20, 35) He further testified that just because Mr. Jackson received medications at Kettering that are often used to treat lung disease did not necessarily mean he had lung disease. Dr. Tuteur was of the opinion that Mr. Jackson's cardiomyopathy explained all of his symptoms. (RX 1 – AE, p. 20)

Dr. Tuteur further testified that Mr. Jackson's pulmonary function testing in 2012 was nearly normal. He acknowledged a mild obstruction at best – or at worst, no impairment of oxygen gas exchange. He further found those findings consistent with one suffering from congestive heart failure and cardiomyopathy. (RX 1 – AE, pp. 21-22) When asked about the various pulmonary function tests Mr. Jackson had undergone, Dr. Tuteur again noted that pulmonary congestion due to heart disease will give the same type of results. Additionally, Mr. Jackson had no history of asthma. (RX 1 – AE, pp. 22-25) Dr. Tuteur acknowledged that Mr. Jackson's records included diagnoses of CWP, asthma, COPD and/or black lung but he found no credible support for those diagnoses with reasonable medical certainty. (RX 1 – AE, p. 25)

Dr. Tuteur also acknowledged that B-readers Meyer, Shipley, Seaman, and Tarver read Mr. Jackson's chest x-rays at the request of Respondent. He also acknowledged that their reports are on letterhead containing the email address and number of Nancy Hudson but he did not know who she was or anything about the logistics of where the doctors were located. (RX 1 – AE, pp. 26- 32)

Dr. Tuteur further acknowledged that it would be possible for one to have pathologic fulfillment of criteria for the diagnosis of CWP and have a normal chest radiograph, normal pulmonary function, and no symptoms and the gold standard for establishing the existence of lung disease is autopsy. (RX 1 – AE, pp. 33 – 40)

Dr. Tuteur was asked about Mr. Jackson's death certificate. He agreed that it did not mention pneumonia and listed the Non-Hodgkin's Lymphoma as the cause of death. He also agreed that death certificates can be inaccurate. He also acknowledged that while cardiac disease and pulmonary disease can co-exist, with reasonable certainty there was no credible evidence indicating the presence of any primary lung disease in Mr. Jackson. (RX 1 – AE, pp. 48-49)

The Arbitration Hearing

Petitioner's claims were presented for arbitration on February 22, 2017. Both cases were consolidated for purposes of the hearing with separate decisions to be issued. Separate Request for Hearing forms were submitted at trial. Mr. Jackson's claim was also amended to indicate Geraldine Jackson was the petitioner, as executor of Mr. Jackson's estate. Petitioner, Geraldine Jackson, was the sole witness testifying at the hearing.

Petitioner, Geraldine Jackson as the executor of her husband's estate, testified that James Jackson's date of birth was 2/14/1949. He passed away on May 19, 2014. She testified that she is the executor of his estate. They were married 26 years. Mrs. Jackson testified that her husband began working with Respondent in December of 1970 and his last day of work was December 31, 2007, when the mine closed. According to Mrs. Jackson, her husband never worked elsewhere following the Respondent's mine closing in December of 2007, including never working for another coal company.

Geraldine Jackson testified that her husband had worked all of his years with Respondent at the #1 Mine in Carlinville, underground. She indicated his job classification as of December of 2007 was an examiner.

Geraldine Jackson testified that she noticed dust from the mine on her husband's clothes when she went to wash them. With regard to physical complaints or problems, she testified that there was coughing. She stated that her husband would get dizzy sometimes and even fell at the mine. She testified that this happened during the time that they were married. She testified that she did witness her husband having shortness of breath. He could not do a lot of stuff. He got to the point where his breathing was really bad and he had a CPAP machine at night. This was when he was still working at the mine. She noticed his problems getting progressively worse. She indicated that her husband had an inhaler, which he used a lot. James Jackson had seen Dr. Chopra as his family doctor for many years until they moved to Ohio in 2011.

Mrs. Jackson testified that, at some point, James Jackson received a pacemaker, probably in 2013. At that point, he was having trouble breathing and catching his breath. Not even a year later, they had to replace the pacemaker with a defibrillator. In 2012, James Jackson was diagnosed with cancer. He was having breathing problems. They discovered a mass that they thought was on his kidney but it was on his lung. This was a lymphoma. They tried to do surgery but it was already too advanced. They could not do chemotherapy because of his reaction to it. There was some radiation treatment. James Jackson had high blood pressure and diabetes and was taking medication for both. In addition to the pacemaker and defibrillator, he had open heart surgery back in 2002. He also had an enlarged heart.

Mrs. Jackson testified that besides the breathing difficulties and cancer, Mr. Jackson also had high blood pressure and diabetes. She agreed that he had an enlarged heart. Mrs. Jackson testified that her husband was an

occasional smoker. He would maybe smoke one or two cigarettes a week. He had not smoked since they had married, this would be approximately 30 years.

Proofs were closed on February 22, 2017.

On/about March 28, 2017 Petitioner's attorney, Mr. Wissore, filed a Notice of Motion and Order in both cases regarding a Motion to Consolidate Evidence. A hearing on this motion was held in Quincy on April 5, 2017. At that time proofs were re-opened for consideration of Petitioner's Motion to Consolidate Evidence. A hearing on the Motion was held in Springfield on May 25, 2017. At that time the Arbitrator denied the Motion and entered a written Order. Proofs were again closed.

The Arbitrator concludes:

In the living miner's claim (08 WC 9203) the Arbitrator found that Petitioner therein failed to prove by a preponderance of the evidence that James Jackson sustained an occupational disease arising out of and in the course of his employment with Respondent. The Arbitrator found the B-readings of Drs. Shipley, Tarver, Meyer, and Seaman to be more persuasive than those of Petitioner's B-readers. Six B-readers reviewed the same chest x-ray dated May 24, 2012. Four of the B-readers found it to be negative for CWP while two of them found it to be positive for CWP. While all B-readers were experienced, the Arbitrator found the fact that four out of the six read the same x-ray as being negative quite compelling.

While the letterhead for the reports of Shipley, Traver, Meyer and Seaman included the name of "Nancy Hudson" along with her email address and telephone number, the Arbitrator does not find that should reduce the weight to be given to their readings/opinions. Petitioner's attorney could have deposed these doctors but did not.

In comparing the evaluations by Dr. Paul and Dr. Tuteur, the Arbitrator notes that Dr. Tuteur's evaluation was more thorough than that of Dr. Paul. It included an arterial blood gas study done both at rest and with exercise, which was always normal. An oxygen saturation level was measured before and during exercise and was normal. In view of the heart issues, Dr. Tuteur also had an electrocardiogram performed. Dr. Tuteur noted a mild obstructive abnormality from his pulmonary function study, but testified that this was not due to any pulmonary disease, but was secondary to Mr. Jackson's cardiac dysfunction. There was no evidence of any restrictive abnormality as the total lung capacity was within the normal range. Additionally, the carbon monoxide diffusing capacity was normal. Both of those numbers were abnormal at the time of Dr. Paul's evaluation. Dr. Tuteur noted that these differences do not take place in the presence of coal workers' pneumoconiosis. He thought the explanation was from the heart problems. A little over a month after Dr. Tuteur saw Petitioner, Petitioner underwent surgery at which time a pacemaker was installed. Dr. Paul did not really address the extent of Mr. Jackson's heart problems. The Arbitrator does note that Dr. Tuteur evaluated Mr. Jackson almost exactly four years after Dr. Paul did. Dr. Tuteur concluded that there was no evidence to support a diagnosis of coal workers' pneumoconiosis or any occupational lung disease. That particular opinion is corroborated by the B-readings of four different board-certified radiologists, Dr. Shipley, Dr. Tarver, Dr. Meyer and Dr. Seaman. Further, the records of Dr. Chopra do not suggest that Jackson was having any problems with breathing or had any type of lung condition or disease. At virtually every office visit over a four year period of time (4/05/07 to 6/16/11), the note indicates that Mr. Jackson denied shortness of breath. The only exceptions were two occasions on which he had a cold. The records support the fact that Mr. Jackson was having significant heart problems. He had the coronary bypass surgery in 2002. The letter from the Department of Health and Human Services noted progressive increase in heart size through the most recent films taken in May of 2007.

While Mr. Jackson's medical records at Kettering Hospital do note black lung disease under "past medical history," no evidence was presented as to how these entries came about. Their inclusion in that section, without more, do not in and of themselves establish that Mr. Jackson had CWP.

The records from Heartland Hospice reflect an admitting diagnosis of Non-Hodgkin's Lymphoma and a terminal diagnosis of Non-Hodgkin's Lymphoma. The death certificate signed by Dr. Ikechi Okwara notes the cause of James Jackson's death to be Non-Hodgkin's Lymphoma. The only other medical condition noted is hypercalcemia. There is no mention of any lung condition or lung disease.

The Arbitrator notes that Dr. Istanbouly testified that Mr. Jackson had a severe case of coal workers' pneumoconiosis. That opinion is not supported by the other medical evidence in the record, including the B-readings. The Arbitrator notes that Dr. Istanbouly never saw Jackson or treated him. Although the doctor testified that Mr. Jackson had chronic hypoxemia, he did not indicate when that condition began. He agreed that with a normal blood gas study in May of 2012, Mr. Jackson did not have hypoxemia at that time. The Arbitrator notes Dr. Tuteur's explanation that Jackson's need for supplemental oxygen was the result of his congestive heart failure, not any lung condition. He found no indication in the medical records reviewed of any treatment Mr. Jackson was getting with regard to any lung problems. Finally, the Arbitrator notes that Dr. Istanbouly did not have a number of medical records which were contrary to his opinion. This includes the death certificate signed by Dr. Ikechi Okwara, which indicates that the cause of death was Non-Hodgkin's Lymphoma. Having noted that the hospice records reflect this as the terminal diagnosis and that Dr. Tuteur indicated that the immediate cause of death was Non-Hodgkin's Lymphoma, the Arbitrator finds that the cause of Mr. Jackson's death was Non-Hodgkin's Lymphoma. The Arbitrator agrees with Dr. Tuteur that Mr. Jackson's employment with Respondent did not play a part in his death in any way.

The Arbitrator is aware that Dr. Tuteur made some general concessions on cross-examination that one could argue favor Petitioner; however, Dr. Tuteur was adamant and consistent throughout his deposition that his concessions were based upon "possibilities" and not specific to Mr. Jackson's case. In the end his belief that Mr. Jackson's death was unrelated to his employment for Respondent was more persuasive, informed, and strong than that of Dr. Istanbouly.

Petitioner's claim for compensation is denied and no benefits are awarded. All other issues are moot.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHARIF ADEN,

Petitioner,

vs. NO: 17 WC 37745

TYSON FOODS, INC.,

Respondent.

19IWCC0170

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the sole issue of accident, 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 Arbitrator found that Petitioner sustained an accident on November 21, 2017, that arose out of and in the course of his employment with Respondent. The Commission agrees with the Arbitrator's finding of accident, but writes to modify and expand the Arbitrator's reasoning on this issue. To obtain compensation under the Act, a claimant bears the burden of showing, by a

preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). "In the course of employment" refers to the time, place, and circumstances surrounding the injury. That is to say, for an injury to be compensable, it generally must occur within the time and space boundaries of the employment. *Id.* A claimant's injury must also "arise out of" the employment; an injury "arises out of" the employment if the injury "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Id.* at 203-04.

The case at bar involves an injury that occurred as a result of a physical altercation between two employees of the employer. Our Supreme Court has consistently held that injuries suffered by employees resulting from assaults are not compensable if there was evidence to sustain a finding by the Commission that the motive was personal to the victim, rather than work-related, or if the injured employee was the aggressor. *Schultheis v. Indus. Comm'n*, 96 Ill. 2d 340, 346-47 (1983); *Franklin v. Indus. Comm'n*, 211 Ill. 2d 272, 279-80 (2004). Further, our Supreme Court has held that injuries suffered in assaults, the motives for which are unexplained, are not compensable. *Rodriguez v. Indus. Comm'n*, 95 Ill. 2d 166, 171 (1982). However, where the assailant's identity was known and there was no evidence of personal motive, an award was proper despite the claimant's inability to give a reason for the assault. *Id.*

On November 21, 2017, Petitioner had finished his shift, and moved his car to a public space adjacent to the employer-owned lot so he could be close to the employee entrance of Respondent's plant; Petitioner was waiting for three co-workers to finish their shift, so he could drive them home. (T.22-25). Petitioner further testified that while he waited for his co-workers, he wanted to clean his lunch box from the passenger side of his car; Petitioner exited his car, walked over to the passenger side, and opened the door. He was subsequently attacked and stabbed by his co-worker, Said Mohamed. (T.25-28). Petitioner had not spoken to Mr. Mohamed that day, prior to being stabbed. (T.30).

The Arbitrator based his Decision on several findings; the Arbitrator found that transporting co-workers to and from work was a benefit to Respondent, and therefore a risk connected with or incident to Petitioner's employment. Respondent disputes this finding, arguing that there is no evidence that Petitioner,

> . . .was tasked with dropping off colleagues after work on behalf of Respondent, under a written agreement, it is impossible to see how voluntarily agreeing to drive some of his colleagues home after work is in any way connected with Petitioner's position as a butcher with Respondent. Respondent was not even aware of this arrangement between Petitioner and his colleagues until the night of the incident. (Respondent's Brief, pg. 12).

The Arbitrator also found that Petitioner was not the aggressor, noting that Petitioner was outside his car, on the passenger side, removing his lunch box to make room for additional passengers, when Mr. Mohamed grabbed Petitioner from behind and attacked him.

The Arbitrator further found that the stabbing arose out of and in the course of Petitioner's employment, because the evidence demonstrated that Respondent was aware that Mr. Mohamed made multiple threats of physical harm against Petitioner starting in 2016, after Petitioner had reported Mr. Mohamed to his supervisor for poor work performance. The Arbitrator noted that Mr. Mohamed threated to kill Petitioner with a knife, and in a separate incident, Mr. Mohamed grabbed Petitioner in the parking lot. The Arbitrator specifically noted that, "Petitioner's testimony and the letter[s] contained in Petitioner's employment file show Said Mohamed's threats started after Petitioner reported Said Mohamed to the supervisor and continued until Petitioner was stabbed." (Arbitrator's Decision, pg. 7).

Respondent's primary position is that there is no evidence that the quarrel between Petitioner and Mr. Mohamed was work-related. Respondent indicated that any alleged dispute between the two men in 2012, would not explain why Mr. Mohamed would have waited until 2016 to begin quarreling with Petitioner. "The first documentation of a conflict between Petitioner and Mohamed is when Petitioner filed his first complaint following the parking lot incident of May 23, 2016, four years after what Petitioner claims is the source of their conflict." (Respondent's Brief, pg. 9).

Respondent also argues that Petitioner contradicts his position by stating in subsequent reports that he does not know why Mr. Mohamed does not like him; Respondent's position is that any issues between Petitioner and Mr. Mohamed are personal in nature. (Respondent's Brief, pgs. 9-10). Respondent notes that Mr. Mohamed himself filed numerous complaints against Petitioner; none of Mr. Mohamed's complaints state a work-related reason for their dispute. Finally, Respondent states that there was nothing in Mr. Mohamed's employment file to demonstrate that he had any propensity toward committing acts of violence. (Respondent's Brief, pg. 10).

On the contrary, Petitioner argues that the altercation with Mr. Mohamed was work-related. By his Brief, Petitioner states that Mr. Mohamed was a butcher at the time of the accident. This was a position superior to that occupied by Petitioner. Petitioner claims that Mr. Mohamed became angry when asked to assist different departments under the supervision of a less senior employee, and became angrier when the junior employee reported him. Mr. Mohamed's employment records demonstrated that Mr. Mohamed was repeatedly disciplined for refusing assigned work, and his failure to obey directions. (Petitioner's Brief, pg. 4).

Turning to the arbitration record, Petitioner testified that some time in 2013, he was working in the team leader position, and Mr. Mohamed was working as a butcher, a higher position than team leader. According to Petitioner, Mr. Mohamed was brought in to assist Petitioner, but refused to do so; Petitioner reported Mr. Mohamed, and Mr. Mohamed was subsequently transferred. (T.44-47; T.49). "After that time he, Said, he started to threaten me, every time he

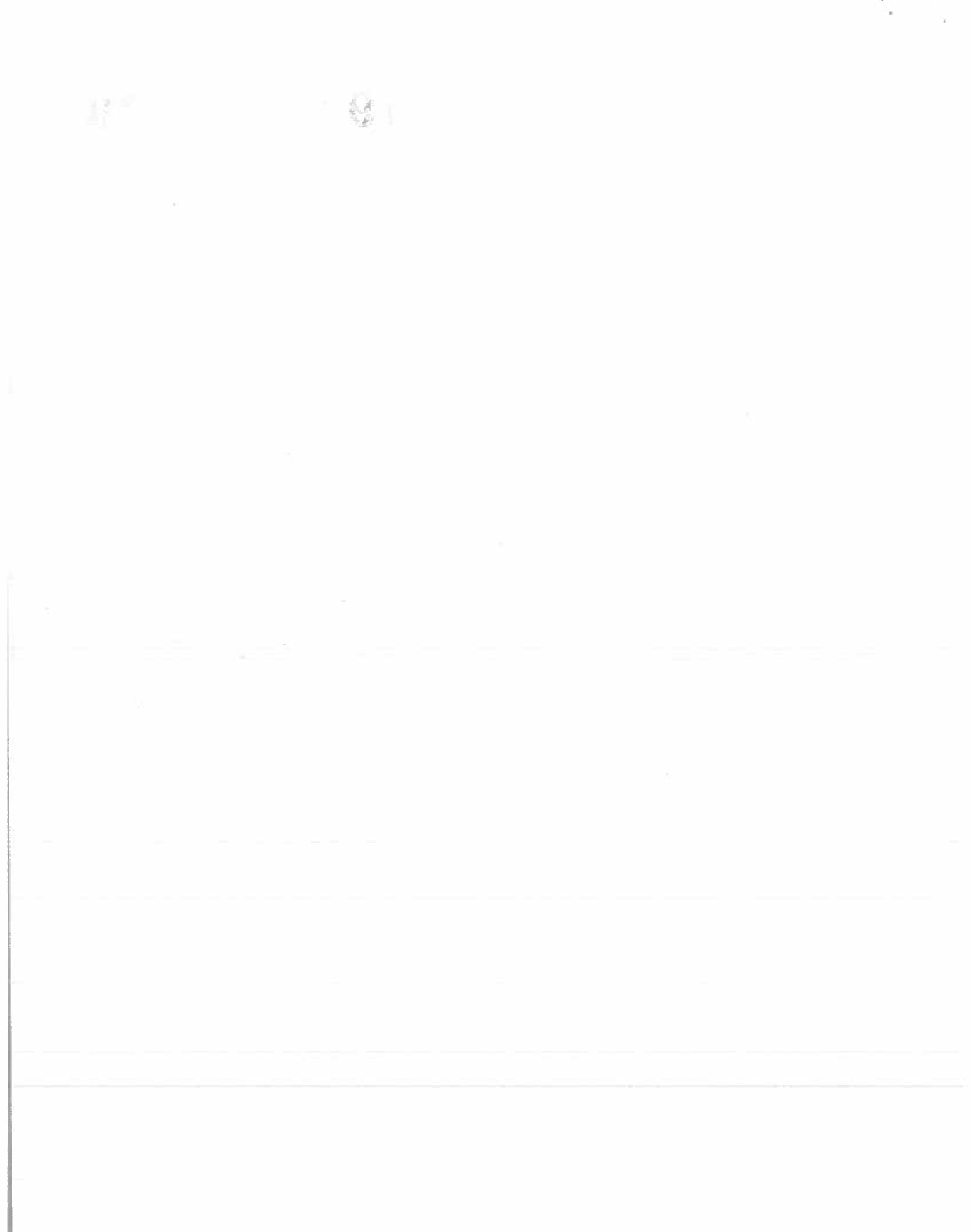
meet me he see me." (T.48-49). Petitioner stated that Mr. Mohamed threatened him every day up until the day of the attack. (T.50). Petitioner did report the threats to Respondent. (T.50). In 2014, Petitioner moved to the butcher position where he saw Mr. Mohamed more frequently. (T.50; T.64). During cross-examination, Petitioner added that when he was promoted at work, he believed Mr. Mohamed was jealous. (T.66-67). A review of the record demonstrates no sufficient basis to deem the attack on Petitioner as personal in nature; there was no other witness who testified to the contrary, and the personnel records provided no clarification as to whether the animosity between both men was work-related or personal in nature. What is known by the record, is that Petitioner testified that he only saw Mr. Mohamed at work; Petitioner never saw Mr. Mohamed outside of the plant; and, the conflict between two men occurred at work. (T.51-52).

What the personnel records do demonstrate is that Mr. Mohamed had been written-up for inappropriate behavior towards his supervisor and failure to follow his supervisor's instructions on three occasions; there was a handwritten report by an unknown individual who noted that Petitioner and Mr. Mohamed were involved in an argument on October 18, 2016, but they were arguing in their native tongue, and that individual could not understand them. That argument occurred after Mr. Mohamed was allegedly hit in the face by some "fat from the skinner" as he walked by Petitioner; there were also written reports from October 2016, signed by Respondent's production manager, Humberto Velazquez, and others, and written by Petitioner and unknown individuals, describing arguments between Petitioner and Mr. Mohamed; Petitioner described another incident where Mr. Mohamed allegedly threatened him with a knife, and threatened to kill Petitioner. (T.53; PX4, pgs. 18-23, 25; RX1, pg. 7, 10, 13, 16, 19-22). The October 11, 2016 report, signed by Humberto Velazquez, indicated that his boss, Alberto Barrios, the production office, union representative, and supervisor Jorge Lopez, were all informed of the argument between Petitioner and Mr. Mohamed. The report stated that both men would be disciplined and if another incident occurred they would be sent home and reported to HR. (RX1, pg. 10).

Petitioner had also been written up, along with Mr. Mohamed, for a confrontation in the parking lot on May 23, 2016; this confrontation was witnessed by a guard at Respondent's plant. (RX1, pgs. 23-24, 28, 30). Mr. Mohamed had also made written reports regarding Petitioner's threats against him. (RX1, pg. 25).

Rodriguez v. Indus. Comm'n, 95 Ill. 2d 166 (1983), is instructive in this case, as *Rodriguez* discussed,

> [A] category of 'neutral assaults' to account for those assaults which are neither personal nor clearly occupational in origin. This category included 'those assaults which are in essence equivalent to blind or irrational forces' (1 A. Larson, Workmen's Compensation sec. 11.31, at 3 -- 224 (1978)), and comprises but is not limited to assaults by insane or drunken co-employees and assaults the motive for which is unexplained although the identity of the assailant is



> known. (1 A. Larson, Workmen's Compensation secs. 11.32-11.34 (1978)). *Id.* at 172.

Although *Rodriguez* pertains to racial or ethnic prejudice as belonging in the neutral assault category, it stands for the overall proposition that assaults on claimants by insane, drunken or irresponsible co-employees and unexplained assaults by identifiable co-employees, may be a compensable workers' compensation claim. *Id. at 172-173.*

> The theory behind the decisions in the irrational co-employee cases is that when a co-employee suffers from a delusion or some similar condition which causes him to erupt into violence, his presence in the workplace in his state is a condition under which his victim is employed and must perform his work, just as a defective machine or ceiling in the workplace would be, and in that sense is a risk peculiar to the employment and not shared by the world at large. *Id. at 173.*

The case of *Hurt v. Indus. Comm'n*, is similar to the case at bar. The claimant in *Hurt*, had just arrived at work, parked his vehicle in the company lot, got out of the vehicle, but still had the driver's door open and was reaching inside the vehicle to remove his lunch bucket when he was approached by a co-employee, Dave Turner. Without provocation or warning and without saying anything, Turner smashed his fist or another blunt object into claimant's face. 191 Ill. App. 3d 733, 738 (4th Dist. 1989). The Appellate Court held that the claimant sustained a work-related accident. The Court found that the claimant demonstrated a reason for the assault, namely, the combativeness and apparent emotional instability of his assailant and co-employee; the claimant showed at the hearing that his assailant had exhibited a propensity toward the kind of assaultive conduct that had occurred; and,

> [T]he assailant's condition, whether known to the employer or not, was not unlike a defect, known or unknown, in a machine in the employee's work environment. Turner's presence in a combative, apparently emotionally unstable state was a condition in which the claimant was required to work. Thus, the risk of assault was one peculiar to his employment and not one shared by the world at large. Therefore, we hold that the accident arose out of claimant's employment. *Id. at 742.*

Thus, in the case at bar, the Commission finds that the evidence demonstrates that on November 21, 2017, Petitioner was not the aggressor in the stabbing altercation with Mr. Mohamed; and, a preponderance of the evidence does not show that the motive for the attack was personal to Petitioner rather than work-related. The evidence is also insufficient to rebut Petitioner's position that after he had reported Mr. Mohamed for his failure to assist Petitioner back in 2013, Mr. Mohamed began threatening him every day up until the day of the attack. (T.50). The best person to refute this position would have been Mr. Mohamed himself, but he did not testify at arbitration. Furthermore, and as noted by the Arbitrator, the evidence demonstrated that

Mr. Mohamed had the propensity toward the kind of violent conduct that he exhibited on November 21, 2017; the personnel records indicated that Mr. Mohamed verbally assaulted his supervisors and co-workers, there was an incident wherein he previously threated Petitioner with a knife and threatened to kill him, and Mr. Mohamed's conduct was known to Respondent's various managing personnel.

The Commission finds that the presence of Mr. Mohamed's combative, abusive state was a condition in which Petitioner was required to work; that the risk of assault was one peculiar to his employment and not one shared by the world at large; and, thus, the November 21, 2017 stabbing incident arose out of Petitioner's employment.

The Commission is not persuaded by Respondent's claim that because Petitioner was parked in a public parking space when the assault occurred, that Petitioner did not sustain a work-related injury. As stated above, Petitioner was subject, by reason of his employment, to a hazard to which the public was not exposed, and to which he was exposed peculiarly and to a greater degree than the public; thus, Petitioner's injury originated from a risk connected with the employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 19, 2018, is hereby modified as stated above; all else is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $330.00 per week for a period of 19 2/7 weeks, commencing November 22, 2017 through April 5, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit of $4,392.00 for employer provided short-term disability payments made to date. Respondent shall also be entitled to credit for any additional payments, hereinafter proven to have been made to Petitioner for additional short and long-term disability payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical services provided to Petitioner by Advocate Illinois Masonic Hospital and Dr. Martin Greenberg, and as evidenced in Petitioner's Exhibit 1c and Petitioner's Exhibit 2, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for medical bills previously paid, if any, for which credit may be allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the compensation accrued from November 21, 2017 through April 5, 2018, and shall pay the remainder of the award, if any, in weekly payments.

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 the Circuit Court.

DATED: MAR 1 8 2019
MJB/pm
O: 2-11-19
052

/s/ Michael J. Brennan
Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

ADEN, SHARIF
Employee/Petitioner

Case# **17WC037745**

TYSON FOODS INC
Employer/Respondent

19IWCC0170

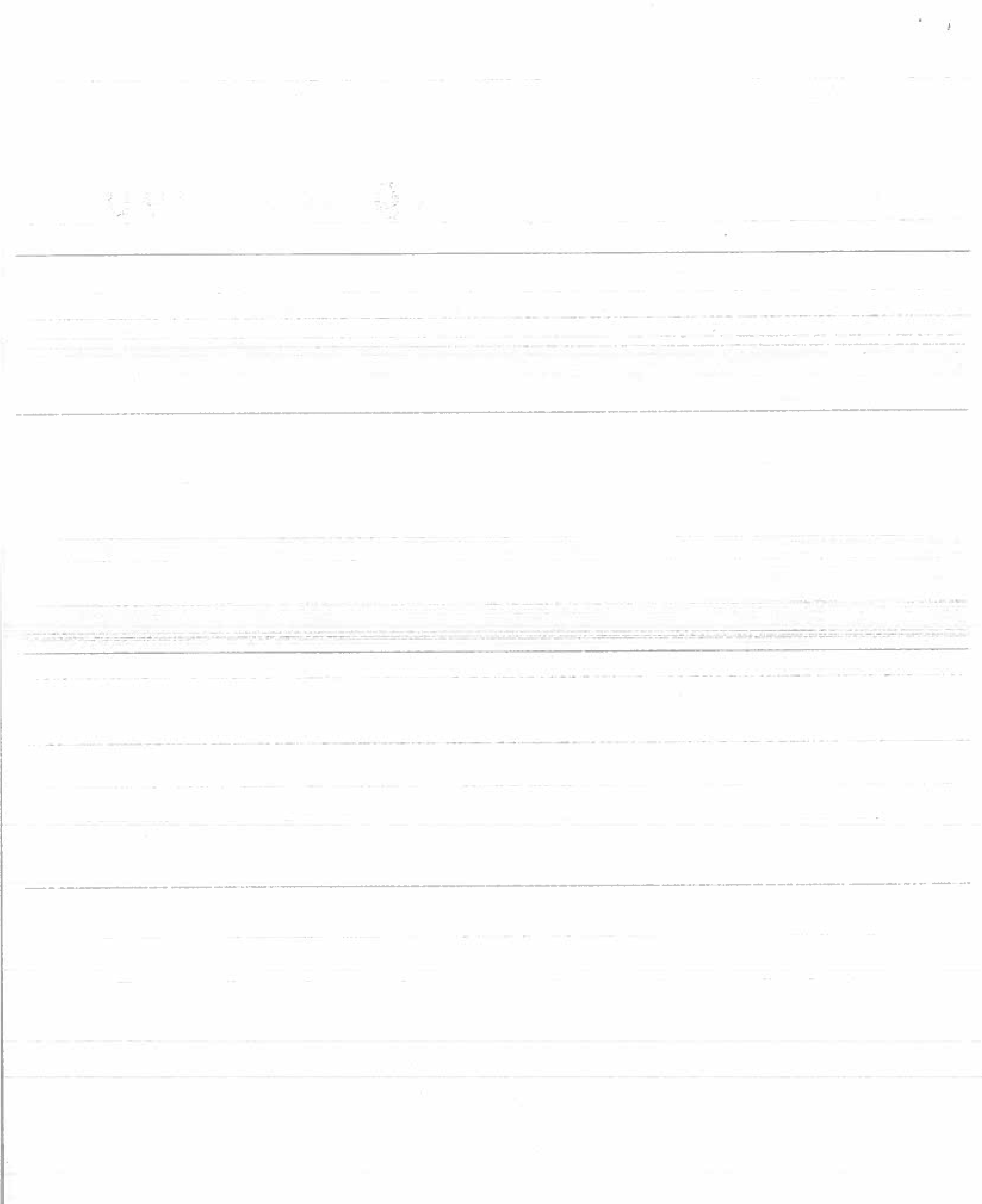
On 6/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

0013 DUDLEY & LAKE LLC
PETER M SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0210 GANAN & SHAPIRO PC
JEROME J WEBB
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602



STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION
19(b)

Sharif Aden
Employee/Petitioner

v.

Tyson Foods, Inc.
Employer/Respondent

Case # 17 WC 37745

Consolidated cases: _____

19IWCC0170

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **04/05/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **11/21/2017**, 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 **$33,800**; the average weekly wage was **$616.84**.

On the date of accident, Petitioner was **38** years of age, *single* with **4** dependent children.

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

Respondent is entitled to a credit of **$4,392.00** for employer provided short term disability payments made to date. Respondent shall also be entitled to credit for any additional payments, hereinafter proven to have been made, to Petitioner for additional short and long term disability payments, employer provided group medical payments made under Section 8(j) of the Act.

ORDER

Arbitrator finds that on November 21, 2017 Petitioner sustained injuries that **did** arise out of and in the course of employment by Respondent as set forth in the Conclusions of Law attached herein.

Respondent **shall pay** Petitioner **temporary total disability benefits** of $330/week for **19 2/7** weeks from **November 22, 2017 through April 5, 2018**, pursuant to Section 8(b) of the Act, less the stipulated **credit amount of $4,392.00** as set forth in the Conclusions of Law attached herein.

Respondent **shall reimburse** Petitioner for the **medical services** provided to Petitioner by Advocate Illinois Masonic Hospital and Dr. Martin Greenberg, as itemized in PX 1c and PX 2, pursuant to Section 8.2 and 8 (a) of the Act and pursuant to the Illinois Medical Fee Schedule as set forth in the Conclusions of Law attached herein.

Respondent shall pay Petitioner the compensation accrued from **11/21/2017** through **4/5/2018** and shall pay the remainder of the award, if any, in weekly payments.

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

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

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

Signature of Arbitrator

6/15/2018
Date

JUN 19 2018

Sharif Aden v. Tyson Foods, Inc., Case #17 WC 37745

PROCEDURAL HISTORY

This matter was tried before Arbitrator on April 5, 2018 pursuant to Section 19b of the Act. The disputed issues involved whether Petitioner sustained accidental injuries that arose out of and in the course of his employment. Respondent also disputed liability for Petitioner's medical bills and TTD benefits. The Parties stipulated that Respondent paid sort-term disability benefits of $4,392.00 and that Respondent would be entitled to a credit, pursuant to Section 8(j) of the Act, in the amount of $4392.00 if TTD benefits are awarded. The Parties further stipulated that Petitioner's average weekly wage was $616.84, pursuant to Section 10 of the Act, and Petitioner was married with four (4) dependent children. (Arb. Ex. #1, Tr. 9).

FINDINGS OF FACTS

On November 21, 2017, Sharif Aden (hereinafter referred to as "Petitioner") worked for Tyson Foods, Inc. (hereinafter referred to as "Respondent") as a butcher. Petitioner testified that he started working for Respondent in 2010. Petitioner was promoted to a butcher on or about November of 2012.

On November 21, 2017, Petitioner arrived at work and parked his vehicle in the employer owned parking lot, located in the back of the plant. At the end of his shift, Petitioner moved his vehicle and parked it in a parking spot located directly in front of the plant entrance, on Kostner Avenue, to pick up three (3) co-workers. Petitioner testified that he provided transportation to and from work to three (3) of his co-workers. The parking spot Petitioner parked is adjacent to the plant parking lot, near a shed used by a security officers. (PX 6). Petitioner testified that the parking spot he used was next to the employee parking lot and that there are no fences separating the public parking on Kostner Avenue from the employee parking. (Tr. 24).

Petitioner testified that he was unaware that he had parked near Said Mohamed. Petitioner testified that after parking his vehicle, he wanted to move his lunch bag and some other things from the front passenger seat to place those items in the trunk while he waited for his co-workers. Petitioner testified that he exited his vehicle and walked around to the front passenger side of his vehicle and was in the process of removing the items from the front seat of the vehicle when he suddenly felt a something pulling his jacket from behind with such force that

it caused Petitioner's body to rotate around. Petitioner testified that as his body rotated around, he was stabbed in the chest with a knife just below his heart. (Tr. 28). At that time, Petitioner recognized that his co-worker of six (6) years, Said Mohamed, was attacking him. (Tr. 29). Petitioner testified that he struck Said Mohamed and tried to run away. Said Mohamed caught Petitioner by his jacket and stabbed Petitioner, again, in the left side. Petitioner testified that started to scream for help when he was stabbed again. At that time, Petitioner grabbed Said Mohamed and placed him in a bear hug to hold down his arms. Petitioner testified that he was unable to hold Said Mohamed who broke free. When that happened, Petitioner placed his right hand on a car and Said Mohamed stabbed Petitioner in the right hand. (Tr. 32-34). Petitioner was in a struggle with Said Mohamed trying to hold the knife when Musilmo Yarani, Said Mohamed's wife, appeared and took the knife away from Said Mohamed. At that time, some people arrived and took Petitioner to the security shed. (Tr. 37). Petitioner testified that prior to being stabbed, he did not have any conversation with Mr. Mohamed. (Tr. 75).

Chicago Fire Department arrived and treated Petitioner for multiple stab wounds to his left flank, left tricep, left shoulder, left forearm and right hand. (PX 1b). Petitioner was taken emergently to Illinois Masonic Hospital. At the emergency room, Petitioner was found to have received stab wounds to the left upper extremity, left lower abdomen and right hand. (PX. 1b, p. 48, and 73-78). Petitioner underwent surgical repair of the stab wounds to his abdomen, left shoulder, left arm-triceps, left elbow, chin and right hand. Petitioner also sustained a large stab wound to the right hand which was treated by orthopedic surgeon, Martin Greenberg, M.D. Petitioner was found to have a large laceration over his right wrist and to the dorsum of the hand and to the index finger. The hand wounds were sutured closed until a second surgical repair could be performed, which occurred on December 8, 2017. (PX. 1a, pp. 58-60).

Petitioner testified that Said Mohamed started threatening him with bodily harm, in March of 2016, after he reported Said Mohamed to a supervisor for failing to perform his job duties. After Petitioner reported Said Mohamed to the supervisor, Said Mohamed as assigned the task of picking up garbage. (Tr. 47). Petitioner testified after reporting Said Mohamed to the supervisor, Said Mohamed regularly threaten Petitioner with bodily harm and Petitioner was in fear for his safety.

(Tr. pgs. 48, 49). Petitioner testified that he reported Said Mohamed's threats to Respondent orally and in writing. (Tr. 50).

Respondent submitted Petitioner's employment file into evidence, without objection. The file contained a letter authored by Petitioner, dated May 24, 2016, which details an incident occurring on May 23, 2016. In that letter Petitioner reported that after leaving work, while walking to his car, near the security shed, Said Mohamed tried to grab Petitioner and said, "*I will kick your ass and kill you*". Musilmo Yarani, who was with Said Mohamed, said, "*kick him he is gay*". (RX 1, pg. 27). The employment file contains a letter containing the observations of the security guard, Robert Hayes, described seeing the parties in each other's "*personal space*" and seeing facial expressions and hand gestures appearing to show anger. The letter indicates that Mr. Hays did not understand what was said because he did not understand the langue the individuals where speaking. (RX 1, pg. 28). Respondent issued a disciplinary action against both Petitioner and Said Mohamed for failing to get along. (RX 1, pg. 24). The Petitioner's employment file does not indicate whether the threats of bodily harm, contained in Petitioner's letter dated May 24, 2016, were further addressed.

Petitioner's employment file contained another letter authored by Petitioner, received by Respondent on September 16, 2016. In that letter, Petitioner stated that each day when he arrives at work, Said Mohamed attempts to confront Petitioner. Petitioner describes an incident in a bathroom, which occurred two weeks prior to authoring the letter. In the letter Petitioner indicates that he was in the bathroom when Said Mohamed approached him and said, "*fuck you*" in Somali. After the incident in the bathroom, Said Mohamed continued to look at Petitioner and make hand gestures of a fist, while pointing outside, and moving his fists toward his face as if he was punching his face. In that letter, Petitioner reported that he did not feel safe because Said Mohamed works with knifes and he was sure what Said Mohamed was capable for doing. In that letter, Petitioner wrote "*...every day when I come to work I fear my safety...I wanted to tell you today because the situation is just getting worse*". (RX. Pgs. 21,22). Petitioner's employment file does not contain documentation indicting whether the threats were addressed internally or referred to the police.

Petitioner's employment file contained another letter authored by Petitioner. In that letter, Petitioner describes an incident occurring on the 4th of October. Petitioner stated that Said Mohamed approached him and said, in Somali, "*I will kill you*". In the same letter, Petitioner reported another incident, occurring on the 8th of October. At that time, Petitioner reported that Said Mohamed, while holding a knife, approached him and said to him in Somali, "*Do you know that I have the ability to take you down right now, and if you open your mouth, I will kill you*". (RX 1, pg. 20). In that letter, Petitioner wrote "I *am really worried about my safety, every time I address my problem or write a letter no one is really investigating the situation. Last time I wrote a letter too and no one bothered to get back to me about it. What happened on Saturday with Said taking his knife out on me was what I have feared for a while and it happened and now I am more than scared for my safety because this isn't a joke.*" (RX 1, pg. 20). Petitioner's employment file does not contain any documentation indicating whether Respondent addressed the threats of violence internally or referred the matter to the police.

Jonathan Perez, who is employed as a human resource manager for Respondent, testified that Petitioner was hired as a food handler responsible for picking up garbage. On April 11, 2011, Petitioner was moved to a different department where Petitioner received training to become a butcher. Petitioner qualified to be promoted as a butcher on November 26, 2012. Jonathan Perez testified that he had never had a problem with Petitioner. (Tr. 86-91). Jonathan Perez testified that Petitioner had a good reputation as a hard worker and he is welcome back to work. (Tr. 92, 93). Jonathan Perez testified that Mr. Mohamed's employment was terminated after the stabbing incident. (Tr. 97). Jonathan Perez confirmed that Said Mohamed received a note of discipline for refusing to follow supervisor's directions that ultimately a general manager having to intervene with a warning of termination. Jonathan Perez also testified that Said Mohamed received discipline notices on March of 2016 and May 2016. (Tr. 94-95). Jonathan Perez testified that he was aware of Petitioner's notices regarding the threats being made to him by Said Mohammed. (Tr. 98).

Humberto Velazquez, who works for Respondent as a projection manager, testified that Said Mohamed was disciplined at least three (3) times for his temper and refusing to obey directions of

supervisors. (Tr. 135). Humberto Velazquez testified that Petitioner was a good worker who did whatever he was told to do. (Tr. 136).

Musilmo Yarani, the wife of Said Mohamed, testified for Respondent. Musilmo Yarani testified that she only knows Petitioner through work. (Tr. 141). Musilmo Yarani testified that she was in the backseat of the car when Petitioner parked his car nearby and, at that time, her husband turned on the car, got out of the car, and walking over to Petitioner's car. Musilmo Yarani testified that she saw someone get hit so she ran to security for help. Musilmo Yarani went to Petitioner's car and she saw the Petitioner bleeding. (Tr. 144,145). Musilmo Yarani testified that she grabbed the knife and threw it into her car but that she did not know who owned the knife. (Tr. 147). Musilmo Yarani also testified that Petitioner hit her husband first. (Tr. 146).

The Arbitrator found the testimony of Petitioner to be credible.

CONCLUSIONS OF LAW

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

The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992). To obtain compensation under the Act, the claimant bears the burden of showing by a preponderance of the evidence, he suffered a disabling injury which arose out of, and in the course of his employment. *Baggett v. Industrial Commission*, 201, Ill 2d. 187, 266 Ill. Dec. 836, 775 N.E. 2d 908 (2002).

WITH RESPECT TO ISSUE (C) DID PETITIONER SUSTAINED AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT, THE ARBITRATOR FINDS AS FOLLOWS:

To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his or her injury "arose out of" and "in the course of" the employment. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). Both elements must be present at the time of the claimant's injury to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478 (1989). An injury "arises out of" one's employment if its origin is in some risk connected with or incident to

the employment, so that there is a causal connection between the employment and the accidental injury. *Jewel Cos. V. Industrial Comm'n*, 57 Ill.2d 38, 310 N.E.2d 12 (1974). A claimant's 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." *Sisbro, Inc. v. Industrial Comm'n*, 2017 Ill. 2d 193, 203 (2003).

Accidental injuries sustained in a parking lot, either owned or controlled by the employer, within a reasonable time before or after work hours generally have been held to occur in the course of employment. *Hammel v. Industrial Comm'n*, 253 Ill. App. 3d. 900, 626 N.E.2d 234 (3rd Dist. 1993). Compensable injuries are those arising out of the conditions under which the employee is required to work and, thus, may include injuries arising out of a fight when the injured employee is not the aggressor and when the fight is about the employer's work in which the employee is then engaged. *Chicago Park Dist. v. Industrial Comm'n*, 263 Ill. App. 3d 835, 635 N.E. 2d. 770 (1st Dist. 1994). An injury sustained by a claimant as a result of a scuffle at the workplace "arose out of" and occurred "in the course of" the claimant's employment when the conversation that prompted the confrontation concerned the quality of the claimant's work. It was the culmination of a series of acts by a co-worker, which followed his having been reported to the foreman by the claimant. *Ford Motor Co. v. Industrial Comm'n*, 78 Ill. 2d 260, 399 N.E.2d 1280 (1980). However, there is an exception to the rule that a fight had to be about work and not of a personal nature when the fight was racially motivated. Assaults by co-employees in the workplace that are motivated by general racial or ethnic prejudice are treated as compensable "neutral" risks "arising out of" employment. *Rodriguez. Industrial Comm'n*, 95 Ill. 2d 166, 447 N.E. 2d 186 (1982).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the evidence that he sustained an accidental injury that arose out of and in the course of his employment by Respondent on November 21, 2017, as more fully described below.

The Arbitrator fist finds that Petitioner was not the aggressor in his incident. Musilmo Yarani, wife of Mr. Mohamed, testified that Said Mohamed got out of his car and approached

Petitioner. The Petitioner testified that he was removing a lunch box from the front seat of the car when he was grabbed from behind and stabbed. Petitioner testified that he did not speak to Said Mohamed prior to the incident. The Arbitrator finds the evidence shows that Petitioner was not aware that Said Mohamed was the attacker until after being stabbed the first time.

Petitioner testified that he moved his vehicle and parked it on Kostner Avenue to pick up three (3) co-workers who Petitioner transports to and from work. The parking spot was located in front of the plant entrance near the guard shed. Respondent's employees, including Said Mohamed, use the Kostner Avenue parking spots. Petitioner testified that he parked his vehicle at that location because it is located in front of factory entrance used by the co-workers. (PX 6). The Arbitrator finds that transporting co-workers to and from work provides a benefit to Respondent and is a risk connected with or incident to employment.

The Arbitrator further finds that the stabbing arose out of and in the course of employment. Respondent was aware that Mr. Mohamed made multiple threats of physical harm against Petitioner starting in May of 2016 after Petitioner reported Said Mohamed to his supervisor for poor work performance. Petitioner's employment file contains numerous complaints of incidents involving threats of great bodily harm and death made by Said Mohamed. In one incident, Said Mohamed threatened to kill with a knife and in another incident Said Mohamed grabbed Petitioner in the parking lot, by the security shed, located near to the location where Said Mohamed grabbed Petitioner from behind and stabbed him. Petitioner's testimony and the letter's contained in Petitioner's employment file show Said Mohamed's threats started after Petitioner reported Said Mohamed to the supervisor and continued until Petitioner was stabbed.

WITH RESPECT TO ISSUE (J) WERE ALL THE MEDICAL SERVIES PROVIDED PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID FOR ALL APPROPRIATE CHANGES FOR THE REASONABLE AND NECESSARY MEDICAL SERVIES. THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims that Respondent is liable for medical bills from Advocate Illinois Masonic Hospital, in the amount of $93,372.00, and Dr. Martin Greenberg, in the amount of $21,940.00.

(Arb. Ex. #1). Respondent disputes liability for the medical expenses and treatment claiming that Petitioner's injuries did not arise out of and in the course of employment. Respondent did not proffer evidence disputing the reasonableness or necessity of the medical bills or treatment. The Arbitrator finds the medical bills and treatment were reasonable and necessary to treat Petitioner for his injuries. As stated above, the Arbitrator finds that Petitioner's injuries arose out of the course and scope of his employment by Respondent and, as such, the Arbitrator further finds that Respondent shall reimburse Petitioner for the medical services provided to Petitioner by Advocate Illinois Masonic Hospital and Dr. Martin Greenberg, as itemized in PX 1c and PX 2, pursuant to Section 8.2 of the Act and pursuant to the Illinois Medical Fee Schedule.

WITH RESPECT TO ISSUE (K) WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY BENEFITS, IF ANY, THE ARBITRATOR FINDS AS FOLLOWS:

The parties have stipulated that Petitioner's injuries have rendered him temporarily totally disabled from November 22, 2017 through April 5, 2018, the date of the hearing. (Arb. Ex. #1). The Parties further stipulated that if TTD benefits are awarded, Respondent would be entitled to a credit of $4,392.00 for short-term disability benefits Respondent paid. (Tr. 9).

When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized (*i.e.* whether the claimant has reached maximum medical improvement). *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132, 142, 923 N.E.2d 266, 271, 337 Ill. Dec. 707 (2010).* Respondent disputed liability for TTD benefits claiming Petitioner's injury did not arise out of and in the course of his employment. (Arb. Ex. #1). Based upon the Arbitrator's findings above, the Arbitrator further finds that Respondent shall pay TTD benefits from November 22, 2017 through April 5, 2018 representing 19 2/7th weeks, less the stipulated credit amount of $4,392.00.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AARON CALHOUN,

Petitioner,

vs. NO: 17 WC 0003

JEWISH COMMUNITY CENTER,

Respondent.

19IWCC0171

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner is entitled to TTD benefits and medical expenses through January 4, 2018. Petitioner underwent an FCE on May 10, 2017 and November 13, 2017. Both FCEs represented a valid effort on behalf of the Petitioner. During the November 13, 2017 FCE, Petitioner demonstrated the ability to work within the medium to heavy physical demand level, which was below his self-stated job demands. Dr. Krishna Chunduri, however, did not release Petitioner back to work until January 4, 2018.

The Commission is not persuaded by Dr. Avi Bernstein's Section 12 opinions. Dr. Bernstein noted that Petitioner was malingering for the purpose of secondary gain. However, his opinion is contradicted by the two valid FCEs, which indicated that Petitioner gave a full effort. Therefore, the Commission finds Petitioner is entitled to TTD through January 4, 2018.

The Commission further finds that Petitioner is entitled to medical expenses through January 4, 2018 as there is no credible evidence to rebut the reasonableness and necessity of the

medical expenses.

As to the nature and extent of Petitioner's injury, the Arbitrator awarded Petitioner 2% loss of use of the person as a whole. The Commission after taking into consideration the following five factors listed under Section 8.1(b) of the Act, awards Petitioner seven and a half percent (7.5%) loss of use of the person as a whole.

The Commission reviewed the Arbitrator's analysis of Section 8.1(b) and disagrees with the weight assigned to subsections (i) and (v). The Commission gives little weight to Dr. Bernstein's April 17, 2018 impairment rating for the reasons stated above. The Commission gives significant weight to subsection (v) noting that the MRI revealed disc bulges at L3-L4 and L4-L5. The FCE revealed that Petitioner has restrictions that precluded him from his full duty work. Further, Petitioner testified that he experiences back pain when he climbs stairs or bends over, and he takes over-the-counter medication for his condition. Based upon the record as a whole, the Commission finds that Petitioner is entitled to 7.5% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2018, 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 $449.33 per week for a period of 53-2/7 weeks (December 28, 2016 through January 4, 2018), 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 $404.40 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 7.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical services incurred through November 13, 2017 only, as provided under Section 8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 18 2019

Michael J. Brennan

MJB/tdm

19IWCC0171

d: 2/11/19
052

Thomas J. Tyrrell

Dissent

I respectfully dissent from the Majority's opinion modifying the Arbitrator's decision. I find the Arbitrator's decision to be thorough and well reasoned. I rely on the Arbitrator's detailed findings and would affirm and adopt this decision.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CALHUN, AARON
Employee/Petitioner

Case# **17WC000003**

JEWISH COMMUNITY CENTER
Employer/Respondent

19IWCC0171

On 8/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

2837 LAW OFFICE OF JOSEPH MARCINIAK
JAMES J MIRRO
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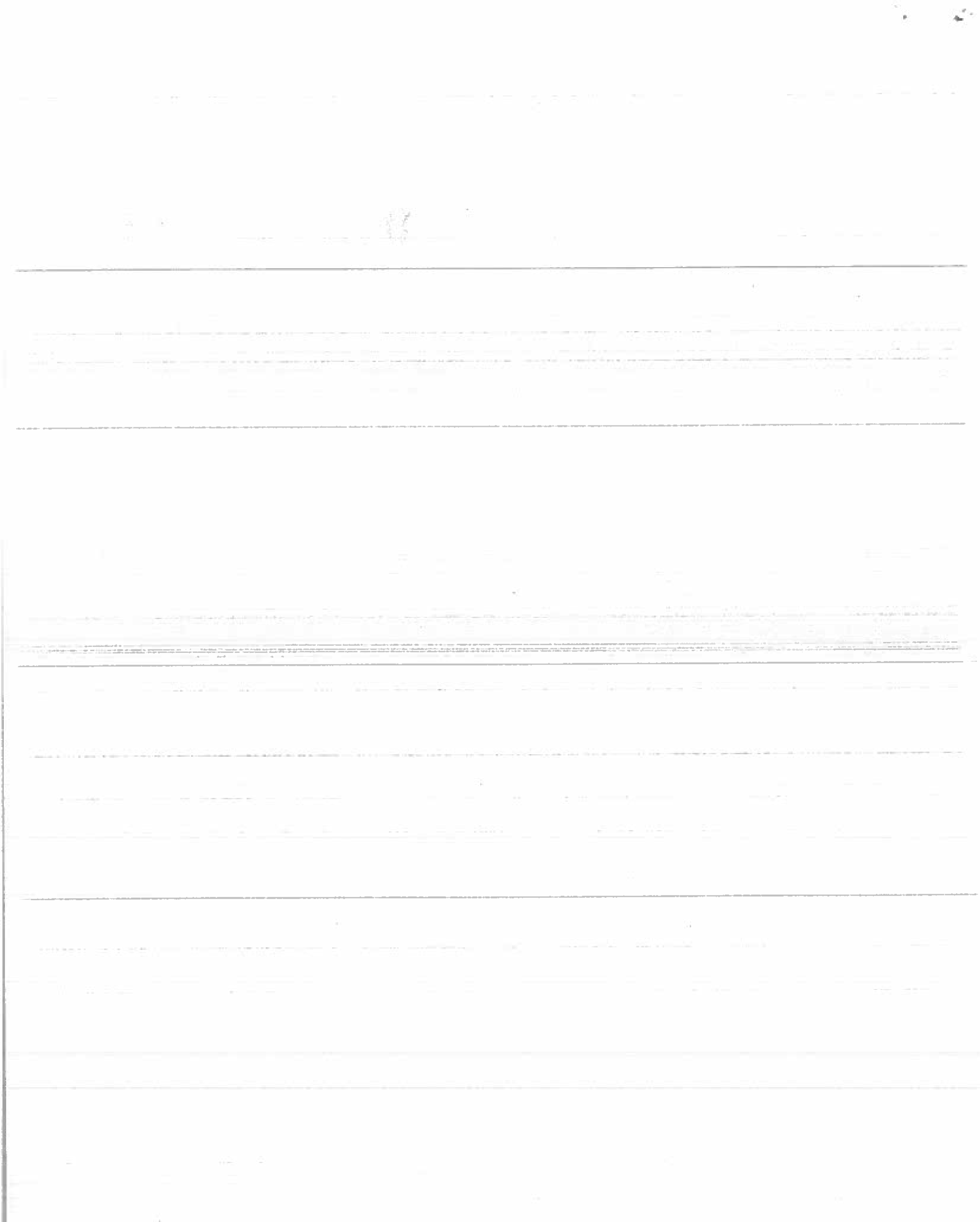
CHICAGO, IL 60606



STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Aaron Calhoun
Employee/Petitioner

v.

Jewish Community Center
Employer/Respondent

Case # 17 WC 000003

Consolidated cases:

19IWCC0171

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Charles Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **June 15, 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 ______

FINDINGS

On **12/27/16**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$35,049.04** ; the average weekly wage was **$674.00**.

On the date of accident, Petitioner was **30** years of age, *married* with **3** dependent children.

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

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

Respondent shall be given a credit of **$10,270.40** for TTD, $ for TPD, $ for maintenance, and **$10,270.40** for other benefits, for a total credit of $.

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 incurred through May 4, 2017 only, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $449.33/week for 20 weeks, commencing December 28, 2016 through May 16, 2017, as provided in Section 8(b) of the Act.

Credits

Respondent shall be given a credit for $10,270.40 for temporary total disability benefits paid under Section 8(b) of the Act.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 0% of the whole person as determined by Dr. Avi Bernstein, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Resp. Exhibit #3). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted non specific low back pain. Because of a lack of any significant findings on physical examination or in the clinical studies, 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 a janitor at the time of the accident and that he *is* able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that petitioner can continue in his line of work and that the accident has had no effect on his ability to continue in that line of work in the future. Because of that finding, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 30 years old at the time of the accident. Because of petitioner having a long work life ahead of him, and as the accident will not affect his ability to continue working in the future, 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's future earnings capacity has not been diminished in any way as a result of the accident. Because of that finding, the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the treating physicians Dr. Chunduri and Dr. Dixon did not see any significant MRI findings, gave a final diagnosis of lumbar spondylosis (a chronic, not acute condition), and returned petitioner to work at level higher than that outlined in the FCE. Because of these findings, 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 2% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

August 21, 2018
Date

AUG 22 2018

Aaron Calhoun v. Jewish Community Center – 17 WC 000003

Finding of Facts

Petitioner alleges an injury to his back incurred on December 27, 2016 when he was carrying chairs and slipped on the wet floor and felt pain. He went to the ER at Advocate Health Care the same day where an accident history was given of carrying folding chairs at work when he slipped on a puddle of water and landed on his back. (Pet. Ex. #1) A CT scan of the cervical spine done on December 27, 2016 showed no acute cervical fracture or malalignment and no high grade spinal canal or foraminal stenosis. (Pet. Ex. #1) Thereafter, Petitioner was ambulating in the ER without issue and stated that he was feeling much better and wanted to go home. (Pet. Ex. #1) Petitioner was subsequently discharged. (Pet. Ex. #1) Petitioner then saw Dr. Chunduri for an initial evaluation on December 29, 2016, where he was taken off work and prescribed physical therapy for cervicalgia and low back pain. (Pet. Ex. #2) Petitioner went to Premier Physical Therapy for an initial examination on December 31, 2016. (Pet. Ex. #3) An accident history was given of falling at work when Petitioner slid on a wet floor while carrying chairs. Dr. Chunduri prescribed an additional two weeks of therapy on January 30, 2017. An MRI of the lumbar spine done on January 30, 2017showed minimal disk bulges at L3-L5 without any significant stenosis. Dr. Chunduri diagnosed Petioner with lumbar radiculopathy and nerve root inflammation at L4-L5. He prescribed an additional 4 weeks of therapy on February 9, 2017, along with epidural steroid injections. Petitioner underwent a left L4 and L5 transforaminal epidural steroid injection for left lumbar radiculopathy on February 16, 2017. He returned to Dr. Chunduri on March 6, 2017 and pain relief from the injection was noted. Claimant underwent medial branch blocks on April 16, 2017. Dr. Chunduri prescribed an FCE on April 20, 2017.

Petitioner underwent an IME with Dr. Avi Bernstein on May 4, 2017. Dr. Bernstein found that the petitioner's objective findings did not support his subjective complaints, and that there was evidence of symptom magnification and exaggeration. (Resp. Ex. #1) Dr. Bernstein found the findings of disc bulges with normal heights and hydration to be consistent with normal shape of the discs, and did not represent any low back pathology. (Resp. Ex. #1) Dr. Bernstein found no reason that petitioner could not return to full duty work; he felt that no further treatment was indicated and believed the patient was malingering for the purposes of secondary gain. (Resp. Ex. #1)

An FCE was performed at ATI on May 10, 2017, which placed Petitioner at the light duty work level. (Pet. Ex. #4) Dr. Chundari noted this result on May 25, 2017. (Pet. Ex. #2)

Petitioner was then referred to Dr. Geoffrey Dixon for a surgical consultation which took place on June 19, 2017. (Id.) Dr. Dixon's physical exam indicated that Petitioner demonstrated normal strength in both upper and lower extremities, deep tendon reflexes were normal and symmetrical, and sensation was intact. (Id.) Dr.

Dixon's evaluation indicated that his review of the lumbar spine MRI demonstrated "very mild degenerative spondylosis without focal disk herniation or nerve root compression" and review of the EMG of both lower extremities was "not suggestive of a lumbar radiculopathy." (Id.) Dr. Dixon diagnosed "possible discogenic low back pain" and did not recommend surgery. (Id.) Dr. Dixon took petitioner off work and sent him for further physical therapy. (Id.) Dr. Dixon indicated that he "will defer all further decisions regarding [Petitioner's] work status and medications to pain management." (Id.)

Petitioner subsequently underwent additional therapy at Premier Therapy from June 21 to August 18, 2017, and then attended a work conditioning program, also at Premier Therapy from September 13 through October 31, 2017. (Pet. Ex. #4) Petitioner had another FCE at ATI on November 13, 2017, which placed petitioner at the medium to heavy duty work level, with occupational physical demand level noted as medium. Dr. Chunduri placed petitioner at maximum medical improvement on January 4, 2018, with work level noted as being medium to heavy work level with permanent restrictions of 60 pounds carrying, 70 pounds lifing, and 100 pounds pushing or pulling. (Pet. Ex. #2)

Dr. Bernstein wrote an IME addendum opinion on February 7, 2018. (Resp. Ex. #2) He reviewed additional medical records, the actual MRI scans, and the last FCE report. He stated that his previously expressed opinions remained unchanged, and that petitioner is capable of performing unrestricted work activity. Dr. Bernstein wrote another IME addendum on 4/17/18 which provided an AMA rating of whole person impairment of 0%. (Resp. Ex. #3)

Petitioner testified that following his discharge from Dr. Chundari's care on January 4, 2018, he has looked for work. Petitioner testified that he has not had additional accidents to his back or left leg. Petitioner testified that he continues to experience lower back and left leg pain that is aggravated by climbing stairs or bending. Petitioner testified that he takes non-prescription pain medication.

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

Petitioner bears the burden of proving by a preponderance of the evidence all of the elements of his claim. R & D Thiel v. Workers' Compensation Comm'n, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the Petitioner must establish is that his condition of ill-being is causally connected to his employment. Elgin Bd. of Education U-46 v. Workers' Compensation Comm'n, 409 Ill. App. 3d 943, 948 (2011). An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." Laclede Steel Co. v. Indus. Comm'n, 128 N.E.2d 718, 720 (Ill. 1955).

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in a disability may be sufficient circumstantial evidence to prove a causal connection between the accident and the employee's injury." Int'l Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63-64 (1982). 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. Schroeder v. Ill. Workers' Comp. Comm'n, 79 N.E.3d 833, 839 (Ill. App. 4th 2017).

The Arbitrator finds Petitioner's demeanor at trial to be guarded and, at times, awkward. The Arbitrator's impression of Petitioner at trial is that his description of his pain at various times over the course of his treatment to be exaggerated. Therefore, the Arbitrator finds Petitioner's testimony overall to lack credibility.

The medical records also support this finding that Petitioner's subjective pain complaints were exaggerated. On the same day as the accident, a CT scan of the cervical spine, done on December 27, 2016, showed no acute cervical fracture or malalignment and no high-grade spinal canal or foraminal stenosis. (Pet. Ex. #1) Thereafter, it was noted that Petitioner was ambulating in the ER without issue and stated that he was feeling much better and wanted to go home. (Pet. Ex. #1)

The Arbitrator notes that the treating physician Dr. Chunduri did not see any significant findings on the MRI and provided only conservative care. As Petitioner had completed his course of physical therapy and noted relief from pain following injections in March 2017, he was referred for an FCE, which normally signals the end of treatment. This was done in April 2017, and it was noted Petitioner could return to work. Nevertheless, despite a lack of objective findings and due solely to Petitioner's subjective pain complaints, he was referred for additional physical therapy and injections. Petitioner received over five months of additional physical therapy and medications before receiving yet another FCE.

Petitioner saw Dr. Avi Bernstein for an IME on May 4, 2017, after the first FCE had been completed. Dr. Bernstein noted a completely normal MRI and found that there were no objective findings on physical examination. He further found evidence of symptom magnification and exaggeration. He found no medical reason for why Petitioner could not return to full duty work, did not find any additional treatment to be indicated, and believed that the petitioner was malingering for the purpose of secondary gain. None of the additional treatments and clinical studies changed his initial opinion; in fact, they only served to reinforce that Petitioner did not suffer any permanent injury and could have returned to work long ago. No recommendation for surgery or treatment other than conservative care was ever made, and the final diagnosis of lumbar spondylosis points to no acute injury being suffered. As the physical examinations beyond Dr. Dixon's finding of "very mild degenerative spondylosis" were benign except for petitioner's subjective pain complaints, and as the MRI scan showed no objective evidence of pathology, the arbitrator finds the opinion of Dr. Avi Bernstein to be more credible than that of the Petitioner's treating physicians. Therefore, Petitioner had reached maximum

medical improvement as of the May 4, 2017 IME and any condition of ill-being after that date is not causally related to the work accident, and subsequent treatment after that date was both unreasonable and unnecessary.

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

The arbitrator finds, as outlined above, that petitioner reached maximum medical improvement as of May 4, 2017. Therefore, Respondent shall pay reasonable and necessary medical expenses incurred through May 4, 2017 only.

Finding on Issue K: What temporary benefits are in dispute? TTD

The arbitrator finds, as outlined above, that petitioner reached maximum medical improvement as of May 4, 2017. TTD benefits had been paid through May 16, 2017 pending receipt of the IME report. Therefore, Respondent shall pay petitioner TTD benefits from December 28, 2016 through May 16, 2017.

Finding on Issue L: What is the nature and extent of the injury?

The arbitrator finds that petitioner has sustained permanent partial disability of 2% loss of use of the person as a whole pursuant to Section 8(d)2, based on the criteria of Section 8.1b as outlined in the arbitration decision above.

STATE OF ILLINOIS)	
) SS.	
COUNTY OF JEFFERSON)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STACY BRYANT,

Petitioner,

vs. NO: 15 WC 32128

STATE OF ILLINOIS,
MURRAY CENTER,

19IWCC0172

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on August 14, 2015. The Commission further finds that Petitioner's Methicillin-resistant Staphylococcus aureus (MRSA), which led to the development of her septic arthritis is causally related to the accident. The Commission awards Petitioner all reasonable and necessary medical expenses related to the August 14, 2015 accident, as well as TTD benefits from August 15, 2015 through October 2, 2015. As to PPD benefits, the Commission awards Petitioner seven and a half percent (7.5%) loss of use of the person-as-a-whole.

The Commission notes that the return date on review was October 12, 2018. As a result, the Petitioner's Statement of Exceptions was to be filed 30 days from the return date and the Respondent's response was to be filed within 15 days from the last day allowed for the filing of Petitioner's Statement of Exceptions. The Commission received the Respondent's "Motion to file

Brief Instanter" on February 25, 2019 for the March 5, 2019 oral argument date. The Commission hereby grants Respondent's Motion.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. The Petitioner, Stacy Bryant, filed an Application for Adjustment of Claim on October 1, 2015. Per the Application, Petitioner was a 35-year old, married female with 2 dependents under the age of 18. Petitioner alleged multiple injuries while working on August 14, 2015.

2. The Petitioner has been employed as a housekeeper for 15 years. On August 14, 2015, she was hanging curtains when she felt a "tug pull" in her left arm followed by some slight pain that progressed. She stated that the curtains were long and semi-heavy and she had to continually hold them up and then hook them. T.9. She denied any prior left arm issues.

3. Petitioner presented to St. Mary's Centralia ER on August 16, 2015 with upper arm and left shoulder pain. It was noted that she woke up yesterday morning with pain. She reported that she was hanging curtains the day before and used her arm, which was the only unusual activity she could think of. Her pain has been constant since its onset. She had tenderness and decreased range of motion. She had no prior injuries. X-rays were normal. The diagnosis was acute, left shoulder pain. PX.3.

4. Petitioner presented to St. Mary's ER on August 18, 2015 for continued left shoulder and left arm pain. Examination revealed normal range of motion, tenderness and decreased range of motion. PX.3.

5. Petitioner was seen by Dr. Aziz Rahman on August 20, 2015 for left shoulder and left upper arm pain that began 3 days ago. Examination revealed limited range of motion and tenderness. An MRI was recommended, and she was taken off work. PX.4.

6. Petitioner underwent an MRI of the left shoulder on August 20, 2015. The MRI revealed a large effusion within the joint, the cause of which was not evident. PX.3.

7. Petitioner completed a Notice of Injury on August 21, 2015. Per the report, Petitioner was hanging curtains when she felt a sharp pain in the left arm. It was noted she tore a

muscle, which leaked fluid around the ball joint. RX.1. Per the Supervisor's Report of Injury, Petitioner hurt her shoulder hanging curtains. Petitioner informed the supervisor of the injury at the end of her shift. RX.2. A witness report was completed by Patti Williams on August 21, 2015. Per the report, they were hanging curtains when Petitioner indicated that she hurt herself and had a sharp pain while hanging curtains. RX.3.

8. Petitioner presented to St. Mary's ER on August 22, 2015 for swelling, tenderness and decreased use of the arm. She described her pain as aching. Her pain had been constant since its onset. The diagnosis was shoulder effusion. PX.3.

9. Petitioner was admitted to St. Mary's on August 24, 2015 and seen by Dr. James Stiehl for severe left shoulder pain. It was noted that she had a left breast abscess that was apparently treated in recent days and the patient revealed a green material came out. Dr. Stiehl noted that the MRI revealed substantial effusion in the left shoulder but no significant anatomical errors. She had a history of chronic MRSA that may have been in a peritoneal area from a small hair follicle cyst. He aspirated the shoulder. PX.3.

10. According to Dr. Angela Freehill's report dated August 27, 2015, Petitioner reported that this was a workers' compensation injury that developed into this infection over the last 2 to 3 weeks. Examination revealed Petitioner was markedly tender about the entire left shoulder with decreased range of motion secondary to pain. The impression was acute glenohumeral joint injury with workers' compensation related shoulder strain that developed into a septic arthritis of the shoulder joint. PX.3.

11. Dr. Freehill performed left shoulder arthroscopy, major synovectomy with debridement of the shoulder capsule, labrum, rotator cuff, biceps tendon, inferior capsule and anterior glenoid, and left shoulder arthroscopic excisional debridement with arthroscopic shaver and lavage of the joint with 3L bags impregnated with bacitracin. The post-operative diagnosis was left shoulder septic arthritis and left shoulder anterior impaction fracture of the glenoid. PX.3.

12. Per the discharge summary, it was noted that there was no open wound and it was not clear how Petitioner got septic arthritis. The discharge diagnosis was septic arthritis of the left shoulder, status post and arthroscopic surgery on the left shoulder, sepsis because of 1 blood culture being positive. She was discharged August 31, 2015. PX.3.

13. Petitioner was seen by Dr. Rahman on September 8, 2015. It was noted that she was recently released from the hospital. She was told that she had a chip fracture of the left shoulder which precipitated the infection. PX.4.

14. Petitioner was seen by Dr. Freehill on November 13, 2015. She was doing much better and had completed her antibiotics. Her pain was a 0. She returned to work full duty on

19IWCC0172

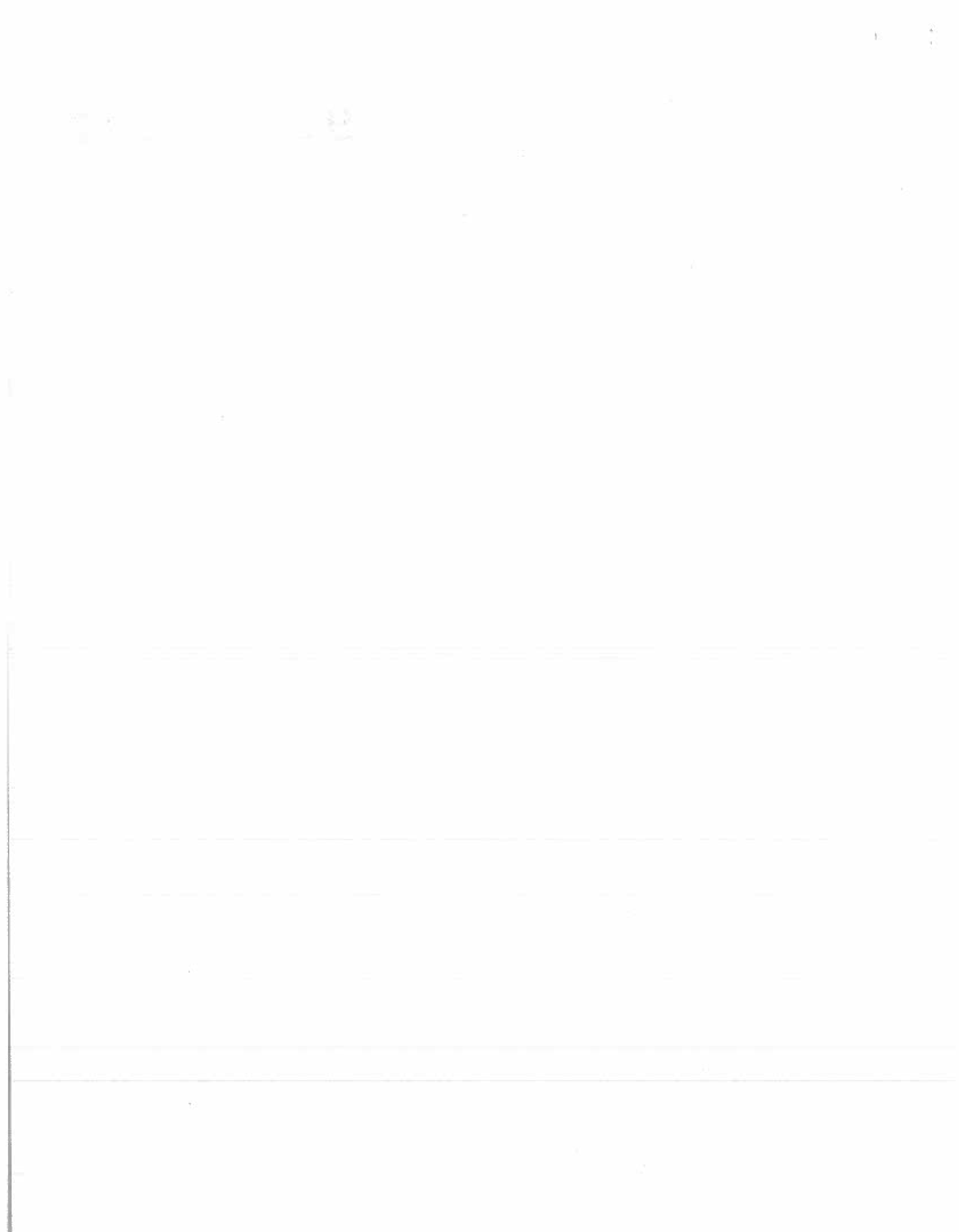
October 5, 2015 and was not having any difficulty. She was at MMI and discharged. PX.7.

15. Respondent obtained a Section 12 examination from Dr. Richard Lehman of Professional Athletic Orthopedics on May 3, 2016. She was status post septic arthritis, left shoulder. He opined that Petitioner did not sustain an infection via her work. This was a seeding of her shoulder and would not have been related to hanging the drapes. She had no break in the skin, and no evidence of injury or anything that would predispose her to an infection. Her septic arthritis was not related to hanging the drapes. She was at MMI. Dr. Lehman opined that hanging the drapes was not consistent with septic arthritis and, even if she had a minor fracture, people with minor fractures do not get septic arthritis. This was either systemic or bloodborne in etiology and not related to her work activities and certainly not related to hanging curtains. RX.5.

16. Petitioner testified that she has been working the same job since her return to work. She experiences soreness in her left arm when she sleeps, shaves her armpits, puts on a bra, or swings her arm when she walks. T.14. The more activity she does, the more symptoms she experiences. *Id.* She is right handed. She has decreased strength because of the injury, which impacts her ability to play with her children. T.15. She takes over-the-counter Advil, twice daily. *Id.*

17. Dr. Freehill was deposed December 19, 2017. She is a board-certified orthopedic surgeon with a subspecialty in sports medicine. She does not perform IMEs. She first saw Petitioner on August 26, 2015 after Petitioner had been admitted to the hospital. Her shoulder was aspirated, and the fluid showed bacteria that was Staph aureus and resistant to Methicillin, MRSA. Her examination revealed that Petitioner was markedly tender about the entire left shoulder. She had decreased range of motion due to pain and swelling. *Id.* Petitioner had extreme pain with passive as well as active range of motion of the shoulder joint. Dr. Freehill was able to palpate a large joint effusion within the anterior shoulder joint. PX.8. pg.10. Dr. Freehill noted that the MRI revealed a very large joint effusion in the joint with no rotator cuff tear. *Id.* Dr. Freehill opined that joint effusion can occur after a traumatic event like the one Petitioner experienced. *Id.* She diagnosed Petitioner with acute left shoulder septic arthritis. Therefore, Dr. Freehill decided to take Petitioner urgently to surgery to treat the septic arthritis. PX.8. pg.9.

18. Dr. Freehill testified that the injury did not cause her to have septic arthritis. As Petitioner was doing well prior to the incident, Dr. Freehill believed that the incident caused Petitioner to develop the joint effusion that somehow got seeded with bacteria and became infected. The accident, therefore, contributed to the septic arthritis. PX.8. pg.12.



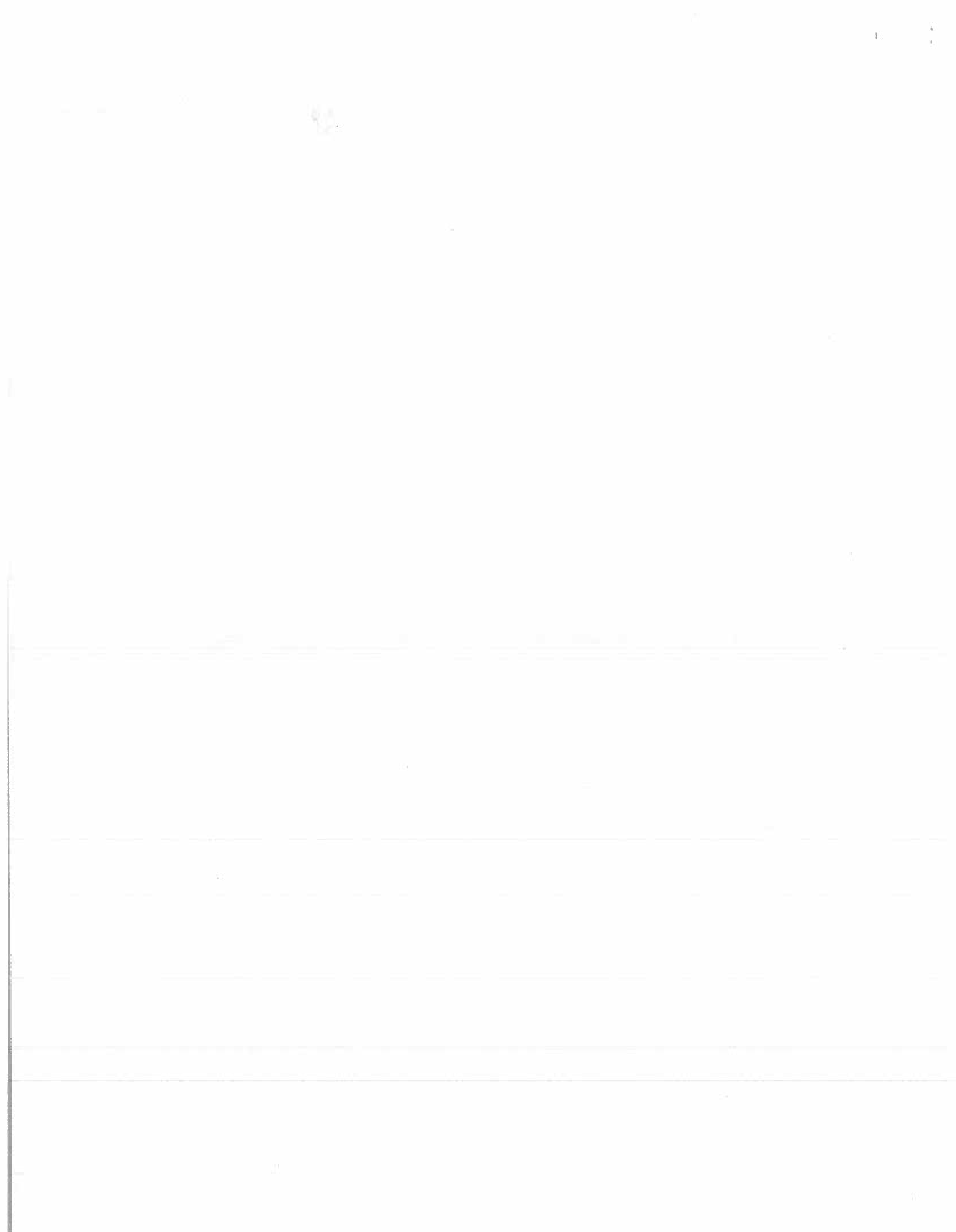
19. During surgery, Dr. Freehill found that Petitioner had an anterior impaction fracture of the glenoid, which meant that a portion of the shoulder socket appeared to have been impacted and cracked. PX.8. pg.14.

20. Dr. Freehill disagreed with Dr. Lehman's opinion that Petitioner would have needed trauma that penetrated the skin to develop septic arthritis as she has seen insidious septic arthritis routinely without skin penetration. Further, people can develop transient bacteremia from simple things. PX.8. pg.15. She also disagreed with Dr. Lehman's opinion that people don't get acute MRSA unless they are in the hospital.

21. On cross-examination, she stated that the injury did not cause septic arthritis, but it did cause an injury to the shoulder joint. PX.8. pg.17. However, she could not state for sure whether the event caused the impaction fracture. Petitioner could have had a previous impaction fracture to the glenoid. As she was pain free prior to the event and had pain after, the incident caused a shoulder strain that caused her to have joint effusion, which was related to the hanging of curtains. PX.8. pg.18. She did not review the records from Dr. Stiehl. She does not know about Petitioner's shoulder condition prior to her visit. She had no way to date when the effusion began. PX.8. pg.19. She stated that the fluid in the shoulder could have been brought about by the MRSA itself. PX.8. pg.21. If Petitioner had MRSA in her blood, it could then get to the shoulder. *Id.* She stated that it is possible that another event could have contributed to her condition.

22. Dr. Lehman was deposed May 23, 2017. He is a board-certified orthopedic surgeon with a subspecialty in sports medicine. He performed a Section 12 examination on May 3, 2016. He noted that the MRI revealed a large effusion. RX.6. pg.8. He reviewed the operative report and noted the main finding was septic arthritis. He noted that Dr. Freehill noted an impaction fracture of the glenoid, which, according to him, indicated that it was chronic as the MRI was negative. The big thing was the hypertrophic synovium which was a classic infection. RX.6. pg.11. He stated that it had to acute as the MRI did not pick up any bone marrow.

23. Dr. Lehman stated that Petitioner had MRSA cultures in her nose and had a history of boils that were drained. He noted that the boils were pockets of MRSA. He also stated that people do not get MRSA acutely unless they are in the hospital. The diagnosis of acute septic arthritis was not related to her work injury. RX.6. pg.14. To get septic shoulder, one must have bacteria in their blood. She also did not have any trauma and, regardless, this is something that happens when bacteria is in the blood. *Id.* As she did not have anything suggestive of penetrating trauma, which is how she might get infected, and did not have any source that could infect her shoulder, and hanging curtains was not a predisposing factor, there was nothing suggestive that this was work related. *Id.* She was at MMI.

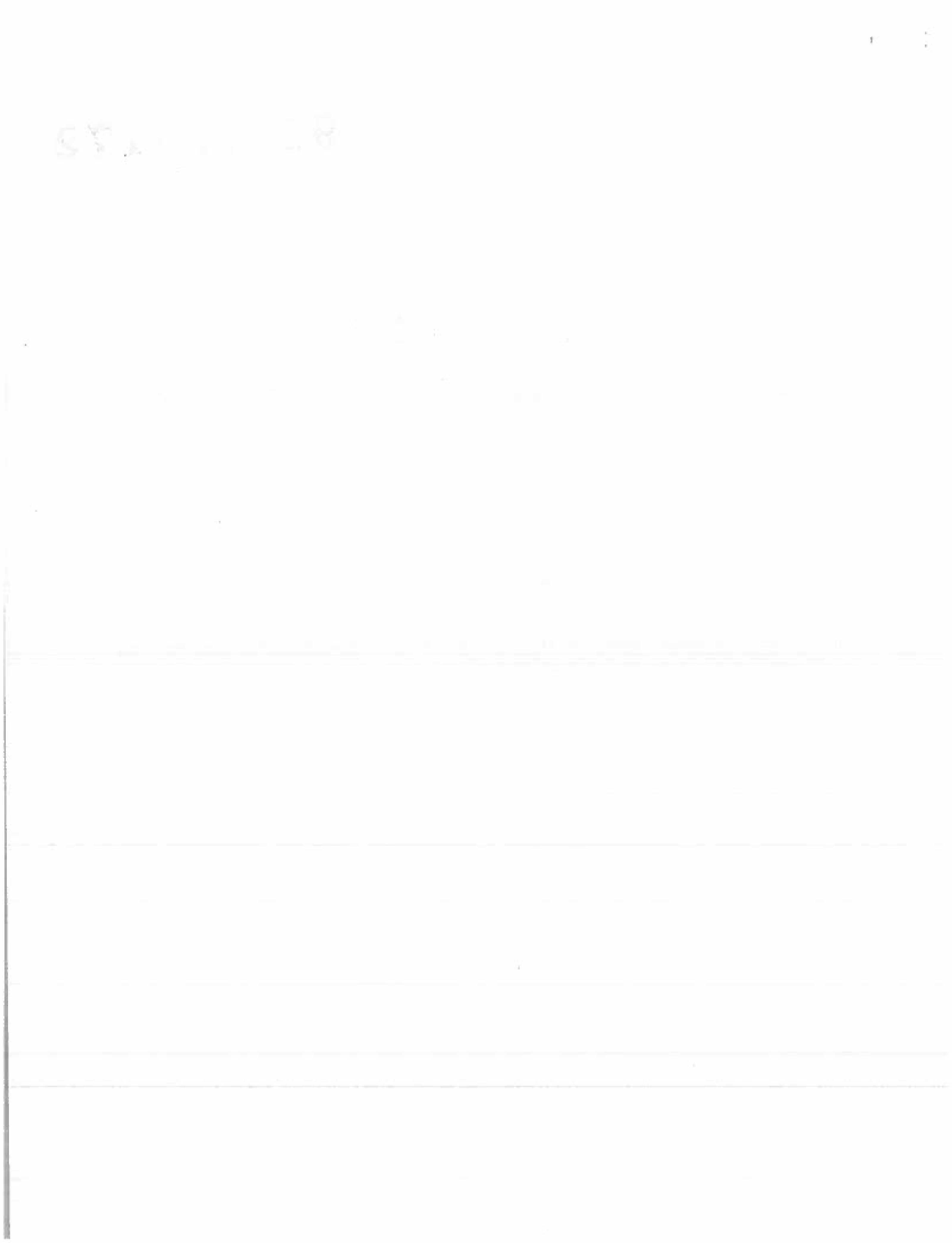


24. On cross-examination, he has no reason to doubt that Petitioner was performing the work she described when the incident occurred. He stated that there is zero chance the MRI missed the impact fracture. He noted that the MRI did support that she was having symptoms, however. RX.6. pg.26. He noted that Dr. Stiehl noted Petitioner had chronic effusion. He noted that MRSA in the nose, is by nature, chronic. RX.6. pg.29. Her history of boils on her perineal area and her breast, and chest wall that were oozing puss, indicated that this was chronic. *Id.* The reason Petitioner had a sharp pain was because she already had effusion in her shoulder. This could have happened by washing her hair. He stated that once you are infected, sooner or later, no matter what happens, at some point it will manifest itself. RX.6. pg.31. He stated that there is no way to know when the effusion began. It usually takes the organisms a long time to populate. RX.6. pg.32. He stated that reaching above the head will not cause a shoulder dislocation. RX.6. pg.36. The injury had nothing to do with her condition. Her pain was from her shoulder already being infected. RX.6. pg.39. She was going to become symptomatic regardless. RX.6. pg.40.

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 reverses the Arbitrator's Decision in its entirety. The Commission finds that Petitioner's testimony as to her injury is sufficiently supported by the record. To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Indus. Comm'n,* 207 Ill. 2d 193, 203 (2003). "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Id.* It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also "arise out of" the employment. *Id.* The "arising out of" component is primarily concerned with causal connection. To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Id.*

The Commission finds that Petitioner encountered an employment related risk. The evidence supports that Petitioner was hanging long, semi-heavy curtains. This required her to lift the curtains above her head and continually hold them up as she hooked the curtains to the rod. She experienced a pulling sensation in her shoulder while performing this work-related task. She completed an accident report, and a supervisor's report of injury and a witness report were also completed; all of which corroborate Petitioner's history of accident. Further, Petitioner sought medical treatment shortly after the accident. The medical records all contained a consistent history



of accident. Therefore, the Commission finds that Petitioner established that she sustained a work-related injury arising out of and in the course of her employment on August 14, 2015.

Employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "[A] preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982). Further, a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

The arbitrator found the issue of causal connection moot. However, the Commission finds that the record supports that Petitioner's condition is causally related to the accident. Petitioner was working without issue prior to the accident. She was installing heavy curtains when she felt a pull in her shoulder. She sought medical treatment thereafter and the MRI revealed substantial effusion of the left shoulder. It was later revealed that she had MRSA, which caused her septic arthritis of the left shoulder. While there is no issue that the MRSA was pre-existing, the credible evidence supports that the accident caused the joint effusion in the shoulder that became seeded with MRSA causing the septic arthritis.

In this respect, the Commission finds Dr. Freehill's opinion is more persuasive than Dr. Lehman's opinion. Dr. Freehill acknowledged that the injury did not cause the septic arthritis but that the injury caused her to develop the joint effusion that somehow got seeded with bacteria and became infected. Her opinion was premised upon the fact that Petitioner was fine prior to the accident and only experienced symptoms thereafter. Dr. Lehman's opinion is not persuasive in that regard. Dr. Lehman acknowledged that Petitioner had an injury to the shoulder, however, it was his opinion that the injury would not have caused the septic arthritis. He opined that she was already infected and would have developed symptoms sooner or later. However, while it may be true that Petitioner may have become symptomatic sooner or later, the facts establish that the accident caused her to become symptomatic. Therefore, the accident was a cause in the development of her condition and her condition is causally related to the accident.

As for medical expenses, Petitioner's exhibit 1 demonstrate that Petitioner incurred $120,145.05 in medical expenses as a result of her injury. The Respondent offered no evidence to rebut the reasonableness and necessity of the medical expenses. After reviewing the record, the Commission finds that Petitioner is entitled to all reasonable and related medical expenses as outlined in Petitioner's exhibit 1. The Respondent is entitled to a credit for all amounts previously paid.

As for TTD, the Commission finds that the Petitioner is entitled to TTD benefits from August 15, 2015 through October 2, 2015.

As to the nature and extent of Petitioner's injury, the Arbitrator did not consider the five factors under Section 8.1(b) of the Act as he considered the issue of nature and extent moot. The Commission having found accident and causal connection in this claim, and taking into consideration the following five factors listed under Section 8.1(b) of the Act, awards Petitioner seven and a half percent (7.5%) loss of use of the person as a whole:

(i) Impairment Rating: The Commission gives no weight to this factor as an impairment rating was not offered into evidence.

(ii) Occupation of Injured Employee: The Commission gives this factor some weight as Petitioner's job duties require her to use her injured shoulder on a regular basis.

(iii) Petitioner's Age: Petitioner was 35-years old on the accident date. The Commission gives some weight to this factor as Petitioner is younger in age and has a lengthy career ahead of her in which to experience the effects of her injury.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to a reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission gives this factor significant weight as evidence of disability was corroborated by the medical records. The records demonstrate that Petitioner sustained a work-related injury that became infected with MRSA and led to development of her septic arthritis. She underwent surgery as a result. She was ultimately discharged from care. She testified that she still experiences soreness daily in her left arm when she sleeps, shaves, puts on a bra, or swings her arms when she walks. The more active she is, the more she experiences her symptoms. She takes over-the-counter medication to help with her symptoms.

Considering the foregoing factors, with no single enumerated factor being the sole determinant of disability, the Commission awards seven and a half percent (7.5%) loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 27, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $568.14 per week for a period of 6-6/7 weeks, from August 15, 2015 through October 2, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibit 1, totaling $120,145.05, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $511.33 per week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused seven and a half percent (7.5%) 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 other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 18 2019

MJB/tdm
O: 3/5/19
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRYANT, STACY
Employee/Petitioner

Case# **15WC032128**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

19IWCC0172

On 6/27/2018, 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:

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 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

JUN 27 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Stacy Bryant
Employee/Petitioner

v.

SOI/ Murray Developmental Center
Employer/Respondent

Case # **15 WC 32128**

Consolidated cases: **N/A**

19IWCC0172

An *Application for Adjustment 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 **April 4th, 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 **8/14/2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$44,314.80**; the average weekly wage was **$852.21**.

On the date of accident, Petitioner was **35** 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 **$All Paid** for TTD, **$-** for TPD, **$-** for maintenance, and **$-** for other benefits, for a total credit of $-.

Respondent is entitled to a credit of **any medical benefits paid through its group carrier** under Section 8(j) of the Act.

ORDER

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner suffered from an idiopathic infection which led to her condition. The condition was not caused by trauma or the claimed work injury. Respondent's section 12 examiner testified quite credibly Petitioner did not suffer any injury to her left shoulder at work and gave a logical and comprehensive explanation for her condition. Petitioner has not suffered an accident at work. Benefits 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]
Signature of Arbitrator

6/25/18
Date

JUN 27 2018

FINDINGS OF FACT

A full hearing was held in this matter. The issues at trial were accident, , causal relationship, TTD, liability for medical costs, and the nature and extent of the injury.

Petitioner testified that she works as a housekeeper, support service worker at the Murray Center. At the time of trial she had been there approximately 15 years.

At trial she testified at the time of the alleged accident she was hanging up curtains which were long, semi heavy curtains that were old with small hooks. In here words it was a continuous drop, hook, back and forth in her words. She stated that as she was doing this, she felt a tug in her left arm and continued to have "slight pain," which progressed. On 8/21/15 Petitioner completed an Employee's Notice of Injury; describing her injury as. "I have a torn muscle which lead to fluid being leaked around my ball joint in left shoulder."

Ms. Bryant presented to the ER at St. Mary's Hospital on 8/16/15 with complaints of left shoulder and upper arm pain. She reported she had woken up with the pain the morning before. She reported the she had been hanging the curtains the day before. The record noted the pertinent negatives included no numbness, loss of motion, muscle weakness, loss of sensation, tingling, fever, wound drainage, redness, streaking, bleeding, swelling, erythema, echchymosis and no abscess. X-rays were performed of the left humerus and left shoulder with no definitive evidence of acute fracture or dislocation. There were no destructive or lytic lesions nor was there any radiopaque foreign bodies or abnormal soft tissue calcifications noted. The diagnosis was that of acute left shoulder pain.

Petitioner returned to the ER two days later on 8/18 with continued complaints of pain in the left arm and shoulder. She also returned on 8/20 and An MRI was completed with findings of a large effusion in the joint, the cause of which was not evident. Correlation with aspiration and evaluation for crystals, cell count and culture and sensitivity was recommended.

She was admitted on 8/24 and discharged on 9/2 from St. Mary's Hospital Centralia Illinois. Dr. Aziz Rahman noted Petitioner had been having pain in the left shoulder for several weeks. He noted she came back on the date of the admission with excruciating pain in the left shoulder. There was no history of trauma. She stated the pain stared about two weeks ago when she was hanging her curtain at the Murray Center. She also reported she had an abscess on the left breast, which got better on its own.

Dr. James Stiehl saw Petitioner for an orthopedic consultation on 8/24/15. He noted her MRI scan on the 20th revealed a substantial effusion of her left shoulder but did not reveal any significant anatomical errors. He also noted she had significant discomfort in her left shoulder and there may have been an injury from two weeks prior but this was unclear. There was a history of chronic MRSA, that may have been done in the peritoneal area from a small hair follicle cyst. She does not offer any significant injury, except the strain.

Dr. Angela Freehill also saw the petitioner on 8/26/15 in consultation with Dr. Rahman. She recorded Ms. Bryant had her initial injury while up on a ladder hanging some curtains. She noted Petitioner had a pulling sensation on her left shoulder and had immediate pain. Her primary care physician ordered an MRI for her which ultimately showed her to have quite a bit of swelling in the joint...She was seen by Dr. Stiehl who did an aspiration of the shoulder and that showed her to have a few gram-positive cocci within the shoulder, growing

ultimately 4+ Staph aureus MRSA. Dr. Stiehl ultimately recommended shoulder arthroscopy, but deferred to me and I am here today to see the patient and take her to surgery for surgical irrigation and debridement. The anesthesia/operative notes recorded as Findings inherent to procedure: large purulent effusion in glenohumeral joint. The Postoperative diagnosis was left shoulder septic arthritis and left shoulder anterior impaction fracture of the glenoid.

The operation consisted of a left shoulder arthroscopy, arthroscopic major synovectomy with debridement of the shoulder capsule, labrum, rotator cuff, biceps tendon, inferior capsule and anterior glenoid, left shoulder arthroscopic excisional debridement with arthroscopic shaver and lavage of the joint with three 3 L bags impregnated with Bacitracin. Dr. Freehill recorded there was approximately 20cc of purulent appearing drainage from the joint. She also noted the articular surface of the humeral head was normal as was the articular surface of the glenoid with the exception of a small impaction fracture that appeared to be at the 9 o'clock position which emcompassed approximately 20% of the articular surface and it was impacted. There was no labral tear at this location

The discharge summary stated, "MRI showing fluid in the joint; this fluid was aspirated by Dr. Stiehl and it showed MRSA…Arthoscopic surgery was performed by Dr. Freehill on the left shoulder…The patient had a history of injury to the left shoulder, but there is not open wound and it is not clear how she got septic arthritis, but she has septic arthritis." The discharge diagnosis was Septic arthritis of the left shoulder, status post arthrocentesis and arthroscopic surgery on the left shoulder and Sepsis because of one blood culture being positive.

The evidence deposition of Dr. Freehill was taken on December 19th, 2017. Her testimony comported with her medical records. She is board certified in Orthopedic Surgery with a subspecialty in sports medicine. She was asked on direct examination if she had reviewed the IME report authored by Dr. Richard Lehman. She responded she had reviewed it "in a cursory manner but I did not study it…" The first time she saw Ms. Bryant was in the hospital on 8/26/15. She noted Ms. Bryant was ultimately admitted to the hospital on 8/24/15 where she was seen by the orthopedic surgeon on duty who aspirated her shoulder pulling out fluid. This showed her to have bacteria growing in her shoulder which ultimately grew out MRSA. She did also state that upon her examination there was a large joint effusion within the anterior shoulder joint. The MRI results indicated a very large joint effusion with no rotator cuff tear. Her diagnosis was that of acute left shoulder septic arthritis. When asked if the Petitioner's reported work injury caused, contributed to, or aggravated the diagnosis of the left shoulder acute septic arthritis. Dr. Freehill stated it certainly did not cause the septic arthritis but she believed it caused her to have an injury to her shoulder joint that developed into a joint effusion that somehow got seeded with bacteria and became an infection. She said she didn't believe it caused the septic arthritis but I think it contributed to it. On cross she was questioned about the small impaction fracture. She was not able to say for sure whether or not the small impact fracture was caused by the alleged work injury. She also was not able to date the effusion, when it began or what was actually causing it. She testified she believed the Petitioner had a shoulder joint effusion and her shoulder joint got infected with MRSA which had traveled from somewhere else.

Respondent had Petitioner undergo a Section 12 exam with Dr. Richard Lehman on May 3rd, 2016. He created a report which was put into evidence at trial. Dr. Lehman recorded a history of Petitioner's present illness. She told him she was putting up curtains and had to hold her arm up with one hand and put the hooks up with another hand and had pain in her left shoulder and then subsequently had significant discomfort in the shoulder. His included copious documentation of the medical records he reviewed and incorporated into his report. His physical examination found full unrestricted range of motion of her shoulder. There was no evidence of instability. She had full forward flexion, full extension, normal abduction, and external abduction. Additionally, there was neither weakness nor anterior posterior instability. Among other things there was not swelling in the shoulder. Dr. Lehman's' diagnosis was that of status post septic arthritis of the left shoulder. Dr.

Lehman did opine, "It is my opinion that there is no causal relationship between her current subjective complaints and the reported action....It would be my impression within a reasonable degree of medical certainty that the patients' septic arthritis would not be related to hanging the drapes...more importantly, it would be my impression that the hanging of the curtains would not be consistent with septic arthritis and even if she a minor fracture, people with minor fractures do not get septic arthritis. I believe this was either systemic or bloodborne in etiology and in my opinion would not be related to her work activities and certainly not hanging curtains."

Dr. Lehman's evidence deposition was taken on 5/23/17. Dr. Lehman is board certified in orthopedic surgery with a sub-qualification in sports medicine. His practice is primarily surgical in nature with a heavy concentration in knee and shoulder injuries. His testimony was he usually performs around 20 surgeries a week. He stated he had reviewed Ms. Bryant's MRI of 8/20/15; with the MRI showing what appeared to be a large effusion, fluid. The rest of the MRI appeared to be essentially normal, the rotator cuff, bone content, and labrum. He took a history from Ms. Bryant, with Petitioner stating she had been hanging curtains the day before, was using her arm, and then subsequently had significant discomfort in her shoulder. His physical examination of Ms. Bryant was of a normal shoulder with full unrestricted range of motion with no evidence of instability. Her swelling was resolved with no suggestion of infection. He had reviewed the operative report of Dr. Freehill and noted the main finding at the time of surgery was septic arthritis. He stated Dr. Freehill noted there was an anterior impaction fracture of the glenoid. Dr. Lehman noted this must have been chronic based upon the negative MRI, noting the MRI did not show any bone marrow changes in terms of fracture, there not being an indication of acute fracture.

He testified in accordance with his report stating in part, Ms. Bryant's kind of mechanism of injury would not cause an impaction fracture. When asked about whether there was anything in the records significant; he responded in looking for the etiology for septic arthritis noting it is usually a systemic problem with bacteremia in the blood stream that goes into the shoulder. He stated, "if you look at her medical records, she had positive cultures of MRSA in her nose and had a history of boils or what are called furuncles that were draining, and had to be drained." He also noted MRSA is a chronic infection. He opined within a reasonable degree of medical certainly a diagnosis of Septic Arthritis for Ms. Bryant's left shoulder and went on to opine this was NOT related to her alleged work incident of 8/14/15. He opined to get a septic shoulder there must be bacteremia in your system, meaning there must be a lot of bacteria in your blood stream that ended up in a joint. Petitioner did not fall, she didn't have a trauma. Noting the septic arthritis happens when there is a lot of bacteria in the blood stream, noting hanging curtains is not a predisposing factor. Last, he noted MRSA is a very virulent organism and it's a chronic organism.

On cross examination Ms. Bryant admitted her earlier testimony was the surgery was to remove the infection in her shoulder. There was no testimony or evidence Ms. Bryant contracted MRSA at work nor was there even mention of this being a possibility. The totality of the evidence demonstrates the Petitioner suffered from Septic Arthritis in her shoulder, on this all of the examining Doctors agreed. The only logical explanation is this was contracted from MRSA. Dr. Lehmans' testimony is logical and is really the only explanation that makes sense. It makes much more sense, especially when looking at the time frame and the speed therein, that Ms. Bryant has the MRSA in her system; this led to infection, purulence and septic arthritis in her shoulder causing her discomfort in the an activity that is not traumatic, hanging curtains. For these reasons Petitioner's claim is denied.

CONCLUSIONS OF LAW

Issue (c): Did an accident occur that arose out of an in the course of Petitioner's employment by Respondent?

NO.

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner suffered from an idiopathic infection which led to her condition. The condition was not caused by trauma or the claimed work injury. Respondent's section 12 examiner testified quite credibly Petitioner did not suffer any injury to her left shoulder at work and gave a logical and comprehensive explanation for her condition. Petitioner has not suffered an accident at work. Benefits denied

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

Petitioner failed to prove accident and all other issues are moot.

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

Petitioner has not suffered an accident at work nor has she suffered a work related injury. Benefits denied.

Issue (K): What temporary benefits are in dispute? (TTD).

Petitioner has failed to prove either accident or injury. Thus the issue of TTD is rendered moot.

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

Petitioner has failed to prove either accident or injury. Thus the issue of nature and extent is rendered moot.

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner suffered from an idiopathic infection which led to her condition. The condition was not caused by trauma or the claimed work injury. Respondent's section 12 examiner testified quite credibly Petitioner did not suffer any injury to her left shoulder at work and gave a logical and comprehensive explanation for her condition. Petitioner has not suffered an accident at work. Benefits denied

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PHILLIP SIKANICH,

Petitioner,

vs. NO: 14 WC 43096

CITY OF CHICAGO,

Respondent.

19IWCC0173

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, temporary total disability and prospective medical, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, filed on September 29, 2017, which is attached hereto and made a part hereof and vacates the Decision of the Arbitrator subsequently filed on May 8, 2018. 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 Petitioner, represented by his first attorney, filed an Application for Adjustment of Claim on December 19, 2014. The Petitioner's case proceeded to an Arbitration hearing pursuant to Section 19(b) on August 18, 2016 and a Decision was filed on October 19, 2016. No Petition for Review of the Arbitrator's first Decision was filed.

On February 7, 2017 Petitioner filed a substitution of attorneys. The case proceeded to a second Arbitration hearing pursuant to Section 19(b) on July 24, 2017. A second Arbitrator's Decision was filed September 29, 2017. On October 6, 2017, the Petitioner's (second) attorney

filed a Petition to Review the second Arbitration Decision, the case at bar. The Return date on Review was December 29, 2017 and the Petitioner' brief was due on or before January 26, 2018.

Without dismissing the Petition for Review, the case proceeded to trial before the Arbitrator on the issue of the nature and extent of Petitioner's injury on January 25, 2018, the day before Petitioner's brief was due. However, without a dismissal of the Petition for Review, the Arbitrator had no jurisdiction while the Review was pending before the Commission.

The Petitioner's attorney that represented the Petitioner at his second Section 19(b) hearing, also filed a Motion to Extend the Deadline to File Brief for the subject review. A hearing on the Motion to Extend was eventually scheduled for April 19, 2018.

The relationship between the attorney that represented Petitioner at his second Section 19(b) Arbitration hearing and that attorney's law firm was severed some time after the last of the three referenced hearings.

On March 28, 2018, the second attorney also filed a Motion to Dismiss the second law firm as Attorney of Record, and to substitute his own law firm, as a sole practitioner, signed by Petitioner, to be presented to the presiding Commissioner on April 19, 2018, at the same time as the scheduled hearing on his Motion to Extend the Deadline to File (Petitioner's) Brief for the subject review.

The second law firm filed a Response to the Motion to Dismiss Attorney of Record on April 17, 2018. The Response enumerated reasons the Commission should deny the Motion to Dismiss the firm as Attorney of Record alleging, *inter alia,* the case was scheduled for a hearing on April 19, 2018 on the Motion for an extension of the time to file the Petitioner's Brief for the subject Review, the law firm was also awaiting a "pending nature and extent decision by the Arbitrator" and Counsel's departure from the law firm, and purporting that elaboration on the reasons could be made to the Commission orally.

On April 19, 2018, the matter was continued to May 17, 2018 at which time a representative from the second law firm and the sole practitioner appeared and the parties stipulated the sole practitioner would substitute as Attorney of Record. The presiding Commissioner granted Petitioner's Motion to Extend (the) Deadline to File (Petitioner's) Brief in part, allowing the filing of a Brief, but denying Oral arguments. No Briefs were subsequently filed by either party.

Thereafter, the second law firm filed a Motion for Attorney Fees to be presented to the Commissioner on June 28, 2018 with Notice sent to the first law firm, the Respondent's attorney and to the sole practitioner as Attorney of Record and representing that the "19(b) is still pending on Review before this Commission and that "the Decision of Arbitrator Cronin was filed on May 8, 2018 wherein the Petitioner was awarded 37.5 weeks of PPD, representing 7.5% loss of use of the person as a whole, representing $27, 576.38."

On July 12, 2018, with all parties present, the presiding Commissioner resolved the second law firm's Motion for Attorney Fees by Ordering the discharge of the liens of all the attorneys, awarding the sole practitioner $600.00 and the second law firm was awarded the remaining fee to be split with the first attorney's firm per their previous agreement.

Notices were sent to the Attorneys of Record on November 15, 2018 that the subject Review would be scheduled for Discussion before Panel A on January 29, 2019. This Decision is based on a Review of the entire record as a whole, both substantive and procedural.

After review of the record as a whole, the Commission affirms and adopts the Section 19(b) Decision of the Arbitrator filed September 29, 2017.

The Commission vacates the Decision of the Arbitrator filed May 8, 2018, however, in doing so, remands the case to the Arbitrator to enter a Decision consistent with the Findings and Conclusions of Law set forth in the Decision filed May 8, 2018.

Although the Arbitrator had no jurisdiction at the time of the hearing on January 25, 2018, the Commission will not disturb the subsequent July 12, 2018 Order regarding attorneys' fees since that Order was based on the parties' representation that the award had been paid by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2017 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 8, 2018 is hereby vacated.

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

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: MAR 2 0 2019
KWL/bsd
O:01/29/19

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

SIKANICH, PHILLIP
Employee/Petitioner

Case# **14WC043096**

CITY OF CHICAGO
Employer/Respondent

19IWCC0173

On 9/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
GERALD CONNOR
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
SUSAN E WALSH
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Phillip Sikanich
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 14 WC 43906

Consolidated cases: ____

19IWCC0173

An *Application for Adjustment 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 **July 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. [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. [x] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **November 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 **$77,740.00**; the average weekly wage was **$1,495.00**

On the date of accident, Petitioner was **34** years of age, *married* with **2** dependent children.

The issue of medical bills, credit for such bills, and any 8(j) credit as it relates to medical bills only, has been deferred to a later hearing.

Respondent is entitled to a credit of **$97,672.68** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$29,774.25** for non-occupational indemnity disability benefits, for a total credit of **$127,446.93**.

ORDER

Respondent shall pay Petitioner **$996.67/week for 98 weeks**, from **11/29/2014** through **10/14/2016**, as Petitioner was temporarily totally disabled during that time, in accordance with Section 8(b) of the Act.

Respondent shall be given a credit of **$97,672.68** for TTD benefits paid.

Respondent has paid non-occupational indemnity disability benefits to Petitioner.

Respondent shall be given an 8(j) credit of **$29,774.25** for non-occupational indemnity disability benefits paid.

Respondent shall pay for prospective medical care in the form of over-the-counter anti-inflammatory medication, as recommended by Dr. Goldberg. All other prospective medical care is denied.

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

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

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

Signature of Arbitrator

9/28/2017
Date

ICArbDec19(b)

SEP 29 2017

STATE OF ILLINIOS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARITRATION DECISION
19(b)

Phillip Sikanich,)
)
Petitioner,)
)
v.) Case No. 14 WC 43096
)
City of Chicago,)
)
Respondent.)

19IWCC0173

FINDINGS OF FACT

Prior 19(b) Decision:

On August 18, 2016, the undersigned Arbitrator conducted a 19(b) hearing. He later issued an Arbitration Decision that he signed on October 18, 2016. He found that Petitioner was a 34-year-old asphalt helper on November 28, 2014, at which time he sustained an accidental injury to his neck and back. Petitioner injured himself while he was descending the stairs of a trailer. The railing on the trailer stairs collapsed and he fell five feet to the ground. (Pet. Ex. 1, Resp. Ex. 4)

The Arbitrator found the opinions of Edward J. Goldberg, M.D., the Section 12 orthopedic surgeon, and the Utilization Reviewers, to be more persuasive than those of Charles M. Slack, M.D., the treating orthopedic surgeon. Consequently, the Arbitrator ordered Respondent to continue authorizing Lyrica, Cyclobenzaprine and Ambien, but denied Dr. Slack's recommendation for lumbar facet joint medial branch blocks, Oxycodone (Percocet), Flector patches and Duexis. (Pet. Ex. 1, Resp. Ex. 4)

Neither party reviewed this 19(b) decision.

Medical History After August 18, 2016:

At Respondent's request, Dr. Goldberg re-evaluated Petitioner on September 21, 2016. Dr. Goldberg reviewed updated medical records and forty-six minutes of surveillance video from June 14, 2016, June 22, 2016, and June 25, 2016. In such video, Dr. Goldberg observed Petitioner running in and out of his house, moving a sprinkler, walking a dog, picking up a child, and carrying small objects. (Resp. Ex. 1)

During Dr. Goldberg's examination on September 21, 2016, he found that Petitioner was in mild distress. Cervical flexion, extension and bilateral rotation were five degrees in each plane. Petitioner complained of pain with any range of motion. His motor exam revealed 5/5 strength in the upper extremity, C5 to T1. In the lower extremities, his motor exam revealed 5/5 strength in the left lower extremity from L3 to S1, whereas on the right it was 3/5 right quadriceps, trace tibialis anterior, and EHL. Gastrocnemius was 2+. Dr. Goldberg noted that while Petitioner was walking into the exam room and down the hallway, he was able to fully dorsiflex his right tibialis anterior (i.e., there was no drop-foot and he was fully weight-bearing at his right knee/quadriceps). He had diminished sensation at L3 to S1 on the right. Sensation was intact C5 to T1 bilaterally and L3 to S1 on the left. He had negative straight leg raising. His Achilles, patellar, biceps, and triceps reflexes were 2+. There was no atrophy or long tract findings. (Resp. Ex. 1)

Dr. Goldberg's diagnosis was aggravation of pre-existing degenerative disc disease of the cervical spine with stenosis at C5-6 and C6-7, as well as aggravation of pre-existing lumbar stenosis, which was extremely mild. The doctor noted inconsistencies during the examination. He recommended an FCE to determine the validity of Petitioner's complaints, an anti-inflammatory medication, and Flector patches. The doctor advised Petitioner not to be on any narcotic medication. In fact, he noted that Dr. Lami had been concerned about narcotic usage. Dr. Goldberg released Petitioner to return to work with a twenty-five-pound lifting restriction. (Resp. Ex. 1)

Dr. Goldberg issued an "IME Addendum" on September 30, 2016, after he had reviewed forty-six minutes of surveillance video in which Petitioner was seen driving; "running out of his residence down the front stairs;" bending over to move a water

sprinkler; running back into his home; talking on his cell phone while leaning his head to one side to support the cell phone in the position to talk; entering and exiting multiple locations without any signs of distress; getting in and out of his car; sitting in his vehicle; bending out sideways to dispose of a plastic cup; bending over into the backseat of his car; squatting; lifting up a small child and putting her in his car; leaning forward and strapping the little girl into the car seat; carrying the child; bending down and squatting to tie the child's shoes; and walking a dog.

Respondent did not offer the surveillance video into evidence.

Based upon review of the surveillance video, Dr. Goldberg opined that Petitioner could return to a trial of full-duty work. He noted that when he examined Petitioner on September 21, 2016, he discovered some non-anatomic findings. Although Dr. Goldberg believed that Petitioner had an aggravation of the cervical and lumbar stenosis, he found that what he saw in the surveillance video was very inconsistent with his examination of September 21, 2016. He released Petitioner to return to full-duty work on a trial basis for six weeks. Dr. Goldberg stated that if Petitioner were unable to perform his regular duty job, he should undergo an FCE. If such FCE turns out to be invalid, and his complaints cannot be substantiated, then he is to return to full-duty work. If such FCE is determined to be valid, then Petitioner should return to work within the parameters of the FCE. Dr. Goldberg recommended no additional narcotic medications or the Flector patches. He felt that an over- the-counter anti-inflammatory medication was appropriate. (Resp. Ex. 2)

In a letter dated October 12, 2016, Monica Somerville, Director of the Workers' Compensation Division for the City of Chicago, asked Petitioner to return to full-duty work pursuant to Dr. Goldberg's full-duty release. (Resp. Ex. 3)

TTD benefits were terminated on October 14, 2016, as a consequence of Petitioner's failure to return to work.

Petitioner underwent an FCE at Athletico on November 17, 2016. Leslie Spalding, P.T., the physical therapist/evaluator, concluded: "Inconsistent Performance/Unacceptable Effort indicates the client's perceived limitations and return to work confidence are markedly affecting symptom expression, consistency of effort, reliability of pain, and quality of effort." According to Ms. Spalding, Petitioner could have performed at markedly higher levels "than willing" during musculoskeletal and functional testing. Behavioral

factors affecting the evaluation results were to such a degree that the evaluator could not identify Petitioner's true musculoskeletal status, and could not project full-time work tasks and/or true impairment. The evaluator concluded that Petitioner was able to function at the heavy physical demand level, at least. (Resp. Ex. 5)

According to Petitioner's testimony at the July 24, 2017 hearing, the last evaluation by his treating physician, Dr. Slack, took place on May 30, 2017. However, the most recent office note in Petitioner's Exhibit 2 is from January 16, 2017. There is a Work/School Status Report dated May 30, 2017 in which Dr. Slack released Petitioner to return to work with the following restrictions: "No lifting over 25 lbs. and no working around heavy machinery/or working around traffic due to medication effects of impaired mentation, sedation during trial return to work." The Work/School Status Report also indicates a diagnosis of persistent right cervical and lumbar radiculopathy, right cervical disc protrusion at C5-6 and C6-7, L3-4 central to right-sided disc protrusion, and right L4-5 central to right-sided disc protrusion. Dr. Slack continued to recommend medication including Percocet, Lyrica, and Duexis, physical therapy for his cervical and lumbar spine, a lumbar epidural injection and facet injections from Dr. Scott Glaser, as well as water therapy while awaiting approval for physical therapy. (Pet. Ex. 2)

CONCLUSIONS OF LAW

In support of his decisions with regard to issues (F) "Is Petitioner's current condition of ill-being causally related to the injury?," (L) "What temporary benefits are in dispute? TTD, " (N) "Is Respondent due any credit?," and (K) "Is Petitioner entitled to any prospective medical care?," the Arbitrator finds as follows:

On September 30, 2016, Dr. Goldberg wrote that he believed Petitioner sustained an aggravation of his cervical and lumbar stenosis. The Arbitrator therefore finds that Petitioner's current condition of ill-being is causally related to the November 28, 2014, accident.

The Arbitrator finds the opinions of Dr. Goldberg and Leslie Spalding, P.T., to be more persuasive than those of Dr. Slack. Therefore, the Arbitrator finds that Petitioner is entitled to TTD benefits from November 29, 2014 through October 14, 2016 since Dr. Goldberg, in a report dated September 30, 2016, released him to full-duty work at that

time. Respondent is entitled to a credit in the amount of $97,672.68 for TTD benefits previously paid to Petitioner.

Arbitrator's Exhibit 1 indicates that Petitioner received non-occupational indemnity benefits, and that Respondent is entitled to an 8(j) credit of $29,774.25 for payment of such benefits.

Furthermore, the Arbitrator finds, per Dr. Goldberg, that other than an over-the-counter anti-inflammatory medication, additional treatment is neither reasonable nor necessary.

Brian T. Cronin, Arbitrator — 9-28-2017, 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 MCHENRY	)	☒ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY STEGAN,

Petitioner,

vs. NO: 17 WC 07749

RELADYNE, LLC,

Respondent.

19IWCC0174

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 issue of temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof, 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).

The Decision of the Arbitrator addressed only the question of whether Petitioner was entitled to temporary total disability benefits after refusing the assignment of his employment to an entity that would allow him to work within his light-duty work restrictions. In this case, it is not disputed that Petitioner sustained a compensable injury to his left shoulder and precluded him from performing his normal and usual tasks as a forklift operator. Petitioner's treating physician, Dr. Matthew Bernstein of Barrington Orthopedic Specialists, eventually allowed Petitioner to work albeit in a light duty capacity.

Lacking a position that accommodated Petitioner's medically-prescribed restrictions, Respondent engaged Transitional Work Solutions to enroll Petitioner in its Transitional Work Program, a program that matches and places injured workers in positions with their restrictions. In this case, Transitional Work Solutions placed Petitioner with Northern Fox Valley Habitat for

Humanity Restore where his work activities were to include "light sorting" of incoming donations and customer service. Petitioner chose not to participate in the Transitional Work Program arranged for him by Transitional Work Solutions and did not present to Northern Fox Valley Habitat for Humanity Restore on the day he was supposed to be being working there, July 6, 2017, or any day thereafter.

Petitioner, testifying at his arbitration hearing on August 3, 2017, acknowledged that he did not work in the position with Northern Fox Valley Habitat for Humanity Restore that Transitional Work Solutions arranged for him and offered no explanation as to why he refused the work in that position. He noted it was Respondent, and not Northern Fox Valley Habitat for Humanity Restore, that was his employer.

In stating that Respondent, and not Northern Fox Valley Habitat for Humanity Restore, was his employer, Petitioner advances a distinction without a difference. Neither Respondent nor Northern Fox Valley Habitat for Humanity Restore claimed otherwise. The letter sent by Respondent to Petitioner, dated June 26, 2017, explicitly stated as much. Not only did Petitioner remain Respondent's employee, per this letter, Petitioner was to be paid his regular salary and remain subject to Respondent's human resources and attendance policies. No inference can be reasonably made from the letter of any changes to Petitioner's employment with Respondent other than where he was to report to work and what work activities he would perform. No claim or evidence was advanced by Petitioner that he understood his employer to be any entity other than Respondent.

Petitioner takes the position that the Act does not empower the Commission to compel him to accept a position with an entity other than his employer. Respondent makes the counterargument that nothing in the Act precludes the arrangement Respondent made on Petitioner's behalf.

"Once an injured employee's physical condition stabilizes, he is no longer entitled to TTD." Mobile Oil Corp. v. Industrial Comm'n, 327 Ill.App.3d 778, 788, 261 Ill. Dec. 924, 934, 764 N.E.2d 539, 549 (3rd Dist. 2002). Petitioner does not claim that his condition has not stabilized. He, nevertheless, claims entitlement to TTD benefits because the work being offered him is not with Respondent but with Northern Fox Valley Habitat for Humanity Restore. The Commission finds nothing in Mobile Oil or any precedential case involving TTD that holds or suggests that an injured employee remains entitled to TTD benefits if work within the prescribed restrictions can be found regardless of with whom and is not otherwise shown to be unreasonable.

The Decision of the Arbitrator noted in Saineghi v. Demar Logistics, 14 IWCC 1093, "[T]he volunteer position at an organization different than that of the employer is not the equivalent of an offer of accommodated duty as the position is unpaid and not offered by the employer." Contrary to Saineghi, and as noted above, the position with Northern Fox Valley Habitat for Humanity Restore was not an unpaid position as Petitioner was to receive his regular pay from Respondent, not from Northern Fox Valley Habitat for Humanity Restore. With respect to who offered Petitioner this position, the Commission concludes the June 26, 2017 letter from Respondent to Petitioner makes it clear that it was Respondent who offered the position to

Petitioner. Respondent undoubtedly worked in conjunction with Transitional Work Solutions to coordinate and arrange for Petitioner to be placed with Northern Fox Valley Habitat for Humanity Restore, but, again, it is evident that Respondent made the offer for Petitioner to work with Northern Fox Valley Habitat for Humanity Restore.

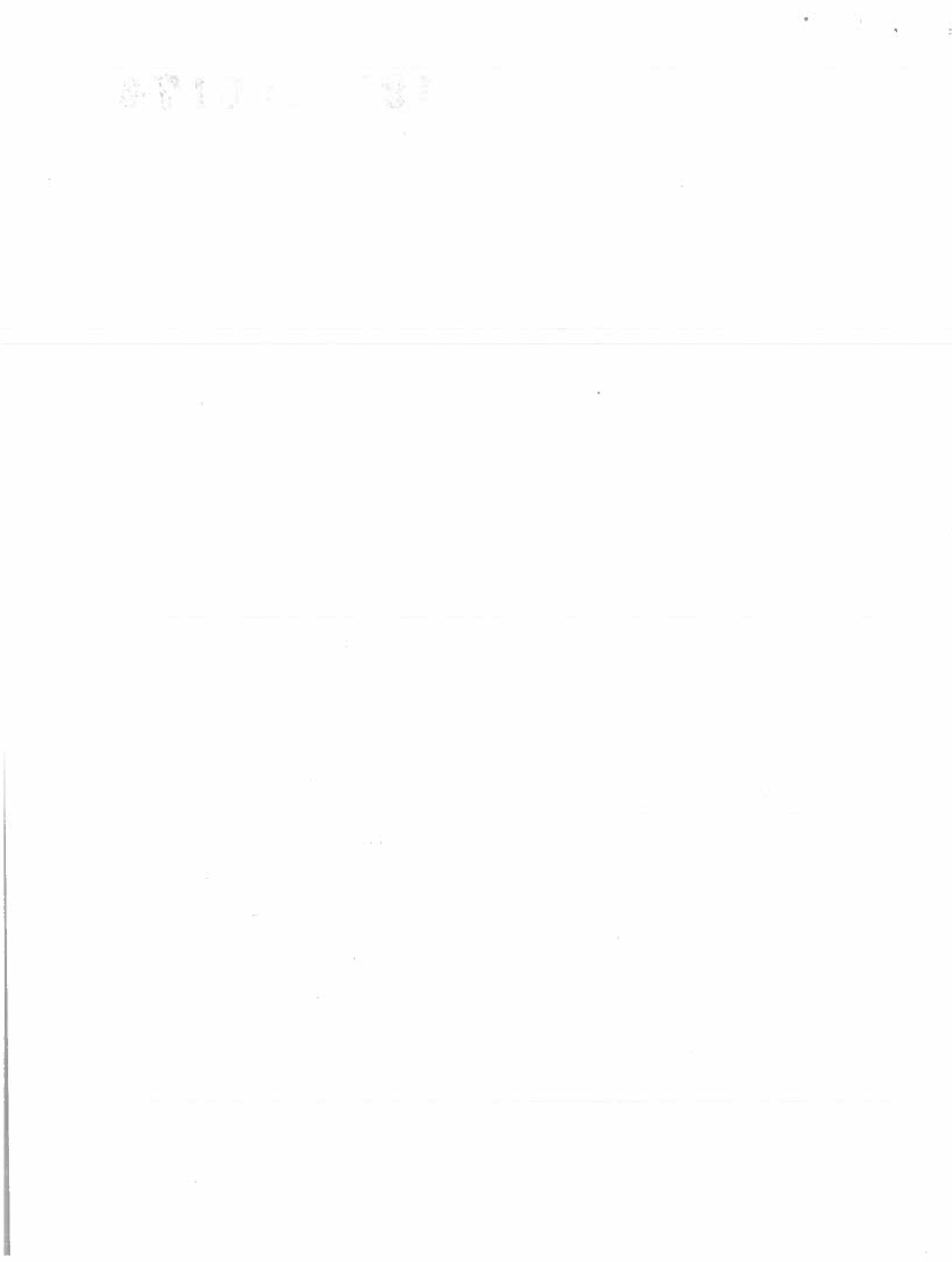
The Decision of the Arbitrator also cites two other Commission decisions, Kilduff v. TriCounty Coal (12 WC 38843) and Lee v. Fluid Mgmt. (11 WC 48656), to stand for the prospect that "it is the obligation of the Respondent during the period of temporary total disability to provide light-duty work for Petitioner within its own company where the Petitioner is under the control and supervision of the employer rather than an individual other than the employer." Differentiating the current case from both Kilduff and Lee, Respondent's aforementioned letter to Petitioner explicitly indicates that Petitioner was to remain Respondent's employee and subject to all of Respondent's human resources and attendance policies. Furthermore, any issue that may have arisen during Petitioner's participation in the Transitional Work Program would be addressed through Respondent as testified to by Dina Snyder, the founder and president of Transitional Work Solutions. So unlike in Kilduff and Lee where authority over the injured employee was delegated to a third-party, Respondent retained control over Petitioner.

"The Act is meant to compensate a claimant for economic disabilities that diminish his value in the labor market . . .." Chlada v. Ill. Workers' Comp. Comm'n, 58 N.E.3d 848, 856, 405 Ill. Dec. 587, 595 (1st Dist 2016). Ironically, Petitioner's prefence to collect temporary total disability benefits, therefore, cuts against the purpose of the Act as pronounced in Chlada as Petitioner is diminishing his own value in the labor market by accepting compensation that is only two-thirds of what he would earn if he participated in the Transitional Work Program.

It is axiomatic, when considering temporary total disability, that a claimant must show not only that he did not work but also that he was unable to work. The position argued by Petitioner seeks to expand entitlement to temporary total disability benefits despite being found capable of working to include the circumstances by which he would return to work. In this case, it is who he returns to work for that he objects to.

The Act is said to be remedial in nature. Petitioner's claim to be entitled to continued temporary total disability benefits simply because the offered light duty work is not with Respondent does not comport with the remedial purpose of the Act. Absent an argument that Northern Fox Valley Habitat for Humanity Restore is objectively too far from his residence to make the endeavor cost-effective or that the work asked of him there is outside the prescribed work restrictions, the Commission is not particularly sympathetic to Petitioner's position. In the vacuum of the evidence presented, the Commission can only conclude Petitioner would rather trade earning his usual wage for the opportunity not to work and receive two-thirds of his usual wage.

The Commission finds Petitioner has no credible justification for declining to participate in the Transitional Work Program under the terms Respondent offered and, accordingly, finds Respondent to be within its rights to terminate temporary total disability benefits effective the day Petitioner failed to present to Northern Fox Valley Habitat for Humanity Restore to begin



participation in the Transitional Work Program. The Commission recognizes that day to be July 6, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the award of ongoing temporary total disability benefits commencing March 8, 2017 as was bestowed in the October 4, 2017 Decision of the Arbitrator is vacated;

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $603.08 per week for a period of 17-2/7 weeks, commencing March 8, 2017 and terminating on July 6, 2017that being the period of temporary total incapacity for work under §8(b) 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; and

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 $10,600.00. 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: MAR 2 1 2019
KWL/mav
O: 01/29/19
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

STAGEN, GARY
Employee/Petitioner

Case# **17WC007749**

RELADYNE LLC
Employer/Respondent

19IWCC0174

On 10/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5625 GRAUER & KRIEGEL LLC
ANDREW KRIEGEL
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

GARY STAGEN
Employee/Petitioner

v.

RELADYNE LLC
Employer/Respondent

Case # 17 WC 7749

Consolidated cases: ____

19IWCC0174

An *Application for Adjustment 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 **Woodstock**, on **August 3, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **11/3/2016**, 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 $**TBD**; the average weekly wage was $**TBD**.

On the date of accident, Petitioner was **34** years of age, *single* with **0** dependent children.

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

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

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

ORDER

Petitioner is entitled to TTD benefits in accordance with §8(a) of the Illinois Workers' Compensation Act based on his current work restrictions that his employer is unable or unwilling to accommodate.

Petitioner's average weekly wage will be determined at a later date.

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

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

[signature]

Signature of Arbitrator

10/3/17

Date

ICArbDec19(b)

OCT 4 - 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION 19(b)/8(a) DECISION

GARY STAGEN,	)	
Petitioner,	)	
v.	)	17 WC 07749
RELADYNE, LLC.	)	19IWCC0174
Respondent.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

The only contested issue at this hearing is Petitioner's entitlement to ongoing TTD benefits (Arb. Ex. 1). The attorneys have reserved the right to address all other issues at a later date (Tr. pp. 4-5).

Petitioner's current work restrictions are not disputed. Petitioner's treating orthopedic surgeon, Dr. Matthew Bernstein of Barrington Orthopedic Specialists, has restricted Petitioner to lifting with the elbow away from the left side up to five (5) pounds frequently and up to ten (10) pounds occasionally. Petitioner has further restrictions of no left-handed overhead lifting and no left-handed pushing, pulling or climbing, and no writing or typing with the left arm. (Rx. 1).

At the time of hearing, the Arbitrator heard testimony from Petitioner and from Dina Snyder on behalf of Respondent.

Petitioner testified he currently has work restrictions of limiting his left side lifting with the elbow away from the side up to five (5) pounds frequently and up to ten (10) pounds occasionally. He has further restrictions of no left-handed overhead lifting and no left-handed pushing, pulling or climbing and no writing or typing with the left arm (Tr. pp. 7-8). Petitioner is currently unable to work at his former job at Reladyne, LLC due to these restrictions. He testified he was offered a position at the Northern Fox Valley Habitat for Humanity Restore, which was not his employer at the time of his alleged work-related accident, nor at any time after. (Tr. p. 9).

Dina Snyder, the president of Transitional Work Solutions, (Tr. pp. 10-11) testified concerning the transitional volunteer position offered to Petitioner with the Northern Fox Valley Habitat for Humanity Restore, an entity that is not affiliated with Reladyne, LLC. Ms. Snyder testified she had no personal knowledge of the job requirements associated with the volunteer position (Tr. p. 23). Despite finding Petitioner a volunteer position within his work restrictions, Ms. Snyder has not reviewed any doctor's notes documenting Petitioner's work restrictions. Her only knowledge of Petitioner's work restrictions is based on information she received from Petitioner's employer (Tr. p 27).

CONCLUSIONS OF LAW

Section 8(b) of the Illinois Workers' Compensation Act provides for the payment of temporary total disability ("TTD") to workers who are temporarily unable to work as a result of a work-related injury. An injured employee is entitled to TTD from the time an injury incapacitates him from working until the time the

employee is recovered to the point the permanent character of the injury will permit. *Mobil Oil Corp. v Industrial Comm'n* 327 Ill.App.3d 778, 261 Ill.Dec. 924, 764 N.E.2d 539 (3d Dist. 2002).

The Arbitrator notes Petitioner is employed by Reladyne, LLC. Petitioner was offered a volunteer position at the Northern Fox Valley Habitat for Humanity. The Northern Fox Valley Habitat for Humanity is not Petitioner's employer. The proffered position does not fall within the category of light duty work yielding temporary partial disability payment in lieu of TTD payments under the Act as the position is unpaid. Additionally, the volunteer position at an organization different than that of the employer is not the equivalent of an offer of accommodated duty as the position is unpaid and not offered by the employer.

The Arbitrator finds no authority in the Act requiring Petitioner to accept an unpaid position for an entity other than his employer. Petitioner's refusal to accept a volunteer position for a company other than his employer does not obviate the need for TTD benefits during a period of restricted duty unaccommodated by Respondent.

The decision the Arbitrator relies upon in support of her decision is *Saineghi v. Demar Logistics*, No. 12 WC 39022. There the Commission confirmed a Petitioner's entitlement to TTD despite his refusal to accept accommodated work at a position with an entity other than his employer. The Commission noted that this type of position was not equivalent to an offer of accommodated duty as the position was unpaid and not offered by the Respondent.

Furthermore, other decisions have ruled similarly on this issue; holding that it is the obligation of the Respondent during a period of temporary total disability to provide light-duty work for Petitioner with its own company where the Petitioner remains under the control and supervision of the employer and not under the direction and supervision of an individual at another employer. See *Kilduff v. Tri-County Coal*, No. 12 WC 38843 and *Lee v. Fluid Mgmt.*, No. 11 WC 48656.

The Respondent's obligation to pay Petitioner's TTD benefits is ongoing and shall continue so long as Petitioner has work restrictions which his employer is unable to accommodate. The Arbitrator finds that Petitioner has work restrictions which Respondent is unable or unwilling to accommodate. Therefore, under the Act, Petitioner is entitled to continued TTD benefits so long as he has work restrictions that his employer is unable to accommodate.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RON ENGLEBRECHT,

Petitioner,

vs. NO: 17 WC 011692

KEYSTONE STEEL & WIRE CO.,

Respondent.

19IWCC0175

DECISION AND OPINION ON REVIEW

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

There is no controversy concerning how Petitioner came to suffer his compensable injury on October 17, 2015. He fell backwards after getting his feet entangled in wiring that was on the floor in the department he worked in. As he fell, he extended his right arm behind his body in an attempt to control his fall onto a concrete floor. He experienced a burning pain in his right shoulder when his right hand came into contact with the floor. Believing his injury would resolve without medical intervention, Petitioner did not immediately seek such treatment.

Petitioner presented to OSF Occupational Health, Respondent's in-house medical clinic, on November 2, 2015 where he was seen by Dr. Homer Pena. He was diagnosed with a strain/sprain, but an MRI was ordered when he returned to Dr. Pena for a follow-up visit on November 10, 2015. The MRI was performed on November 24, 2015 and revealed a supraspinatus tear, mild glenohumeral joint disease, and AC joint degenerative changes. Dr. Pena subsequently referred Petitioner to an orthopedic surgeon, Dr. Mark Phillips.

Petitioner was examined by Dr. Phillips on December 15, 2015, and Dr. Phillips' resulting consultation note indicated that he had reviewed the November 24, 2015 MRI and agreed with the radiologist's interpretation of the films that indicated a full-thickness rotator cuff tear. On December 15, 2015, a decision was made to proceed with surgical intervention to repair the rotator cuff. As to the chronicity of the tear, Dr. Phillips indicated that could not be determined at that time but did acknowledge the possibility that Petitioner's condition might be an acute-on-chronic-type scenario.

The right rotator cuff repair surgery was performed by Dr. Phillips on January 18, 2016. As a result of the surgery, he came to diagnose Petitioner's injuries as right shoulder rotator cuff pathology, acromioclavicular joint arthropathy, internal derangement with Type-I/II SLAP lesion variant, and a limited, partial long-head biceps tendon tear with a full-thickness supraspinatus complex tear. He also wrote in the Postoperative Diagnoses section of the Operative Report, "a non-traumatic full-thickness tear with AC joint arthropathy."

It is Dr. Phillips' operative findings are at the heart of the case. Dr. Troy Karlsson, Respondent's Section 12 examining physician, took note of Dr. Phillips' description of the full-thickness tear as being "non-traumatic." Dr. Karlsson, relying on Petitioner's medical records, including diagnostic test results that indicated Petitioner had degenerative conditions in his shoulder as well as Dr. Phillips finding of a "non-traumatic full-thickness tear," concluded that the then-current condition of Petitioner's right shoulder was not causally connected to his October 17, 2015 accident and resultant injury. The presiding Arbitrator concurred with Dr. Karlsson and found the injury to Petitioner's right rotator cuff unrelated to that accident. The Commission disagrees with that finding.

Dr. Phillips testified that he did provide a postoperative diagnosis that there was a "non-traumatic full-thickness tear" present in Petitioner's right shoulder but also testified that the tear was not completely a chronic tear, noting the surgical findings were more consistent with an acute tear or an acute-on-chronic component tear. His specific findings in support of this testimony were that the tendon was not completely detached, that the tendon was repairable without tension with the arm in a neutral position, and that there was no significant muscle atrophy that would be consistent with a chronic and long-present tear.

Petitioner's radiographic films, in addition to Dr. Phillips' postoperative diagnoses, appear to be the primary basis for Dr. Karlsson's conclusion that the tear in Petitioner's right shoulder was solely degenerative. He noted Petitioner's initial x-rays revealed degenerative changes to the AC joint and an osteophyte, a finding noted to be a very common source of rotator cuff impingement. He noted a keel spur was identified in an MRI of Petitioner's right shoulder; the keel spur was also noted to be a source of impingement of the rotator cuff. Also noted by Dr. Karlsson was that the MRI showed what he deemed was "extensive" retraction and mild atrophy, indications of chronic change in the rotator cuff. Dr. Karlsson's interpretation of Petitioner's radiographic films and Dr. Phillips' observations while performing the rotator cuff repair give credence to Dr. Phillips' proffered suggestion that Petitioner sustained an acute-on-chronic injury. Dr. Karlsson, himself, acknowledged the possibility of that a rotator cuff being jammed into a bone spur by way of a forceful motion could result in the tearing of a rotator cuff.

The Commission is not as concerned about Dr. Phillips' postoperative diagnosis of a "non-traumatic full-thickness tear" as was Dr. Karlsson for several reasons. First, Dr. Phillips wrote of finding a "non-traumatic full-thickness tear" as well as AC joint arthropathy. Although Dr. Phillips did not describe the AC joint arthropathy, he did note seeing "internal derangement with type I/II SLAP lesion" during the surgery. The focus of Dr. Karlsson would have appeared to be myopically focused on the non-traumatic tear. Second, even allowing for the "non-traumatic full-thickness tear," Petitioner testified that he never experienced any discomfort, including pain, in his right shoulder prior to October 17, 2015, the date of Petitioner's accident. If Dr. Karlsson was correct and Petitioner had a chronic tear in his right shoulder, it was, per Petitioner's unrebutted testimony, asymptomatic. On October 17, 2015, that tear, again per Petitioner, became symptomatic. In the words of Dr. Phillips, Petitioner had experienced an acute-on-chronic injury.

As indicated above, the Commission modifies the Decision of the Arbitrator and does so by finding, contrary to the presiding Arbitrator, the torn rotator cuff in Petitioner's right shoulder was causally related to his October 17, 2015 accident as was the medical and physical therapy treatment and expenses rendered to treat that injury.

The Commission modifies the Decision of the Arbitrator further by increasing the permanency award bestowed under Section 8(d)2 of the Act to 15% loss of the person as a whole. The Commission justifies this award under Section 8.1b(b) of the Act as follows:

(i) Impairment: Dr. Karlsson performed a permanent partial disability impairment report. He used the Diagnosis-Based Impairment Rating System and classified Petitioner as having a full-thickness rotator cuff tear along with some residual loss; he found Petitioner had pain and symptoms with normal activities; and he performed a physical examination of Petitioner and noted it demonstrated some atrophy and slight loss of motion. The Commission gives this factor considerable weight. The Commission finds the presiding Arbitrator's interpretation conflated Dr. Karlsson's Section 12 examination findings with the findings he articulated in his impairment report.

(ii) Occupation: No job title was bestowed upon Petitioner, but he worked in Respondent's galvanizing department from July 26, 1976 through January 2018 and, on the date of accident, he was pulling wire. Petitioner was released from medical care and found to be at maximum medical improvement on August 2, 2016. Petitioner testified that his retirement in January 2018 was prompted, in part, by residual pain felt in his right shoulder. The Commission gives this factor significant weight.

(iii) Age: Petitioner was 60 years old at the time of the accident. The Commission gives this factor no weight as no evidence was introduced to indicate the relationship between Petitioner's age, the accident, and his recovery from the accident.

(iv) Future Earning Capacity: Petitioner is retired and offered no indication that he

intended to reenter the labor market. The Commission gives this factor no weight.

(v) Evidence of Disability: Petitioner's medical records indicate he suffered a torn right rotator cuff and AC joint arthropathy that resulted in some away-from-the-body and forward flexion-type endurance issues. This medical record entries were repeated by Petitioner at his arbitration hearing. The Commission gives this factor considerable weight.

IT IS THEREFORE ORDERED BY THE COMMISSION that Decision of the Arbitrator dated May 10, 2018 is modified as noted above;

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss 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 $56,800.00. 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: MAR 2 1 2019
KWL/mav
O: 02/05/19
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ENGLEBRECHT, RON
Employee/Petitioner

Case# **17WC011692**

KEYSTONE STEEL & WIRE
Employer/Respondent

19IWCC0175

On 5/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

0225 GOLFINE & BOWLES PC
KEVIN ELDER
4242 N KNOXVILLE AVE
PEORIA, IL 61614

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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

RON ENGLEBRECHT
Employee/Petitioner

v.

KEYSTONE STEEL & WIRE
Employer/Respondent

Case # **17** WC **11692**

Consolidated cases: **NONE**

19IWCC0175

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **March 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ___

FINDINGS

On **10/17/2015**, 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*** in part causally related to the accident.

In the year preceding the injury, Petitioner earned $**104,891.28**; the average weekly wage was $**2017.16**.

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

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

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

Respondent shall be given a credit of $**48,219.25** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**48,219.25**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/9/18
Date

MAY 10 2018

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on October 17, 2015. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident; 2) causation; 3) nature and extent.

Petitioner was a 62-year-old factory worker employed in Respondent's galvanizing department on October 17, 2015. He worked for Respondent from July 1976 until his voluntary retirement in January 2018. On October 17, 2015, Petitioner was working second shift for Respondent. He testified that at approximately 6:30 PM, he was pulling back on a wire when his feet got tangled in wire on the floor, causing him to fall backwards onto his outstretched right arm and then onto the concrete floor. He immediately felt burning pain in his right shoulder, but he continued to work and finished his shift that day. At the conclusion of his shift, he reported his injury to the security shack as it was a Saturday night and the medical department was closed. He filled out and signed an incident report that night. (PX 3) Petitioner continued to work his normal hours for approximately two weeks before he sought medical attention.

On November 2, 2015 Petitioner had an initial visit with the in-house company doctor, Dr. Pena. (PX 4, pp.25-26) Petitioner gave Dr. Pena an accident history and was diagnosed with a sprain/strain. Petitioner indicated his pain remained 1 on a scale of 10 and had not changed. He stated this was nothing like his left shoulder injury as following it he could not lift his arm. Petitioner acknowledged that his prior left shoulder injury resulted in pain 8 on a scale of 10. Dr. Pena's physical examination revealed vague findings. He was sent for x-rays of the right shoulder, which showed no fracture or dislocation. Dr. Pena allowed Petitioner to continue working without restrictions but ordered an MRI. The right shoulder MRI performed on November 24, 2015 revealed: a full thickness partial width tear of the supraspinatus with 3.4 cm of medial retraction; degenerative fraying of the posterior superior labrum and degenerative changes of the acromioclavicular joint with large fibrous capsule formation and a small subacromial keel spur measuring 2 mm in the craniocaudal dimension with a type II acromion noted; and subinsertional cysts of the greater tuberosity and mild glenohumeral degenerative joint disease. (PX 4, pp.42-43) Dr. Pena saw Petitioner on November 30, 2015, took him off work completely, and referred him to Dr. Mark Phillips, an orthopedic surgeon. (PX 4, p.15)

Petitioner saw Dr. Phillips on December 15, 2015. He provided Dr. Phillips with his accident history and complained of night pain and pain with movement of the right arm away from the body. He had a full ROM in the shoulder with decreased strength. Dr. Phillips recommended surgery. He also commented in his notes, "Chronicity cannot by totally defined at this point and it may possibly be an acute on chronic type of scenario, which we typically see at this age group." (PX 2, pp.13-14) On January 18, 2016, Dr. Phillips performed an arthroscopy of Petitioner's right shoulder, with biceps-labral, long head biceps tendon and rotator cuff debridement, subacromial decompression, partial acromioplasty, distal clavicle excision, and an open rotator cuff repair. (PX 2, pp.2-3) Following surgery, Petitioner underwent physical therapy, work conditioning, and was released to return to full duty work as of August 8, 2016. (PX 4, p.2) Respondent has paid all of Petitioner's TTD benefits and his medical expenses.

Dr. Phillips testified via evidence deposition on November 21, 2017. (PX 1) Dr. Phillips is a board certified orthopedic surgeon, specializing in sports medicine involving knees and shoulders. Dr. Phillips did not review any records other than the x-ray and MRI. Dr. Phillips confirmed Petitioner's accident history of tripping and falling backwards, catching himself with an outstretched right arm. Dr. Phillips testified that he operated on Petitioner on January 18, 2016, and that his post-operative diagnosis was: rotator cuff pathology, AC Joint

arthropathy with a type I/II SLAP lesion variant, limited partial long head biceps tendon tear, with full thickness supraspinatus complex tear. (PX 1, pp.10-11) Dr. Phillips testified that during surgery, he noted a "V" shaped tear in the supraspinatus tendon. He opined that his "surgical findings were more consistent with a more acute tear or possibly an acute on chronic component tear" and that Petitioner's accident was directly related to his need for treatment. (PX 1, pp.12-14) Dr. Phillips testified that the Petitioner's tear in his shoulder was not retracted to any significant extent.

Respondent obtained a Section 12 examination with Dr. Troy Karlsson. Dr. Karlsson testified via evidence deposition on December 18, 2017. (RX 1) He is a board certified orthopedic surgeon who examined the Petitioner on July 25, 2017. 95% of Dr. Karlsson's practice is devoted to the treatment of individuals. Dr. Karlsson opined that the Petitioner's reported complaints immediately after his alleged accident and his medical records are not supportive of his claim that he sustained an acute rotator cuff tear on July 25, 2017. Dr. Karlsson noted that the Petitioner's initial x-rays showed degenerative changes of the AC joint and an osteophyte - which was a common source of impingement on the rotator cuff; as well as a tiny osteophyte of the humeral head indicative of slight arthritic change. The spur could lead to impingement on the rotator cuff and is a common source leading to a degenerative tear of the rotator cuff. (RX 1, p. 13, 14) In his review of the MRI results, Dr. Karlsson stated that the keel spur noted on MRI was a common source of impingement on the rotator cuff leading to a chronic tear. (R 1, p. 13-14) The cyst on the greater tuberosity and portion of the humeral head were also signs supporting chronic problems with the rotator cuff. (RX 1, p. 14-15). Dr. Karlsson, in viewing the MRI film, noted extensive retraction of the supraspinatus back to the level of the glenoid with mild atrophy of the supraspinatus muscle. (RX 1, p. 15-16). The atrophy would be another sign of chronic change of the rotator cuff. It would have taken months to a year to develop and were not signs of an acute traumatic rotator cuff tear. (RX 1, p.16)

Dr. Karlsson agreed with Dr. Phillips' postoperative diagnosis of "nontraumatic full thickness tear of the rotator cuff" with AC joint arthropathy. (RX 1, p.19 and PX 2, p.16) With regard to the large v-shaped tear noted by Dr. Phillips, Dr. Karlsson opined that the tear was retracted and chronic in nature, and would require a long time to have developed.

Dr. Karlsson also noted that with an acute rotator cuff tear, an individual would have severe pain, as Petitioner experienced in 2005 with his prior left shoulder injury, wherein he complained of pain at 8 on a scale of 10, and had difficulty lifting his arm. The fact that Petitioner's pain was 1 on a scale of 10 and that he had a normal range of motion would be consistent with a chronic tear and not indicative of an acute tear. The fact that Petitioner was able to continue to perform his regular duties through November 1 without medical care, would also be consistent with a chronic tear. (RX 1, p. 10). Based upon his review of all records and the MRI films, Dr. Karlsson opined that there was no causal connection between the condition of ill-being in the Petitioner's right shoulder and the mechanism of injury of October 15, 2015. All signs pointed towards a chronic large tear that was retracted, including cysts of the humeral head and atrophy of the supraspinatus. (RX 1, p. 23). The operative report noted sclerosis in the bone and high ridging of the humeral head, all signs of a chronic, retracted rotator cuff tear. There was nothing acute about the tear. (R. Ex. 1, p. 23, 24). Dr. Karlsson performed an AMA impairment rating in which he noted that Petitioner had 5 out of 5 strength and excellent range of motion. (RX 1, p. 23) Dr. Karlsson's AMA impairment rating was 6% of the arm or 4% of a man as a whole. (RX 1, p. 27-28).

Petitioner testified on cross examination that he had a prior left workers' compensation claim involving his left shoulder, resulting from a fall in 2005. Petitioner testified that following the fall he sustained in 2005, his pain

was 8 on a scale of 10 and that he could not lift his arm. Petitioner confirmed that following his October 17, 2015 incident, he reported his right arm pain was 1 on a scale of 10 and that he had full range of motion. He also confirmed that he mentioned in his initial medical records that he did not want medical treatment. Petitioner worked full duty without restrictions from October 17, 2015 through November 29, 2105. He also worked full duty on his return to work in August, 2016 through his retirement in January, 2018.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the initial medical records indicating Petitioner fell down on October 17, 2015 when his foot got tangled in wire. He put out his right arm to stop his fall and reported the incident to Respondent soon after. There was no evidence introduced to rebut Petitioner's account of his accident. Accordingly, the Arbitrator finds that the Petitioner sustained an accident while working for the Respondent on October 7, 2015.

2. Regarding the issue of accident, the Arbitrator finds that the Petitioner proved he sustained a sprain/strain injury to his right arm, but that the Petitioner's torn rotator cuff is not causally related to his work accident. In support of this finding, the Arbitrator relies on Petitioner's testimony and the medical evidence. Petitioner's initial medical records show that he had relatively minor complaints for which Dr. Pena diagnosed him with a sprain/strain and there was no evidence presented to refute that medical finding. The main issue in this case is whether Petitioner's torn right rotator cuff is related to his work accident. On this question, the Arbitrator finds Dr. Karlsson's opinions persuasive. Dr. Karlsson reviewed all the medical records in this case, including the diagnostic test results showing that Petitioner suffered from degenerative conditions in his shoulder. He notes the records show Petitioner's complaints of pain following the accident were very minimal – particularly when compared to Petitioner's prior acute rotator cuff injury to his other arm – and reasonably opined that an individual with an acutely torn rotator cuff would not be able continue working full duty and would have more significant pain. The fact that the Arbitrator found most convincing was Dr. Karlsson's agreement with Dr. Phillips' post-surgical diagnosis of Petitioner's "nontraumatic full thickness tear of the rotator cuff" with AC joint arthropathy. (RX 1, p.19 and PX 2, p.16) Dr. Phillips' attempt to explain the apparent contradiction between his post-operative diagnosis of Petitioner's nontraumatic rotator cuff tear and his later opinion that the Petitioner's torn rotator cuff was an acute injury caused by his accident – was not the least bit convincing. Dr. Phillips testified to having made a drawing of a V-shaped tear he found in Petitioner's surgery – to bolster the doctor's opinion regarding the acute nature of Petitioner's condition – but there is no mention in any of the medical records of a V-shaped tear suggesting an acute condition at any time prior to his evidence deposition testimony.

Based on the medical evidence, the Arbitrator concludes that the Petitioner's right torn rotator cuff is not causally related to his October 17, 2015 accident. In reviewing the medical evidence, it is more likely that the Petitioner sustained a sprain/strain injury, which was noted in the initial records by Dr. Pena.

3. 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.

19IWCC0175

(i) Impairment. Dr. Karlsson performed an AMA impairment rating in which he noted that Petitioner had 5 out of 5 strength and excellent range of motion. Dr. Karlsson's AMA impairment rating was 6% of the arm or 4% of a man as a whole. The Arbitrator gives great weight to this factor.

(ii) Occupation. Petitioner was employed in Respondent's galvanizing department at the time of the accident, and was medically able to return to work in his prior capacity as a result of said injury full duty and without any restrictions. The Arbitrator gives considerable weight to this factor.

(iii) Age. Petitioner was 60 years old at the time of the incident. Given the questions regarding the chronicity of Petitioner's conditions, the Arbitrator gives considerable weight to this factor.

(iv) Future Earning Capacity. There was no evidence offered regarding Petitioner's future earning capacity 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: a left shoulder strain/sprain. The evidence shows that Petitioner had very minimal complaints as a result. Based on the evidence introduced at trial, the Arbitrator gives significant weight to this factor.

Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 4% loss of the man as a whole, as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AMANDA WYLIE,

Petitioner,

vs. NO: 15 WC 35711

STATE OF ILLINOIS/DEPARTMENT OF
JUVENILE JUSTICE,

19IWCC0176

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability (TTD) benefits, and permanent partial disability (PPD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on October 10, 2015. The Commission also finds that Petitioner's right shoulder condition is causally related to the October 10, 2015 accident. The Commission further finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the October 10, 2015 accident, as well as TTD benefits from October 11, 2015 through March 16, 2016. As to PPD benefits, the Commission awards two-and-a-half percent (2.5%) loss of use of the person as a whole.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1) Petitioner testified that on October 10, 2015, she was employed by Respondent as a juvenile justice specialist intern at Pere Marquette Youth Center; her duties included supervising youths who were between the ages of 13 and 19 years old. (T.9-10; T.24; Arbitrator's Exhibit 2).

2) During cross-examination, Petitioner stated that she was considered an intern because she was under a probationary period. However, her duties were the same as a regular juvenile justice specialist. (T.25).

3) Petitioner started working for Respondent in February 2015. (T.9). The parties stipulated that Petitioner earned $1,156.36 per week in this position. (Arbitrator's Exhibit 1, Request for Hearing form).

4) On October 10, 2015, Petitioner was assigned by her supervisor to take some of the youths on a recreational trip to go swimming at Principia College. (T.10-12). To the best of her knowledge, Petitioner was not aware whether or not she could refuse the assignment. (T.11). Petitioner explained the purpose of the recreational trip:

> Because we were a low security facility the correction facility portrays itself as maybe not being exactly a rehabilitative center but they do like to participate and attempt to – it's less of a punitive approach in watching over the youth so they encouraged interaction and participation with the youth. My job was to provide supervision. I attended a recreational trip to participate with the youth as well. (T.11-12).

5) During the recreational trip, on October 10, 2015, Petitioner decided to get into the pool with the children. She testified that she had not done this on prior trips. "I had been asked before, weeks before, oh, are you going swimming with the children on this trip? No, I hadn't really thought about that." (T.12). However, on this particular date, Petitioner decided to swim because, "I had witnessed other staff swim with the youth so this particular trip that I was assigned to I brought my swimming gear along and participated and swam with the youth, was able to supervise the youth while swimming with them just like I had seen my colleagues do." (T.13).

6) Petitioner testified that she injured her right shoulder on October 10, 2015, after diving from the diving board, and her arm struck the water. (T.13; T.15; T.24). The incident report, dated October 14, 2015, indicated that Petitioner had injured her shoulder, and felt sharp, burning pain at the point of entry into the water. (PX1; RX2).

7) Petitioner testified to this effect, stating that right after the dive, she experienced a quick, deep shock and a sharp, shooting pain in her right shoulder. (T.13). Thereafter, Petitioner, "floated around the water for a few minutes trying to wiggle it back because my first impression was, oh, it just dislocated or something strange like that. Tried to shake it off

and when I felt able to I got out of the pool." (T.14). Petitioner put her clothes back on and continued to supervise the youths from the side of the pool. (T.14).

8) During cross-examination, Petitioner acknowledged that at the time of her injury, she had not been aware that she was not supposed to be swimming with the youths. (T.35).

9) Petitioner completed her shift on October 10, 2015 at 10:00 PM. (T.15-16).

10) Petitioner waited until the following day, October 11, 2015, to seek treatment for her right shoulder because she wanted to "sleep it off"; Petitioner did take some ibuprofen. (T.16).

11) Petitioner confirmed that she had never injured her right shoulder prior to October 10, 2015. (T.17).

12) On October 11, 2015, Petitioner went to Downtown Urgent Care. (T.17). The history recorded was that Petitioner was diving into a pool – "Once she hit the water, felt her shoulder move out laterally. Felt her right elbow go laterally as well. Felt like she dislocated shoulder." Petitioner presented with complaints of burning pain, tenderness, numbness and tingling, and radiating pain into her right elbow; Petitioner's pain level was an eight out of 10. The record noted that Petitioner had not previously injured her right shoulder. (PX2).

13) The physical exam revealed that Petitioner had tenderness to palpation over the AC joint; there was no edema or erythema; Petitioner was able to abduct and extend her arm up to 90 degrees; she was also able to supinate and pronate her arm but it was painful. (PX2). X-rays of the right shoulder and right elbow indicated no obvious fractures or gross abnormalities. (T.17; PX2). Petitioner was diagnosed with right shoulder and right elbow sprains. Petitioner was given light duty restrictions and was ordered not to use her right arm. She was also prescribed Tylenol, Flexeril, and Ibuprofen, and given a sling. If her condition did not improve, physical therapy and an MRI would be ordered. (T.17; PX2).

14) Petitioner's condition did not improve, and she underwent an MRI for her right shoulder on October 20, 2015, at Metro Imaging. The impression revealed a subtle, non-displaced fracture originating near the junction of the greater tuberosity and articular margin of the humeral head. The report stated, "This extends inferiorly along the base of the greater tuberosity as well as into the region of the humeral neck. This is associated with extensive adjacent marrow edema." A possible tear in the area of the superior glenoid labrum could not be excluded. The rotator cuff tendons appeared intact. (T.17; PX3).

15) On October 23, 2015, Petitioner consulted with Dr. Jay Keener. (T.17-18; PX5). The history recorded was, "She was on an outing for work. She was diving. She hit awkwardly to the water. Her arm was extended overhead and then forced into an adduction moment immediately. She felt immediate pain in her shoulder. Prior to that her shoulder was completely normal." Dr. Keener examined Petitioner and reviewed the imaging tests, including the MRI of the right shoulder. He diagnosed Petitioner with an acute greater tuberosity non-displaced fracture. He indicated that the fracture would heal on its own, but would take time. (PX5). Dr. Keener gave Petitioner restrictions of no lifting more than five

pounds, and to avoid heavy pushing and pulling, and no overhead activities. Dr. Keener did want Petitioner to use her arm lightly with her arm at her side. Petitioner testified that Respondent was unable to accommodate Petitioner's restrictions. (T.18; PX5). Dr. Keener took Petitioner off work again on January 5, 2016. (PX5).

16) Dr. Keener had also ordered physical therapy. (T.18; PX5). Petitioner commenced physical therapy for her right shoulder on November 3, 2015, at SSM Physical Therapy. (PX4).

17) Petitioner last saw Dr. Keener on February 2, 2016. (T.19). Dr. Keener's February 2, 2016 office visit note stated that Petitioner was doing well and did not have much pain anymore. He noted that Petitioner did feel weak, but her exam was normal; Petitioner's range of motion lacked the last bit of elevation and rotational motion. Petitioner had pretty good external rotation and abduction strength. Petitioner was eventually fully discharged on March 16, 2016; Petitioner had been released full duty. (T.20-21; PX5).

18) After Petitioner completed her treatment with Dr. Keener, she did not return to work for Respondent. "I was out of work for so long without any pay I was actually scared to go back to work at this position for fear of retaliation so I had started looking for other jobs in 2016." (T.19). Petitioner eventually found employment with the St. Louis Center for Family Development as a mental health professional. (T.20).

19) As of the date of arbitration, Petitioner noted that her right shoulder remained weak and her shoulder did not have the same level of tension that it did before the injury. (T.21).

20) Respondent called Chad Burns to testify on its behalf; Mr. Burns worked for Respondent as a juvenile justice supervisor at IYC Pere Marquette. (T.37). His duties included internal affairs investigations. (T.37). Mr. Burns confirmed that on October 10, 2015, Petitioner was the only security staff on the recreational trip and therefore not allowed to swim with the youth. (T.39). One other person, named Tyler Gregory, was on the recreational trip as well. (T.29). Mr. Burns testified that Mr. Gregory was a temporary leisure activities personnel on October 10, 2015. (T.49). Mr. Burns stated that from a security standpoint, Mr. Gregory was not responsible for the safety of the children. (T.50). However, if a fight broke out, Mr. Burns agreed that Mr. Gregory would not just stand there; Mr. Burns agreed that there would be circumstances in which Mr. Gregory would have to provide safety and security. (T.50-51).

21) Mr. Burns further testified that he had witnessed some security staff members swim if there was more than one. (T.38). On cross-examination, Mr. Burns clarified the rules as to security staff and swimming: "According to the policies and procedures, no. If there's written permission – I would say that there would have to be an exception. I believe you'd have to have written permission to justify the ability to swim." (T.48-49).

22) Respondent's Exhibit 4, No. 10, the "General Work Rules," reveal no evidence that Petitioner was precluded from swimming, or any rules regarding swimming for that matter. Respondent's written rules do indicate that employees were allowed to socialize with youths in the performance of an assignment or as approved in writing; traveling to court,

medical treatment, and other scenarios was allowed as outlined in the Rules. (RX4, No. 10).

23) Mr. Burns further testified to a DVD, dated October 10, 2015, that his superintendent had asked him to review. The DVD showed Petitioner locking the door and walking up the stairs; she was not holding onto the handrail with either hand. (T.39-42). He described Petitioner walking into the facility's kitchen, and using both hands to open the refrigerator door; Petitioner was wearing a blue shirt and khakis. (T.42-43). The last video was of Petitioner sitting behind her desk at the recreational center, then raising her right arm to put on her coat and putting her hands behind her head to fix her hair. (T.43-44; RX10).

24) On cross-examination, Mr. Burns confirmed that although he read the investigation reports in this claim, he was not involved in the actual investigation; he was involved in the video aspect of this claim. (T.46-47).

25) The documents contained in Respondent's Exhibit 2 included a typed report purportedly signed by Mr. Gregory, and dated October 15, 2015. The report stated that Mr. Gregory did not witness or hear any accident or injury involving Petitioner on October 10, 2015. (RX2).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on October 10, 2015. The Commission reverses the Arbitrator's Decision in its entirety.

By the record, the Commission notes that Petitioner was allowed to travel with youths away from Respondent's premises, for example, to court or for medical care, and was in fact on a recreational trip at the time of her accident. The Commission finds Petitioner's injury compensable under the theory of traveling employee.

> An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2. An injury 'arises out of' one's employment if 'its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury.' 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.'

> 'In the course of the employment' refers to the time, place, and circumstances under which the claimant is injured. Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment.
>
> The determination of whether an injury to a traveling employee arose out of and in the course of employment is governed by different rules than are applicable to other employees. A 'traveling employee' is one whose work requires him to travel away from his employer's office. It is not necessary for an individual to be a traveling salesman or a company representative who covers a large geographic area in order to be considered a traveling employee. Rather, a traveling employee is any employee for whom travel is an essential element of his employment. A traveling employee is deemed to be in the course of his employment from the time that he leaves home until he returns. An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, *i.e.*, conduct that 'might normally be anticipated or foreseen by the employer.' *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P14-P17.

The inquiry as to whether Petitioner was a traveling employee on October 10, 2015, is critical to the analysis for accident as traveling employees are governed by different rules than that established for other employees. *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P16. Here, Petitioner's duties qualify her as a traveling employee, because on October 10, 2015, Petitioner was required to travel away from her employer's office to the off-site swimming pool at Principia College. "A finding that a claimant is a traveling employee, however, does not relieve the employee of the burden of proving that her injury arose out of and in the course of her employment." *Mlynarczyk v. Ill. Workers' Comp. Comm'n*, 2013 IL App (3d) 120411WC, P17.

In the case at bar, Petitioner testified that on October 10, 2015, she was employed by Respondent as a juvenile justice specialist intern; her duties included supervising youths who were under the care of the detention facility. (T.9-10). On October 10, 2015, Petitioner was assigned by her supervisor to take some of the children on a recreational trip to go swimming at Principia College. (T.10-12). Petitioner explained that Respondent took a less punitive approach in watching over the youth, "[S]o they encouraged interaction and participation with the youth. My job was to provide supervision. I attended a recreational trip to participate with the youth as well." (T.11-12). Petitioner testified that she injured her right shoulder while on this swimming trip; she had jumped off the diving board at the pool, and when she struck the water, she felt a sharp, burning pain. (T.13-15; T.24; PX1; RX2). By these facts, Petitioner, was a traveling employee, and in the course of her employment, at the time of her accident.

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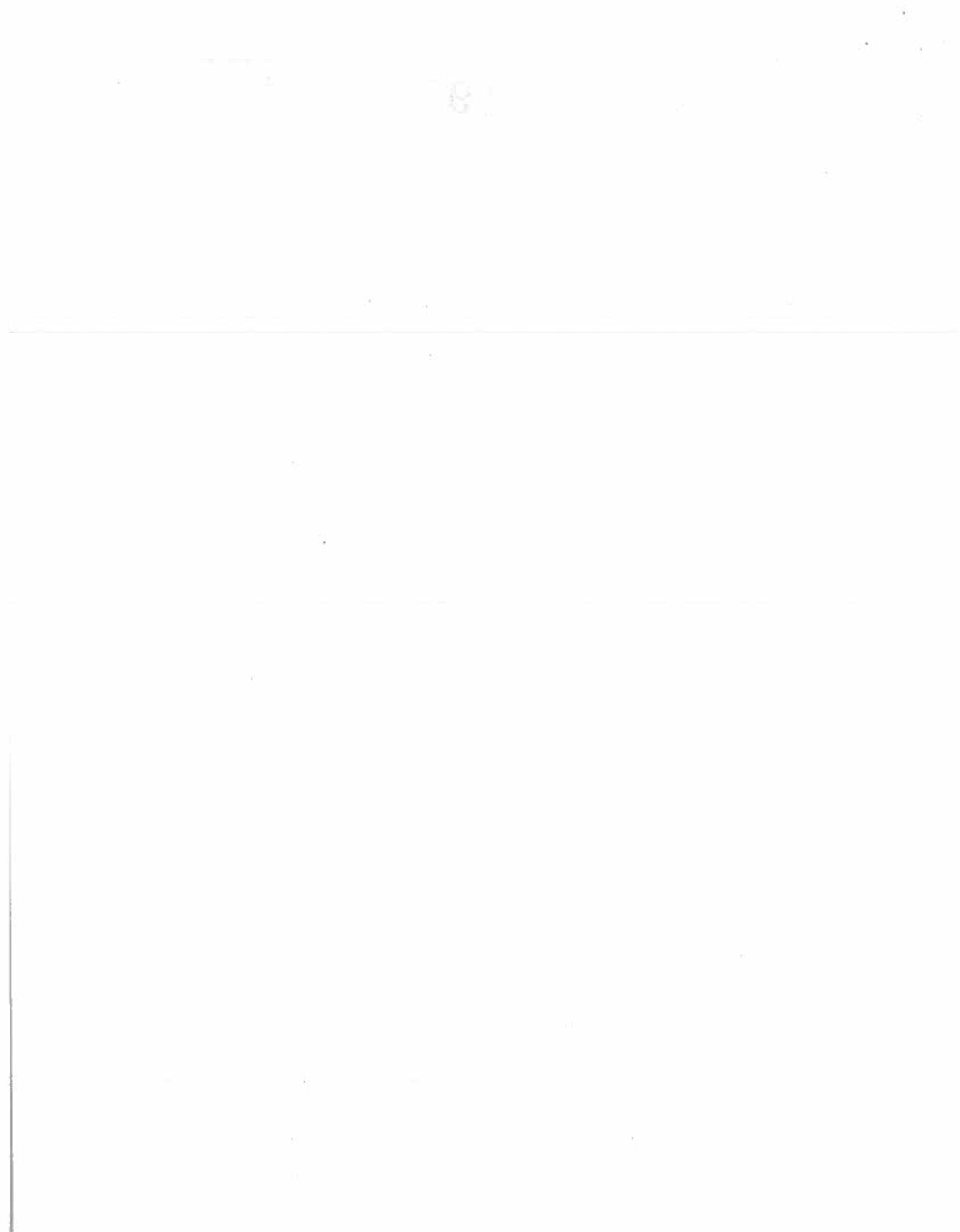
The next element is whether Petitioner's injury arose out of her employment. "An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, *i.e.*, conduct that 'might normally be anticipated or foreseen by the employer.'" *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P16. The Commission finds that Petitioner's conduct was reasonable and foreseeable to the employer. There is nothing in the record to suggest that Petitioner's conduct was unreasonable at the time of the accident, or that diving and swimming were not allowed during these recreational trips to the pool. In fact, Respondent's written Rules indicate that employees were allowed to socialize with youths in the performance of an assignment. (RX4, No. 10).

Petitioner's testimony is that although she had never swam with the youths before, she had witnessed her colleagues swim with the youths on previous trips. (T.12-13). Therefore, on October 10, 2015, "I brought my swimming gear along and participated and swam with the youth, was able to supervise the youth while swimming with them just like I had seen my colleagues do." (T.13). Petitioner acknowledged on cross-examination, that at the time of her injury, she had not been aware that she was not supposed to be swimming with the youths. (T.35).

Respondent had Chad Burns, its juvenile justice supervisor at IYC Pere Marquette, testify on its behalf. (T.37). Mr. Burns explained that on October 10, 2015, Petitioner was the only security staff on the recreational trip and therefore not allowed to swim with the youth; Petitioner would have also required written permission in order to swim. (T.39; T.48-49). However, Mr. Burns had acknowledged that he had previously witnessed security staff members swim with youths, but there had to be more than one security staff member. (T.38). The Commission notes that Petitioner was with another person, named Tyler Gregory, on this recreational trip. (T.29). According to Mr. Burns, Mr. Gregory was a temporary leisure activities personnel on October 10, 2015, and not a security staff member. (T.49). Mr. Burns could not testify as to the job duties of a temporary leisure activities personnel, but stated that from a security standpoint, Mr. Gregory was not responsible for the safety of the children. (T.49-50). However, if a fight broke out, Mr. Burns agreed that Mr. Gregory would not just stand there; Mr. Burns agreed that there would be circumstances in which Mr. Gregory would have to provide safety and security. (T.50-51).

Notwithstanding the purported rule violation, as will be discussed further below, Petitioner's conduct during the recreational trip was not unreasonable, nor was it unforeseeable. It was reasonable and foreseeable that Petitioner, in the furtherance of her duties on October 10, 2015, would utilize the diving board and pool to interact and participate with the youths during their recreational trip, as well as supervise the youths in and out of the pool – as had previously been done by her colleagues and as acknowledged by Mr. Burns.

Our Appellate Court has stated in similar cases that where the analysis applicable to traveling employees is utilized, we do not need to address the alternative argument that the claimant was exposed to a neutral risk more frequently than members of the general public by virtue of the employment. As a "traveling employee," Petitioner's exposure to hazards away from the employer's premises, by definition, is greater quantitatively than that of the general public, as long as her conduct at the time of the injury was reasonable and foreseeable to the employer. *Mlynarczyk v. Ill. Workers' Comp. Comm'n*, 2013 IL App (3d) 120411WC, P19. Thus, in this case, the dispositive question is whether Petitioner was injured while engaging in conduct that was



reasonable and that might reasonably be anticipated or foreseen by the employer. The Commission finds the answer to be in the affirmative.

As to whether Petitioner violated any swimming rules, Illinois Courts have held that:

> Where the violation of a rule or order of the employer takes the employee entirely out of the sphere of his employment and he is injured while violating such rule or order it cannot be then said that the accident arose out of the employment, and in such a case no compensation can be recovered. If, however, in violating such a rule or order the employee does not put himself out of the sphere of his employment, so that it may be said he is not acting in the course of it, he is only guilty of negligence in violating such rule or order and recovery is not thereby barred. [Citation.] * * * [It] does not matter in the slightest degree how many orders the employee disobeys or how bad his conduct may have been, if he was still acting in this sphere of his employment and in the course of it the accident arose out of it. *Chadwick v. Indus. Comm'n*, 179 Ill. App. 3d 715, 717 (4th Dist. 1989).

Whether or not Petitioner violated any rule or order of the employer is not the inquiry; the question is whether Petitioner's purported violation took her entirely out of the sphere of her employment. Here, Petitioner was performing the duties for which she was hired, namely to interact with and supervise youths. Petitioner was not engaged in any work activity which was strictly unauthorized by Respondent or any of its written Rules. Petitioner was also not in a place where she was forbidden to be. It is also interesting to note that for all its alleged claims to safety, security, and adherence to rules, Respondent sent Petitioner, a juvenile justice specialist intern under a probationary hiring period, to be the sole security personnel on the October 10, 2015 recreational trip.

In light of the foregoing, the Commission finds that Petitioner was where she was supposed to be, doing what she was hired to do – supervising and interacting with youths on their recreational trip to the pool, thus, Petitioner was acting in the sphere of her employment, and in the course of it the accident arose; Petitioner's injury is compensable.

As to the issue of causal connection, the Arbitrator rendered this issue moot as the Arbitrator had determined that Petitioner failed to prove accident. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982). Here, the consistent and credible evidence supports a finding of causal connection. Petitioner testified consistent with the incident report and medical records as to injuring her right shoulder after diving into the pool and striking the water on October 10, 2015. Petitioner further testified that she had never injured her right shoulder prior to October 10, 2015; the medical records corroborate Petitioner's testimony. (T.17; PX2). Following the October 10, 2015 accident, Petitioner had immediate complaints in her right shoulder; physical examination and the October 20, 2015 MRI

indicated positive findings, including a subtle, non-displaced fracture originating near the junction of the greater tuberosity and articular margin of the humeral head. (PX3). Petitioner's treating physician, Dr. Jay Keener, explained Petitioner's injury as follows: "She was on an outing for work. She was diving. She hit awkwardly to the water. Her arm was extended overhead and then forced into an adduction moment immediately. She felt immediate pain in her shoulder. Prior to that her shoulder was completely normal." Dr. Keener diagnosed Petitioner with an acute greater tuberosity non-displaced fracture. He indicated that the fracture would heal on its own, but would take time. Thereafter, Dr. Keener ordered physical therapy and put Petitioner on restricted duty. (PX5). Respondent offered no evidence to rebut Petitioner's testimony as to her condition nor to rebut the medical evidence. Therefore, the Commission finds that Petitioner's right shoulder condition was causally related to the October 10, 2015 accident.

As such, the Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's Exhibits 6 and 7, namely the physical therapy bill totaling $1,174.09, the MRI bill totaling $775.80, the Urgent Care bill totaling $850.00, and only those charges attributed to Dr. Keener; Dr. Keener's bill was paid through Petitioner's group carrier. Therefore, the Commission finds Respondent is entitled to credit under Section 8(j) of the Act for any medical bills paid by Respondent's group carrier. (PX6). Petitioner's Exhibit 7 are the out-of-pocket expenses and co-pays totaling $244.06; any additional co-pays not accounted for in this total are included in the aforementioned itemized statements. (PX6; PX7).

The Commission further awards TTD benefits to Petitioner from October 11, 2015 through March 16, 2016, or 22 4/7 weeks. The record indicates that Petitioner had been given light duty restrictions, but there is no evidence that Respondent attempted to accommodate Petitioner. Dr. Keener took Petitioner off work on January 5, 2016, and she remained off work until her full duty release in March 2016.

As to the nature and extent of Petitioner's injury, the Arbitrator did not consider the five factors under Section 8.1(b) of the Act as he considered the issue of nature and extent moot. The Commission having found accident and causal connection in this claim, and taking into consideration the following five factors listed under Section 8.1(b) of the Act, awards Petitioner two-and-a-half percent (2.5%) loss of use of the person as a whole:

(i) Impairment Rating: The Commission gives no weight to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: The Commission gives this factor no weight. Petitioner was released full duty on March 16, 2016. She did not return to her job as a juvenile justice specialist intern by her own choosing. Petitioner eventually found employment with the St. Louis Center for Family Development as a mental health professional. (T.20). The parties offered no evidence to indicate that the injury had impacted Petitioner's occupation.

(iii) Petitioner's Age: Petitioner was 34 years old on the accident date; the Commission gives no weight to this factor as there is no evidence in the record that Petitioner's age had any effect on the level of permanent partial disability.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission gives this factor significant weight as evidence of disability was corroborated by the medical records. Petitioner was diagnosed with an acute greater tuberosity non-displaced fracture, which required treatment by way of prescription medication, a sling, and physical therapy.

Dr. Keener's last office visit note, dated February 2, 2016, stated that Petitioner was doing well and did not have much pain anymore. He noted that Petitioner did feel weak, but her exam was normal; Petitioner's range of motion lacked the last bit of elevation and rotational motion. Petitioner had pretty good external rotation and abduction strength. At arbitration, Petitioner noted that her right shoulder remained weak and her shoulder did not have the same level of tension that it did before the injury. (T.21).

In light of the foregoing factors, with no single enumerated factor being the sole determinant of disability, the Commission awards two-and-a half-percent (2.5%) loss of use of the person as a whole for Petitioner's right shoulder condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 27, 2018, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $770.91 per week for a period of 22 4/7 weeks, from October 11, 2015 through March 16, 2016, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibits 6 & 7, namely the physical therapy bill totaling $1,174.09, the MRI bill totaling $775.80, the Urgent Care bill totaling $850.00, and only those charges attributed to Dr. Keener, as well as the out-of-pocket expenses and co-pays totaling $244.06, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit for amounts paid on behalf of Petitioner on account of said accidental injury under its group health plan pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $693.82 per week for a period of 12.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused two-and-a-half percent (2.5%) 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 other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 21 2019
MJB/pm
D: 3-5-19
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WYLIE, AMANDA
Employee/Petitioner

Case# **15WC035711**

ST OF IL/DEPT OF JUVENILE JUSTICE
Employer/Respondent

19IWCC0176

On 6/27/2018, 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:

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RISK MANAGEMENT SERVICES
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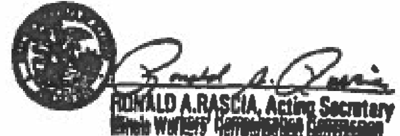
SPRINGFIELD, IL 62794-9208

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

JUN 27 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

AMANDA WYLIE
Employee/Petitioner

Case #**15** WC **35711**

v.

Consolidated cases:

STATE OF ILLINOIS/DEPARTMENT OF JUVENILE JUSTICE
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 **Collinsville**, on **3/28/18**. 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. [ ] 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

19IWCC0176

FINDINGS

On **10/10/15/**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,847.12**; the average weekly wage was **$1156.36**.

On the date of accident, Petitioner was **35** years of age, *single* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$any benefits paid through group** under Section 8(j) of the Act.

ORDER

No benefits awarded.

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

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

Signature of Arbitrator — 6/25/18 — Date

JUN 27 2018

The Arbitrator finds the following facts:

The issue in this case is accident, causation, medical, and TTD.

At the time of the injury, Petitioner was a 35 year old employee of the State of Illinois at Illinois Youth Center at Pere Marquette. (Arb. Ex. 2, Rx.1) On the date of the accident, Petitioner was working as Juvenile Justice Specialist Intern. The job duties of a Juvenile Justice Specialist Intern are to go supervise the youth in the facility.

On October 10, 2015, Petitioner was called to field trip to a pool with youth from the facility. As on the trip was a Leisure Time Activity Specialist.

Petitioner testified that while on the trip, she swam with the youth. As Petitioner dove into the pool, Petitioner testified that she felt shoulder pain. After her dive she could no longer swim and she sat on the side of the pool and supervised the youth.

Following the incident, Petitioner returned to the facility and finished her shift.

On October 11, 2015 Petitioner presented to Urgent care with right arm pain. (Px. 2) An MRI of the shoulder was ordered and showed a fracture of the proximal humerus. (Px. 3)

On October 23, 2015 Petitioner began treating with Dr. Jay Keener. (Px. 5) Dr. Keener prescribed physical therapy. (Id.) Petitioner last saw Dr. Keener on February 2, 2016. (Id.) She was released to full duty work in March 2016.

Chad Burns was called as a witness. Mr. Burns is the Internal Affairs officer for Pere Marquette. Mr. Burns testified that on October 10, 2015 Petitioner was the only person in charge of the supervision of the youth and should not have been swimming with the youth on this date. Mr. Burns testified when there is more than one person in charge of supervision of the youth and there is written permission a specialist can swim with the youth.

Additionally, Mr. Burns was asked to review the security camera footage of Petitioner upon her return to the facility. The footage did not show Petitioner to have any injury to her right arm. The footage showed Petitioner performing her duties in a normal manner. One scene showed Petitioner putting on her coat using both hands without any signs of injury.

Following the incident, Petitioner was reprimanded for not following the Administrative Directives of the facility when she swam with the youths. Specifically, Petitioner was found to have failed to maintain constant supervision of the youth and failed to secure the "knife for life" while swimming with the youth. (Rx. 3)

An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. *Orsini v. Indus. Comm'n*, 509 N.E.2d 1005 (1987).

In this case based on Mr. Burn's testimony it's questionable whether Petitioner should have been swimming at all. The Arbitrator finds that the Petitioner diving off the diving board to be a risk clearly personal to her and therefore an accident not arising out of her employment.

THEREFORE, THE ARBITRATOR FINDS that Petitioner has failed to meet her burden of proof to show by a preponderance of the evidence that October 10, 2015 accident arose out of her employment with Respondent. As a result thereof, all benefits are denied. The remaining issuing of are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERESA CIACCIO,

Petitioner,

19IWCC0177

vs.

NO: 16 WC 398

RIVERSIDE MEDICAL 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 issues of accident, causal connection, medical expenses, temporary total disability and permanent partial disability, and being advised of the facts of 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 thereof.

Findings of Fact

1. On November 20, 2015, Petitioner was employed by Respondent as a trauma registrar, a position that required her to observe patients' emergency department records, evaluate who was a trauma patient, and enter data into the Illinois Department Trauma Registry. Petitioner was also an emergency preparedness specialist, and in this role, Petitioner trained staff and lifted heavy manuals, emergency cachet supplies, and boxes of paper.

   In addition to her job duties, Petitioner served as a chairperson on Respondent's Partners in Care Committee (hereinafter, "the Committee"). Petitioner testified at arbitration that Respondent encouraged her to serve on the Committee and her participation was considered in her employee reviews.

   As a chairperson, Petitioner oversaw Committee fundraisers. Petitioner was paid for the days she put on fundraisers the same way she was paid for any other workday.

2. On November 20, 2015, Petitioner oversaw a treadmill-a-thon fundraiser for the Committee. During the fundraiser, employees exercised on treadmills or stationary bikes for 24 hours and made pledges with payroll deduction or cash. The fundraiser also sold tickets for another of Respondent's events called "Jeans Day." All proceeds from the fundraiser went to the Committee.

   The fundraiser took place during normal business hours in Respondent's lobby. A temporary barrier was placed around the fundraiser's exercise area to divide it from the rest of the lobby. Petitioner testified that only employees could enter the exercise area.

   One of Petitioner's duties during the fundraiser was to hand sanitation wipes to the participants on treadmills and stationary bikes as they concluded their exercise sessions. As Petitioner was attempting to step over the temporary barrier to give wipes to a participant, her high heel got caught in the temporary barrier's chain, causing her to fall onto her left side and arm.

   Petitioner was diagnosed with a closed fracture of the left wrist's distal radius and underwent an open reduction internal fixation surgery on December 7, 2015. She was thereafter returned to work with a five-pound weight restriction on February 8, 2016. Following a course of occupational therapy, Petitioner was discharged from therapy and found to have achieved "maximum potential" on April 27, 2016. Petitioner has not treated for her left wrist injury since her discharge from occupational therapy.

3. Petitioner testified she was paid by Respondent during the fundraiser the same as she was paid for a normal workday. Respondent provided no additional monetary incentive to participate in the fundraiser.

   Lynn Marie Christian, an employee wellness manager for Respondent who sat on the Committee with Petitioner, also testified that employees were not paid money to participate in the fundraiser and received their normal set wages. Ms. Christian testified employees could participate during their normal work hours or come in on their day off to participate in the fundraiser. She explained that employees who did not volunteer at the fundraiser simply went about their normal job duties. Ms. Christian testified there was no requirement that employees had to sign up for anything related to the event.

4. Ms. Christian further testified that in addition to the exercise participants, volunteers signed up for consent to participate and helped with such tasks as wiping down machines and getting water for those exercising. Ms. Christian testified the pool of volunteers came from several entities, including from Respondent's wellness program called Reach and the volunteer services department.

   Petitioner also testified that only employees participated in the exercise activities on the equipment, but the individuals manning the volunteer table, which Petitioner was manning immediately before her accident, were both employees and people who commonly volunteered for Respondent. Petitioner did not consider the volunteers to be members of the general public. She characterized a volunteer as someone who worked through

19IWCC0177

Respondent's volunteer department and was trained and available to help in various places throughout Respondent's hospital.

5. Elizabeth Delong, a trauma emergency preparedness coordinator for Respondent, also testified at arbitration that she was Petitioner's supervisor when she retuned to work in February 2016. However, Ms. Delong did not work with Petitioner in her capacity as a Committee chairperson and was not familiar with the fundraiser.

6. The matter proceeded to hearing on September 20, 2017. In the Decision issued on October 13, 2017, the Arbitrator denied benefits and found Petitioner was injured while participating in a voluntary recreational program not covered by Section 11 of the Illinois Workers' Compensation Act.

Conclusions of Law

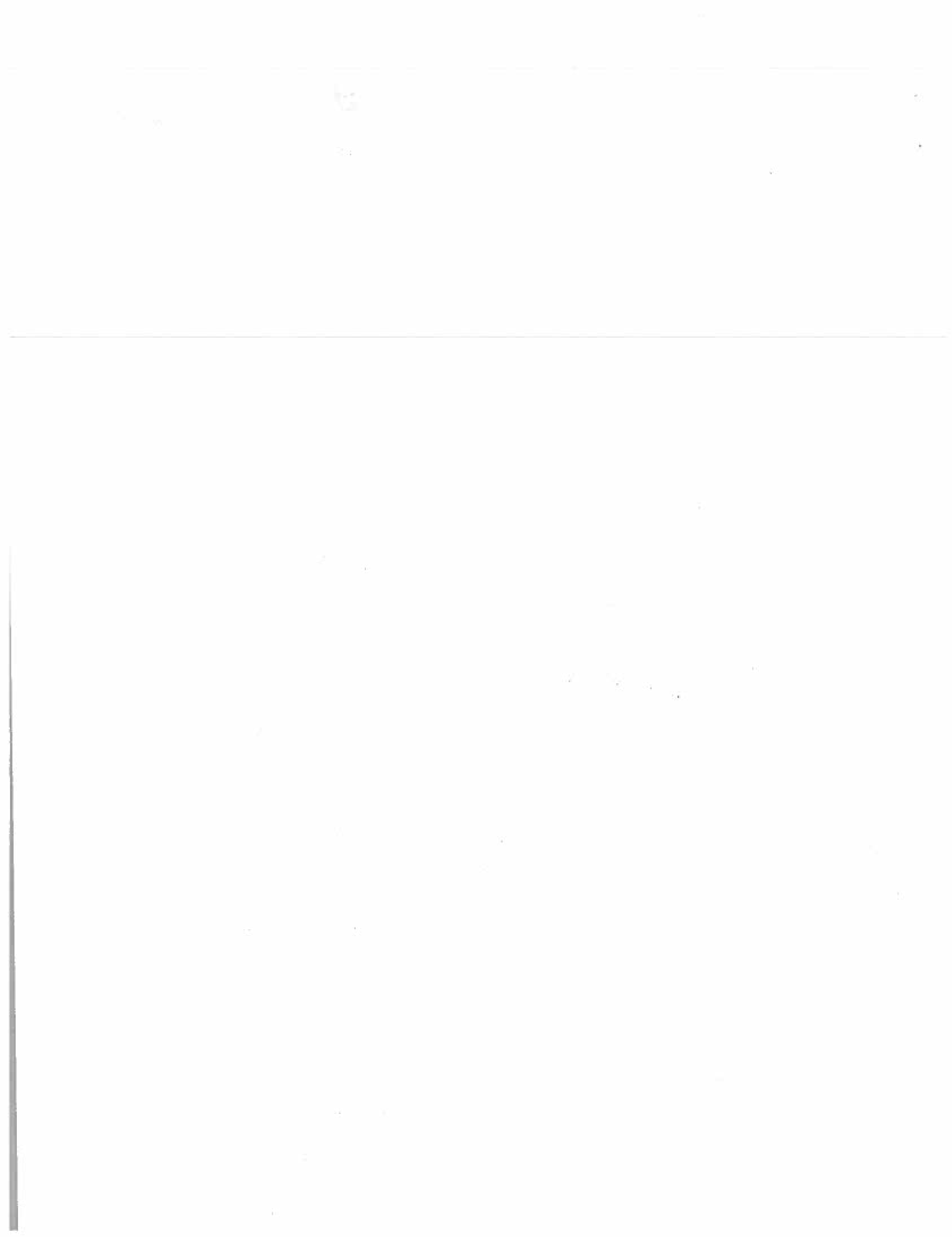
Following a careful review of the entire record, the Commission finds Section 11 does not apply to the case at hand. Section 11, in relevant part, provides:

> "Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program." 820 ILCS 305/11.

The Commission finds that a fundraising event, such as the treadmill-a-thon, does not clearly fall within the purview of a "reactional program" contemplated by Section 11.

Although Section 11 provides athletic events, parties, and picnics as examples of covered voluntary recreation programs, it indicates that coverage is not limited to these activities. In *Elmhurst Park District v. Illinois Workers' Comp. Comm'n*, the Illinois Appellate Court acknowledged that the Act does not expressly define the word "recreational" and therefore contemplated the word's ordinary and popularly understood meaning. 395 Ill. App. 3d 404, 408-409 (1st Dist. 2009). As such, the Appellate Court applied the dictionary definition of "recreation," which was "the act of recreating or the state of being recreated: refreshment of the strength and spirits after toil: DIVERSION, PLAY." 395 Ill. App. 3d 404 at 409.

Although some of the fundraising participants were exercising and such exercise in other contexts could be considered recreational, the function of the treadmill-a-thon was to fundraise money for a cause. The participants were not exercising for diversion or play, but instead, they were exercising for the purpose of fundraising money. Because the Commission does not find participation in such fundraising events to constitute recreational activity pursued for diversion or play, the Commission does not find Section 11 to be controlling.



19IWCC0177

Nevertheless, the Commission finds Petitioner failed to prove she was required as part of her job as trauma registrar or emergency preparedness specialist to participate in the Committee or help run the treadmill-a-thon fundraiser.

Petitioner's choice to be on the Committee was entirely voluntary as no employees were required to participate in any aspect of the fundraiser. Employees received no monetary incentive to participate. If Petitioner did not want to participate in the fundraiser, she could have simply gone about her normal job duties like the other employees who chose not to participate.

The Commission also recognizes that the task Petitioner was performing at the time of her accident was also being completed by volunteers, further showing that Petitioner's participation was not conditioned upon nor dictated by her employment.

Petitioner was injured while participating in a voluntary event and not in the performance of her required job duties that arose out of and in the course of her employment as a trauma registrar. For this reason, the Commission affirms the Arbitrator's denial of benefits.

The Commission modifies the reasoning for the denial of Petitioner's claim for benefits as stated herein but otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated October 13, 2017 is modified as stated herein.

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: MAR 25 2019

Deborah L. Simpson

Deborah L. Simpson

Stephen J. Mathis

DLS/met
o: 1/24/19
46

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0177

CIACCIO, TERESA
Employee/Petitioner

Case# **16WC000398**

RIVERSIDE MEDICAL CENTER
Employer/Respondent

On 10/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
WILLIAM P SCHMITZ
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

2389 GILDEA & COGHLAN
EDWARD COGHLAN
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

19IWCC0177

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

Teresa Ciaccio
Employee/Petitioner

v.

Riverside Medical Center
Employer/Respondent

Case # **16** WC **00398**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Kankakee**, on **September 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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] 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 **November 20, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,394.72**; the average weekly wage was **$988.36**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **no** 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 $**$6,557.35** for other benefits, for a total credit of **$6,557.35**.

Respondent is entitled to a credit of **$6,557.35** under Section 8(j) of the Act.

ORDER

BASED ON THE ARBITRATOR'S FINDING ON THE ISSUE OF ACCIDENT, BENEFITS ARE 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

10/11/17
Date

OCT 13 2017

19IWCC0177

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on November 20, 2015. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident, 2) causation and 3) nature and extent. Petitioner testified that she is now known as Teresa Zack

Petitioner was employed by Respondent as a trauma registrar. In addition to her job as a trauma registrar, she also participated in Respondent's Partners in Care Committee, which would hold various fundraisers throughout the year.

One of the fundraisers was the "Treadmillathon", an event held in Respondent's lobby, where participants would use a treadmill or exercise bike over a 24-hour period to raise money for charity. The "participants" are Respondent employees who raise funds thru pledges for participation, and the "volunteers" are both Respondent employees and Respondent volunteers who sit at a help desk during the event.

The volunteers who participate are paid their regular wages during the Treadmillathon. For example, Petitioner was paid her regular wages on the date in question, November 20, 2015, the date on which she was volunteering at the Treadmillathon. The volunteers were not given any monetary reward, over and above their regular wages, nor were they provided any additional incentives to participate, such as gift certificates. The employees who were not volunteering at the Treadmillathon went about their regular business day.

The Treadmillathon on November 20, 2015 was set up in Respondent's lobby. The area was set up with two treadmills and two exercise bikes, with one of each machine in use and of each as a "backup" in the case of any malfunctions. Additionally, a help table was set up to the west of the machines, and "Jeans Day" tickets were sold at the desk. Along with collecting contributions, volunteers would wipe down machines after use and also provide water to the participants. The area was separated from the general public thru the use of stanchions, set up approximately three feet in front of the exercise machines.

On November 20, 2015, Petitioner was volunteering at the Treadmillathon and handed a wipe to a participant after stepping over the stanchion. When stepping back over the stanchion, her heel got caught in the stanchion, and she fell to the ground, landing on her left wrist. Both the surveillance footage of her fall and pictures of the area in which she fell were introduced into evidence (RX 1). Petitioner stated that she "had to" reach over the stanchion to hand wipes to the participants. She further testified that she did not walk around the stanchion because "one side was blocked by equipment and coolers and the other side was where the participants would change their shoes and make the exchange." The surveillance footage and the pictures both show an easy path of ingress and egress from the exercise machines, with no "blockages" present. Petitioner later testified during cross examination that "nothing" was blocking the stanchions on either the west or east side.

Following her fall, Petitioner was taken to Respondent's emergency room, where she was diagnosed with a fractured left distal radius (PX 1). Subsequently, on December 7, 2015, Dr. Kermit Muhammad operated on Petitioner's left wrist, performing an open reduction internal fixation procedure. Post-operatively, Petitioner underwent a course of therapy, with her last course of therapy ending on April 27, 2016. Her last exam with Dr. Muhammad took place on February 8, 2016.

With respect to her work status, Petitioner was off of work from November 20, 2015 thru February 8, 2016, the date on which she resumed her regular job duties as a trauma registrar. She was subsequently terminated by

19IWCC0177

Respondent in August 2017 for a HIPAA violation unrelated to this claim. During her time off of work, Petitioner received both group disability and group medical benefits.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet her burden of proof. In support of that finding, the Arbitrator relies on the witness testimony, the investigative evidence, Section 11 of the Act, and the relevant case law.

Section 11 of the Illinois Workers' Compensation Act states in part:

> Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program.

The Illinois Appellate court further analyzed Section 11, noting that the "pivotal issue which determines whether the activity is within the coverage of the Workers' Compensation Act is whether the employee is ordered or assigned to participate in the activity, as this is the only exception to the Section 11 of the Act exclusion from coverage." *Pickett v. Industrial Comm'n*, 625 N.E.2d 69, 252 Ill.App. 3d 355 (1993).

In the present case, Petitioner was injured while participating in a voluntary recreational program. The Arbitrator notes the following facts established by the witness testimony:

- Respondent's employees were not ordered to participate, and participation was strictly optional;
- Those employees that participated received their regular wages, with no monetary incentives of any sort provided for volunteering;
- Those employees who opted to not participate in the Treadmillathon simply went about their regular workday.

Furthermore, with respect to the accident itself, the Arbitrator notes that both the surveillance footage and the pictures call Petitioner's credibility into question. Both the video and the photos show that the area where the Treadmillathon was located was set up in a safe and reasonable manner. The machines were located approximately three feet behind the stanchions, with plenty of room to walk to and from the exercise machines. Both the spare machines and the coolers were located off to the side, far from the stanchions. It is clear from viewing the surveillance footage of the fall that contrary to the Petitioner's testimony, her decision to climb over the stanchion was not made necessary by any "blockages."

Based on the testimony adduced at trial, along with the review of the surveillance footage and the pictures of the accident scene, the Arbitrator finds that the Petitioner's accident did not "arise out of" her employment in accordance with Section 11 of the Illinois Workers' Compensation.

2. Based on the Arbitrator's conclusions with regard to the issue of accident, all other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINICK PAVONE,

Petitioner,

19IWCC0178

vs.

NO: 09 WC 16312

WALSH CONSTRUCTION,

Respondent.

DECISION AND OPINION ON REVIEW

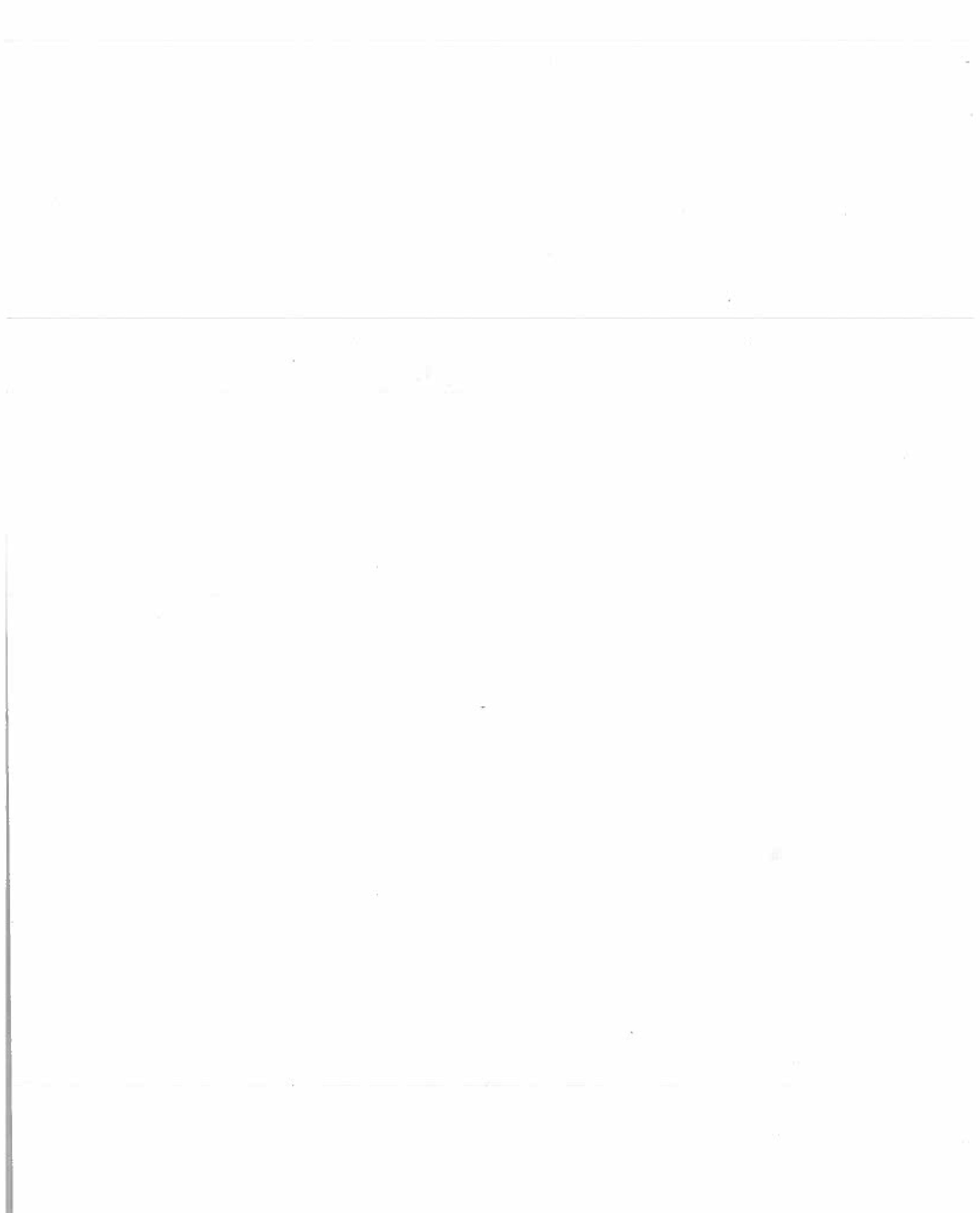
Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability, Petitioner's entitlement to §8(d)1 wage differential benefits and alleged noncompliance under §19(d), and being advised of the facts of 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 thereof.

Findings of Fact

1. On May 28, 2008, Petitioner was employed as a construction laborer for Respondent and member of the Local 25 union. The position required Petitioner to lift up to 60 pounds, including overhead lifting. Petitioner also used jackhammers weighing 60 pounds and climbed scaffolding and ladders in the performance of his duties.

   On May 28, 2008, Petitioner was working on a jobsite to build a bridge on Interstate 88. As Petitioner was walking on a support connected to sheeting 15 feet high over the creek bed, he lost his balance and fell, first striking a coworker who tried to catch him and then hitting with his right side on the stone below.

2. Prior to working for Respondent, Petitioner obtained his GED in 1976. He thereafter attended DeVry Institute from 1977 to 1978 and earned a certificate in electronics. Petitioner then took a job in the electronics field for Zenith Television Company, where he



was an assembly line inspector for three years.

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Petitioner testified he has not kept up with the electronics field and never returned to DeVry Institute for follow up courses. He testified electronics are different today than they were in the 1970s because everything is now computerized. Petitioner has had no training in computers or the maintenance of modern televisions.

3. Petitioner was taken by ambulance on the accident date to Advocate Good Samaritan Hospital with scalp abrasions and complaints of right shoulder, abdomen, and lower back pain. Petitioner was diagnosed with an acute closed head injury, blunt abdominal trauma, and cervical and thoracic para ligamentous strains. When Petitioner thereafter presented to DuPage Medical Group on May 30, 2008, he was further diagnosed with right shoulder pain and a right rib strain. Petitioner was provided an orthopedic referral and kept off work.

   On June 2, 2008, Petitioner presented to orthopedic surgeon Dr. Richard Rosseau, who diagnosed Petitioner with a series of contusions and strains with a possible AC joint Grade 1 right shoulder separation. At Petitioner's return visit on June 10, 2008, Dr. Rosseau reported Petitioner had returned to light duty work in a clipboard-type job.

   Petitioner thereafter participated in physical therapy from June 12, 2008 to September 3, 2008. As Petitioner attended physical therapy, a June 25, 2008 right shoulder MRI found mild tendinopathy without evidence of a full thickness rotator cuff tear and significant degenerative changes of the AC joint with osteophyte formation. Dr. Rosseau's post-MRI diagnosis was an AC joint strain with some periscapular strain.

   On September 9, 2008, Dr. Rosseau began recommending surgical intervention, specifically an arthroscopic subacromial decompression and distal clavicle resection. However, Petitioner declined surgery at that time.

   On November 25, 2008, Dr. Rosseau opined Petitioner was unlikely to make significant progress unless he pursued the surgery; however, Petitioner again declined. Dr. Rosseau then placed Petitioner at maximum medical improvement unless surgery was considered and provided permanent light duty restrictions of no lifting, pushing, or pulling greater than five pounds and no repetitive overhead activities.

   Petitioner thereafter underwent multiple right shoulder injections, but consistently declined surgery in favor of medication, conservative monitoring, and the permanent light duty restrictions. On October 3, 2014, Dr. Rosseau further restricted Petitioner to careful protective activities with minimized overhead lifting and no lifting greater than 10 pounds on a permanent basis until surgical intervention was entertained.

   At Petitioner's last treatment visit on April 20, 2016, Dr. Rosseau administered another injection and advised Petitioner to continue topical measures, light duty restrictions, and Voltaren.

   At hearing, Petitioner testified he decided not to proceed with the surgery because he was

afraid of the risks, including possible nerve damage to his neck. However, on cross examination, Petitioner suggested he was still considering surgery.

4. The parties deposed Dr. Rosseau on June 20, 2016. Dr. Rosseau testified that as of his last April 2016 visit, Petitioner remained a surgical candidate. Dr. Rosseau calculated Petitioner had a 90% chance of improving after surgery. Specifically, he believed Petitioner had an 80% chance of a good recovery without restrictions and a 10% chance of remaining stiff and uncomfortable, but still being better than before surgery. He believed the surgery was reasonably necessary to reduce Petitioner's pain and improve his function.

5. Petitioner also presented for two independent medical examinations with orthopedic surgeon Dr. Christos Giannoulias on September 16, 2008 and November 17, 2015. Dr. Giannoulias was thereafter deposed on November 7, 2016 and testified consistent with his reports. Dr. Giannoulias found Petitioner's accident had caused an AC joint strain and contusion as well as a temporary aggravation of preexisting cervical arthrosis. Dr. Giannoulias also recommended surgical intervention. He noted the surgery had routine low risks and a high success rate. Dr. Giannoulias projected Petitioner had a 90% to 95% chance of returning to full duty within four months after the surgery.

   Dr. Giannoulias further testified he had no reason to disagree with the permanent restrictions Dr. Rosseau placed on Petitioner on October 3, 2014.

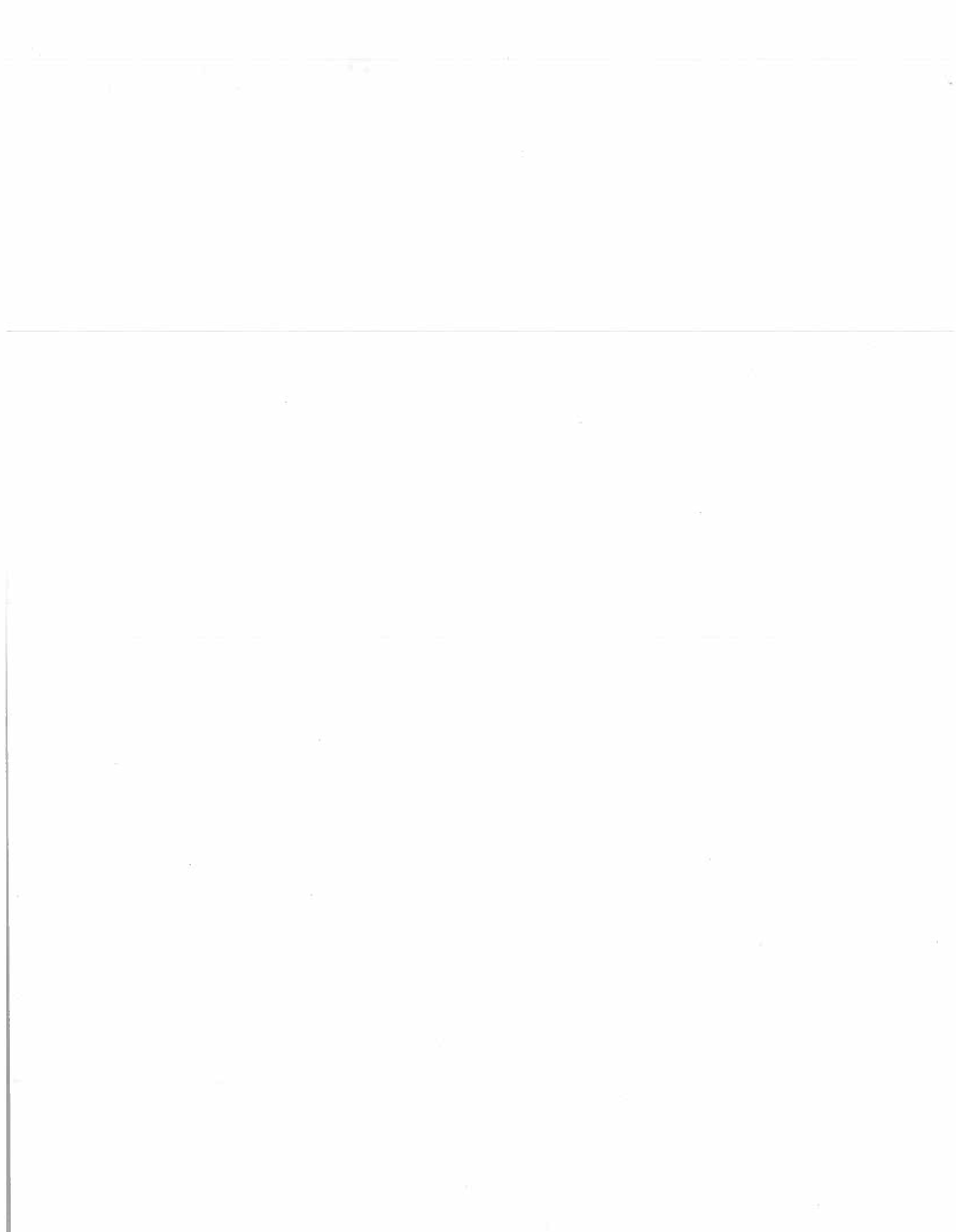
6. On June 2, 2015, Thomas Grzesik, a certified rehabilitation counselor, provided a vocational assessment. Based on Petitioner's permanent restrictions, Mr. Grzesik found Petitioner to be unable to perform his job duties as a construction laborer. He also believed Petitioner's vocational profile limited him to a narrow range of employment opportunities.

   Mr. Grzesik further opined, based on a May 2015 labor market survey, that Petitioner would experience a significant wage differential compared to his pre-accident wages as a construction laborer if he were able to find future employment.

   At his September 3, 2015 deposition, Mr. Grzesik testified Petitioner's participation in the certificate training program in electronics repair from DeVry Institute and his prior work as an electronics assembler in the 1970s had no vocational relevance today. Mr. Gresik believed Petitioner did not have any transferable skills.

   Nevertheless, Mr. Grzesik opined Petitioner was employable within the confines of the May 2015 labor market survey and there was a reasonably stable labor market for him. Mr. Grzesik noted the list of potential jobs in the labor market survey was not exhaustive. Examples of possible employment set forth in the labor market survey included security guard, dispatcher, guest service representative, and consumer service representative.

7. Following the accident, Petitioner never returned to performing his regular job duties as a construction laborer. Petitioner testified he was paid workers' compensation benefits from June 19, 2008 to July 20, 2008. He then worked for Respondent from July 21, 2008 to November 30, 2008 in a light duty position, which involved checking in trucks and keeping



track of material brought in on a clipboard. In this accommodated light duty position, Petitioner did not perform any heavy lifting nor work with a shovel or jackhammer. Petitioner was paid his regular union scale wages for this period of work.

Petitioner was then laid off by Respondent on November 30, 2008 and obtained unemployment benefits. Petitioner testified he never looked for alternative work after November 30, 2008 and eventually applied for social security benefits. He then put in for union retirement a couple years after the accident and presently collects retirement benefits. Petitioner never sought any additional skills training from his union after the accident.

Petitioner has not received medical care for his right shoulder since April 2016. Petitioner testified he has daily shoulder pain that varies but is ever-present like a toothache. He also has stiffness and tenderness across the superior right shoulder and AC joint. He noted difficulty showering, shaving, and making turns while driving. Petitioner testified he cannot use his right shoulder for daily activities, so he uses his left hand to compensate. Petitioner also testified he cannot garden, cut grass, or wash his car anymore. He takes over-the-counter Ibuprofen and uses topical cream for pain.

Petitioner is right handed and had no other pre-accident or post-accident right shoulder injuries.

8. The matter proceeded to hearing on June 28, 2017. The Decision of the Arbitrator, which was thereafter issued on October 4, 2017, awarded wage differential benefits, finding Respondent must pay Petitioner $576.60 per week from November 25, 2008 through the duration of his disability as provided by §8(d)1. The Decision of the Arbitrator further found Petitioner was compliant with medical treatment as provided by §19(d).

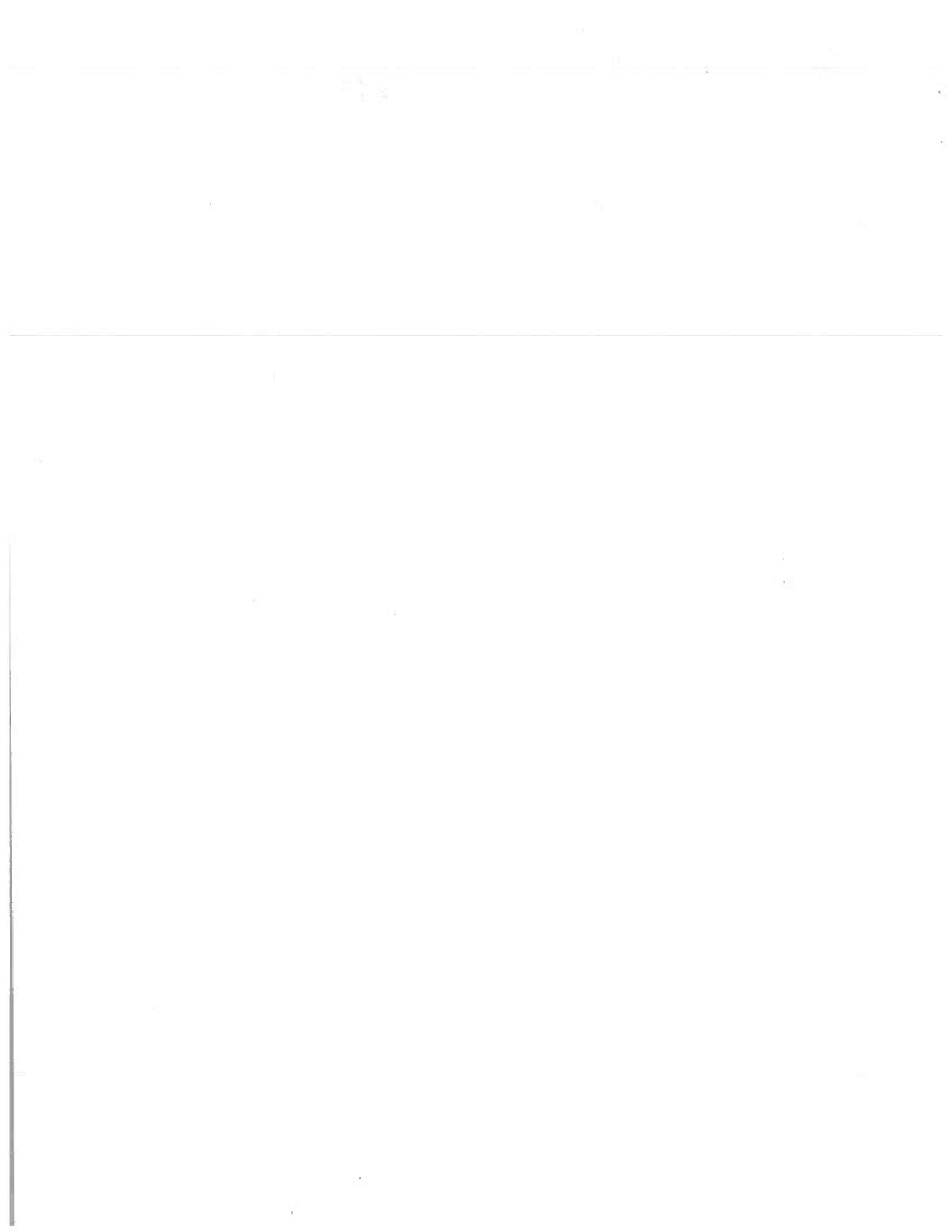
Conclusions of Law

Following a careful review of the entire record, the Commission finds Petitioner failed to meet his burden of proving entitlement to wage differential benefits pursuant to §8(d)1.

For a wage differential award, Petitioner must prove both a partial incapacity that prevents him from pursuing his usual and customary line of employment and an impairment of earnings. *Copperweld Tubing Products v. Comm'n*, 402 Ill.App.3d 630, 633 (1st Dist. 2010).

Petitioner has established a partial incapacity that prevents him from pursuing his usual and customary employment as a union construction laborer. Mr. Grzesik classified Petitioner's employment at the heavy demand level and found Petitioner's permanent work restrictions to be inconsistent with the physical requirements of his job.

However, the Commission finds Petitioner failed to prove an actual impairment of his earnings because he made no attempt to find suitable employment after the accident. Following a period of accommodated light duty, Petitioner was laid off on November 30, 2008 and thereafter obtained unemployment benefits. Petitioner testified he never looked for alternative work after November 30, 2008 and eventually applied for social security benefits. Petitioner never sought



additional skills training from his union nor submitted any job search logs. He subsequently began obtaining union retirement benefits a few years after the accident.

As Petitioner never once looked for a post-accident job opportunity and instead opted for receiving unemployment and retirement benefits, Petitioner effectively chose to remove himself from the workforce. Mr. Grzesik opined that Petitioner was employable within the confines of the labor market survey and there was a reasonably stable job market for him. However, Petitioner made no subsequent attempt to pursue any of the potential job options presented in the labor market survey. For this reason, the Commission finds Petitioner failed to establish an actual impairment of earnings, and as such, Petitioner is not entitled to wage differential benefits.

Nevertheless, the Commission recognizes Petitioner sustained a substantial injury that resulted in the loss of his employment as a construction laborer, and as such, his permanent partial disability award should reflect this loss. Petitioner further testified to experiencing daily ever-present right shoulder pain that affects his ability to perform such tasks as showering, shaving, making turns while driving, gardening, cutting grass, and washing his car. Petitioner uses over-the-counter Ibuprofen and topical cream to manage his pain.

Because the accident rendered Petitioner incapable of returning to his construction laborer employment and caused Petitioner considerable residual pain, the Commission finds an award of 50% MAW to be warranted.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated October 4, 2017 is modified as stated herein.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 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 a 50% 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.

19IWCC0178

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: MAR 25 2019

Deborah L. Simpson

Stephen J. Mathis

DLS/met
o: 1/24/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0178

PAVONE, DOMINICK
Employee/Petitioner

Case# **09WC016312**

WALSH CONSTRUCTION
Employer/Respondent

On 10/4/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

1682 HINSHAW & CULBERTSON
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601-1081

19IWCC0178

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

DOMINICK PAVONE
Employee/Petitioner

v.

WALSH CONSTRUCTION
Employer/Respondent

Case # **09 WC 16312**

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **June 28, 2017**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's present condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [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 whether Petitioner was noncompliant with medical treatment pursuant to Section 19(d)

FINDINGS

On 5/28/2008, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $68,868.80 ; the average weekly wage was **$1,324.40**.

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

Respondent shall be given a credit of $4,036.16 for TTD, $-0- for TPD, $-0- for maintenance, and $-0- for other benefits, for a total credit of $4,036.16.

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

ORDER

- Respondent shall pay Petitioner the sum of $576.60/week commencing 11/25/2008 and for the duration of the disability as provided in Section 8(d)1 of the Act because the injuries sustained by Petitioner caused Petitioner's inability to pursue his usual and customary line of employment.
- Petitioner was compliant with medical treatment as provided in Section 19(d) of the Act and acted reasonably when he elected not to undergo surgery to his right shoulder.
- See Rider attached hereto and made a part thereof.

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

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

[signature]
Signature of Arbitrator

10/3/17
Date

OCT 4 - 2017

STATE OF ILLINOIS)
COUNTY OF DUPAGE)

19IWCC0178

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

DOMINICK PAVONE,)
Employee/Petitioner,)
)
-vs-) Case # 09 WC 16312
)
WALSH CONSTRUCTION,)
Employer/Respondent.)

ADDENDUM TO THE ARBITRATION DECISION

Petitioner's testimony and medical treatment

On the accident date Petitioner was employed by Respondent as a journeyman construction laborer and had been so employed for more than (20) years.

Regarding his job duties, Petitioner worked on roads and highways, lifting in excess of sixty (60) pounds at a time. Petitioner climbed scaffolding and ladders and used various tools such as sledgehammers, (60) pound jackhammers, hammers, lasers and shovels in the performance of his job duties.

Petitioner is right hand dominant.

Petitioner retired a couple of years following the work-related accident and is receiving social security disability benefits.

Petitioner testified that on May 28, 2008 he was working at a job site for Respondent that involved the construction of part of Highway I-88, building a bridge. Petitioner was shoveling and preparing a footing for the bridge. Specifically, he was working with a piece of sheeting, which is a large piece of metal that is used to hold back water from the river. Petitioner was walking on a one-foot-wide support connected to the sheeting which was fifteen (15) feet above the bed of the creek, which the bridge ran over. Petitioner was checking the elevation of the material with a laser while walking across the support. The laser was attached to a 25-foot pole. As Petitioner was walking along the support, he lost his balance and fell (15) feet onto his right side, striking the stone footing of the bridge, below the support. He also hit a co-worker when he fell.

Petitioner was taken by ambulance to Good Samaritan Hospital where he underwent multiple diagnostic studies which were negative. Petitioner was diagnosed with an acute closed head injury, blunt abdominal trauma as well as cervical and thoracic para ligamentous strains. (PX 1).

Petitioner was next examined at DuPage Medical Group by Dr. Robert Hurst on May 30, 2008 at which time the doctor referred Petitioner to an orthopedic surgeon for his right shoulder condition. (PX 2).

On June 2, 2008, Petitioner was examined by Dr. Richard Rosseau at DuPage Medical Group. (PX 2). Dr. Rosseau recommended Naprosyn and a sling. (PX 2). Petitioner was again examined by Dr. Rosseau on June 10, 2008. (PX 2). Dr. Rosseau recommended light duty work and physical therapy. (PX 2). Petitioner

participated in the recommended physical therapy at Functional Physical Therapy from June 12, 2008 through September 3, 2008. (PX 3).

On June 19, 2008, Dr. Park, at DuPage Medical Group, recommended that Petitioner undergo a right shoulder MRI and referred Petitioner to Dr. Lange for an evaluation of his neck and back. (PX 2).

Petitioner underwent the recommended MRI study on June 25, 2008 which revealed mild tendinopathy without evidence of a full thickness rotator cuff tear and significant degenerative changes of the AC joint with osteophyte formation. (PX 4).

On July 1, 2008, Dr. Rosseau recommended modifications in physical therapy and trigger point injections. (PX 2). Petitioner continued to participate in physical therapy and have follow up appointments with Dr. Rosseau. (PX 2-3). He was discharged from physical therapy on September 3, 2008. (PX 3).

Petitioner was again examined by Dr. Rosseau on September 9, 2008 at which time the doctor instituted restrictions of no lifting more than five (5) pounds. (PX 2). On October 21, 2008, Dr. Rosseau performed an AC joint injection to the right shoulder. (PX 5). On November 25, 2008, Petitioner followed-up with Dr. Rosseau who noted that the prior injection provided minimal relief. (PX 2). Petitioner complained of pain in the AC joint with range of motion, repetitive lifting, pushing and pulling. (Id.). Dr. Rosseau discussed Petitioner's options including observation, working around the pain and maintaining limited duty although the doctor noted Petitioner was not likely to make significant progress unless he considered arthroscopic decompression of the distal clavicle. (PX 2). Petitioner indicated he did not desire surgery. Dr. Rosseau noted permanent light duty restrictions of no lifting, pushing or pulling greater than five (5) pounds and no repetitive overhead activities. (PX 2). He stated that Petitioner was at maximum medical improvement unless surgery was considered. (PX 2).

Petitioner continued to follow-up with Dr. Rosseau who recommended arthroscopic subacromial decompression and clavicle resection versus a series of injections. (PX 2). Dr. Rosseau continued to recommend the above-mentioned permanent restrictions. (PX 2).

Petitioner underwent a subacromial injection on April 7, 2010. (PX 5). The injection provided significant, but temporary, relief. (PX 2).

On July 7, 2010, Dr. Rosseau noted that Petitioner's continued complaints in his right shoulder with reaching, pinching, pulling and lifting. (PX 2). Dr. Rosseau again noted that Petitioner's options were to live with the pain or undergo the previously recommended surgery. (PX 2).

Petitioner was again examined by Dr. Rosseau on January 31, 2014 at which time complaints of pain in the AC joint, tenderness in the subacromial space and a positive cross-chest compression sign were noted. (Id.). X-rays of the shoulder revealed type 2 acromion process and mild AC joint degeneration. Dr. Rosseau recommended an updated MRI and continued his surgical recommendation. (Id.).

On May 20, 2014, Dr. Rosseau noted that the MRI was not approved. (PX 2). He administered an injection to Petitioner's right shoulder. (PX 5).

On October 3, 2014, Dr. Rosseau noted Petitioner's complaints of increasing pain. (PX 2). He set forth permanent restrictions of no lifting more than ten (10) pounds. (PX 2).

Petitioner underwent another injection on May 27, 2015. (PX 5). On July 8, 2015, Dr. Rosseau documented that Petitioner's pain was less intense, but his shoulder was still tender to the touch. (PX 2). Dr. Rosseau recommended a repeat MRI. (PX 2). He noted that Petitioner was considering surgery. (PX 2).

Petitioner was last examined by Dr. Rosseau on April 20, 2016 at which time the doctor noted Petitioner experienced painful range of motion at the AC joint and focused pain in the right AC joint. (PX 2). Dr. Rosseau set forth an impression of symptomatic AC joint degeneration and performed an AC joint injection. (PX 5). He recommended Voltaren gel and continued Petitioner's light duty work restrictions. (PX 2).

Petitioner testified that he decided not to proceed with the surgery recommended by Dr. Rosseau due to his concerns about possible risks and complications involving the nerves in his neck and face.

Petitioner testified that Dr. Rosseau provided him with medical treatment for the left knee prior to the work-related accident of May 28, 2008 including surgery without complications. Petitioner testified that the knee surgery appeared less complex to him than the shoulder surgery.

Deposition of Dr. Rosseau

The evidence deposition of orthopedic surgeon, Dr. Rosseau was taken on June 20, 2016. (PX 8). He testified his practice involves shoulder treatment and surgery. (PX 8 at 6, 9).

Dr. Rosseau testified that the history of Petitioner's accident was consistently documented in the medical records. (PX 8 at 19).

Dr. Rosseau further testified that the injections administered to Petitioner were diagnostic and for pain relief. (PX 8 at 26).

Dr. Rosseau testified that Petitioner had localized pain in the acromioclavicular joint, difficulty with overhead activities, range of motion and routine daily activities. (PX 8 at 32). He stated that Petitioner's subjective complaints were consistent with the objective findings and a diagnosis of a degenerative process at the acromioclavicular joint and posttraumatic degenerative acromioclavicular joint degeneration. (PX 8 at 33). The basis of the diagnosis was the injury, mechanism of accident, MRI study, Petitioner's localized pain and his response to injections. (PX 8 at 33-34). Dr. Rosseau testified that the diagnosis was causally related to the work-related accident of May 28, 2008. (PX 8 at 34).

Dr. Rosseau testified that he recommended Petitioner undergo surgery to alleviate his chronic pain. (PX 8 at 29). Petitioner was a surgical candidate based on the level of pain he experienced and the fact that he obtained temporary relief from the injection. (PX 8 at 31-32). Dr. Rosseau testified that because Petitioner did not undergo the recommended surgery, he would have reached MMI around November 25, 2008. (PX 8 at 37).

Dr. Rosseau has not changed his work restrictions since he provided them on October 3, 2014 consisting of minimizing overhead work and no lifting greater than ten (10) pounds on a permanent basis until surgical intervention has been entertained. (PX 8 at 40). Dr. Rosseau explained that the restrictions were based on the physical demand level where Petitioner began to experience pain in his shoulder. (PX 8 at 69). Dr. Rosseau testified that the work restriction placed on Petitioner were reasonable. (PX 8 at 77). He testified that an FCE would only provide additional information regarding work restrictions. (PX 8 at 78).

Dr. Rosseau explained the risks of surgery to the shoulder including the use of anesthesia. (PX 8 at 34). Further, Dr. Rosseau could not guarantee the outcome of the surgery or that Petitioner would not experience pain following the surgery. (PX 8 at 35). He stated that there could be postoperative stiffness, limitations and posttraumatic changes. (PX 8 at 35). Risks also included infection and neve injuries. (PX 8 at 35).

Dr. Rosseau reviewed the reports of Dr. Giannoulias. (PX 8 at 36). He agreed that a patient's healing time and outcome can deteriorate with age. (PX 8 at 36). He also testified that given Petitioner's age, he would expect some limitations following surgery. (PX 8 at 38).

Dr. Rosseau explained that injections have the risk of infection, decreased immune response and tissue break down. (PX 8 at 70). He acknowledged that the surgery would reduce pain and increase function of the shoulder. (PX 8 at 71). However, Dr. Rosseau could not predict the outcome of the shoulder surgery. (PX 8 at 73). He clarified that the risks of surgery and the risks of injections are different. (PX 8 at 75). Further, the risks of surgery are greater than those of an injection which is less invasive and carries less risk. (PX 8 at 75).

Dr. Rosseau testified that the clavicle resection surgery recommended had a high reliability and a low risk. (PX 8 at 55). He did not recall why Petitioner did not want to undergo surgery. (PX 8 at 57). He testified that Petitioner would not improve without the surgery. (PX 8 at 58). Dr. Rosseau explained the risks and options available to Petitioner and allowed him to make his own judgement based on his personal needs. (PX 8 at 59). Dr. Rosseau testified that he cannot comment as to whether Petitioner would be able to return to work if he underwent the surgery. (PX 8 at 66).

Dr. Rosseau testified that he performed knee surgery on Petitioner and was not aware of any hesitancy towards surgery that Petitioner may have had. (PX 8 at 43). He was not aware of any complications from the knee surgery. (PX 8 at 43-44). Dr. Rosseau explained that the shoulder surgery might have a level of complexity that the knee surgery lacked. (PX 8 at 46).

Deposition of Dr. Giannoulias

The evidence deposition of Dr. Giannoulias, Respondent's Section 12 physician, was completed on November 7, 2016. (RX 1). Dr. Giannoulias first examined Petitioner on September 16, 2008 at which time he obtained a history from Petitioner, reviewed the MRI study, medical records and performed a physical examination. (RX 1 at 11-13).

The doctor noted the MRI study revealed a significant amount of fluid around the collarbone joint and arthritis. (RX 1 at 13). He noted a diagnosis of arthritis in the neck, AC joint arthritis and AC joint edema. (RX 1 at 14). The AC joint arthritis and edema was a typical condition after a fall and a common injury. (RX 1 at 15). He further opined that falling from a 10-foot scaffold, landing on the right side was a competent cause of Petitioner's AC joint injury and that the arthritic changes in his cervical spine were aggravated as a result of the fall. (RX 1 at 16). Dr. Giannoulias recommended injections to the AC joint and if Petitioner's symptoms did not improve surgery to resect the arthritic joint. (RX 1 at 19).

Dr. Giannoulias again examined Petitioner on November 17, 2015. (RX 1 at 21). Dr. Giannoulias testified that the AC joint was worse than at the September 16, 2008 examination. (RX 1 at 24-25). Dr. Giannoulias did not ask Petitioner why he did not have surgery. (RX 1 at 25). He noted that because of Petitioner's age, recovery from surgery would be more difficult. (RX 1 at 26). Dr. Giannoulias testified that the problem with Petitioner's shoulder is not curable without surgery. (RX 1 at 27). He noted that patients can live without surgery. (RX 1 at 27). However, he testified that Petitioner would continue to experience symptoms in his right shoulder, which was to be expected given the AC joint pathology. (RX 1 at 27). Dr. Giannoulias recommended that Petitioner proceed with an arthroscopic resection of the AC joint. (RX 1 at 27). Dr. Giannoulias testified that if the injection worked than a person should be able to return to full duty work. (RX 1 at 29). If the injection did not work, then the patient would require surgery. (RX 1 at 29). If the patient underwent surgery, they can return to work in three (3) to four (4) months following surgery. (RX 1 at 29). He testified that the success rate of the surgery is very high. (RX 1 at 30). Dr. Giannoulias testified that the risks of surgery included infection, blood clots and complications with anesthesia. (RX 1 at 33). Dr. Giannoulias testified that if Petitioner did not undergo surgery then he was at MMI. (RX 1 at 35).

Dr. Giannoulias stated that between his two examinations, Petitioner would have restrictions of no lifting more than ten (10) or fifteen (15) pounds and no overhead work. (RX 1 at 37). Dr. Giannoulias set forth work restrictions of no pushing or pulling greater than five (5) pounds and avoidance of overhead work in his September 16, 2008 report. (RX 1 at 54). He would agree that the restrictions would still be in place as of the

November 17, 2015 examination. (RX 1 at 55). He would also agree with Dr. Rosseau's restrictions of minimal overhead work and no lifting more than ten (10) pounds. (RX 1 at 55). Dr. Giannoulias would defer to a valid FCE for work restrictions. (RX 1 at 38). Dr. Giannoulias stated that if Dr. Rosseau set forth permanent work restrictions, then he would not recommend an FCE. (RX 1 at 45). Dr. Giannoulias testified that an FCE would be beneficial in determining restrictions. (RX 1 at 71). However, he would expect limitations in overhead lifting and that Petitioner would not be able to return to heavy lifting. (RX 1 at 71-72).

Dr. Giannoulias testified that patients sometime opt to not undergo surgery. (RX 1 at 43). Dr. Giannoulias set forth that a risk of surgery could be that the outcome is not favorable. (RX 1 at 58). He cannot guarantee the outcome of surgery. (RX 1 at 58). Further, he never guarantees to a patient the outcome of surgery. (RX 1 at 58). Dr. Giannoulias testified that he could not guarantee excellent results if Petitioner underwent surgery. (RX 1 at 59). Moreover, a patient cannot be forced to undergo surgery. (RX 1 at 59). Dr. Giannoulias testified that knee surgery has the same risks as shoulder surgery. (RX 1 at 63).

Petitioner's return to work and subsequent termination

Petitioner returned to work for Respondent on July 21, 2008 through November 30, 2008 as a gate guard. Respondent paid him union scale. When Petitioner returned to work for Respondent, he returned to work with restrictions and was working within restrictions. Petitioner checked in trucks and the materials brought into and out of the trucks. He used a clipboard provided to him by Respondent. Attached to the chipboard was a piece of paper to write down the truck number and the amount of loads the truck brought in or took out. Petitioner performed this job duty at the I-99 job site. Petitioner did not perform any shoveling, working with jackhammers or heavy lifting.

Petitioner was laid off from employment with Respondent on November 30, 2008. Petitioner has not been contacted by Respondent to return to work since November 30, 2008. Petitioner received unemployment benefits after he was laid off.

Vocational Rehab Counselor Thomas Grzesik

Petitioner was not provided vocational rehabilitation by Respondent following November 30, 2008 nor did Petitioner did not look for alternative employment following that date. Petitioner did not request vocational rehabilitation services from Respondent. However, his attorney requested vocational rehabilitation services and was evaluated by Thomas Grzesik, a vocational rehabilitation counselor, pursuant to his attorney's request.

Mr. Grzesik prepared three (3) reports, which were admitted into evidence. (PX 6). The initial report was dated June 2, 2015. (PX 6). Mr. Grzesik conducted a vocational interview of Petitioner. (PX 6). Mr. Grzesik opined that Petitioner would not be able to return to his pre-injury job duties as a construction laborer for Respondent based on the restrictions instituted by Dr. Rosseau. (PX 6). Further, based on Petitioner's vocational profile (60 years old, GED, certificate in electronic repair in 1978, lack of transferable skills, work history and work restrictions), Mr. Grzesik opined that Petitioner was limited to a narrow range of employment opportunities. (PX 6). Mr. Grzesik conducted a labor market survey that concluded that Petitioner could earn between $8.25 per hour and $15 per hour. (PX 6). Mr. Grzesik stated that Petitioner would experience a significant wage differential if he did not return to work. (PX 6). Mr. Grzesik further opined that Petitioner may remain unemployable. (PX 6).

Mr. Grzesik prepared an addendum report dated March 28, 2016 where he set forth the wage range for security guard positions. (PX 6). Based on the labor market survey, Mr. Grzesik found that security guards earned between $10 and $13 per hour in the Chicago-Naperville area. (PX 6). As of August 2008, the entry level pay for a security guard was $8.33 per hour and the median wage was $11.39 per hour. (PX 6). The wage information was obtained from the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics for 2008, for the Metropolitan Area of Chicago-Joliet-Naperville, Illinois. (PX 6). In

2008, Petitioner earned approximately $36 per hour while working in a light duty capacity for Respondent. (PX 6). Mr. Grzesik concluded that the wages that Petitioner was paid while working light duty for Respondent as a gate guard (security guard) were significantly inflated. (PX 6).

Mr. Grzesik prepared an addendum report dated August 3, 2016 where he reviewed the paystubs from the time Petitioner returned to work for Respondent. (PX 6). He stated that Petitioner earned $34.75 per hour while working within his restrictions. (PX 6). He opined that the compensation which Petitioner received while working for Respondent with restrictions as a security guard were significantly inflated. (PX 6).

The evidence deposition of Mr. Grzesik was completed on September 3, 2015. (PX 7). Mr. Grzesik testified that Petitioner was 61 years old and had obtained a GED. (PX 7 at 18). He also had a certificate in electronic repairs. (PX 7 at 19). Mr. Grzesik testified that the certificate was not vocationally relevant. (PX 7 at 19). Further, Petitioner's job with Zenith was not vocationally relevant since it was more than fifteen (15) years ago. (PX 7 at 20). Mr. Grzesik testified that a construction laborer was considered a heavy job. (PX 7 at 20). Petitioner would have to lift more than 50 pounds on a frequent basis and up to 100 pounds occasionally. (PX 7 at 20). The definition of heavy physical demand level comes from the U.S. Department of Labor, Dictionary of Occupational Titles. (PX 7 at 21).

Mr. Grzesik testified that Petitioner did not have any transferable skills. (PX 7 at 23). The basis of his opinion was that Petitioner's work restrictions would not allow Petitioner to perform the tasks that lead to the development of the skills. (PX 7 at 23-24). Mr. Grzesik opined that Petitioner would not be able to return to his pre-injury employment as a laborer with the restrictions set forth by Dr. Rosseau. (PX 7 at 24).

Mr. Grzesik testified that Petitioner returned to work for Respondent for four (4) to five (5) months. (PX 7 at 25). Petitioner checked vehicles or trucks and singed trucks into and out of the construction site. (PX 7 at 25). Mr. Grzesik testified that Petitioner was employed as a gate guard for Respondent in his light duty work. (PX 7 at 25). Mr. Grzesik testified that gate guards were considered security guards. (PX 7 at 26). Further, Mr. Grzesik testified that there was a reasonably stable labor market for gate guards. (PX 7 at 26).

Mr. Grzesik stated that the job duties of a laborer were using a pneumatic hammer to break up concrete, removing concrete, shoveling debris, demolish areas and other laboring tasks. (PX 7 at 27-28). Prior to the accident, Petitioner did not perform any job duties of a gate guard. (PX 7 at 28). Mr. Grzesik testified that the job duties of a gate guard were not part of the function, duties and responsibilities of a construction laborer. (PX 7 at 29).

Mr. Grzesik testified that Petitioner is currently employable within the confines of the labor market survey that he conducted. (PX 7 at 30). Petitioner would be employable as a security guard, dispatcher, call center representative, customer service representative, guest service agent and patient access representative. (PX 7 at 31). The wage range for employment would be between $8.25 and $15 per hour. (PX 7 at 32). The jobs which Mr. Grzesik listed would constitute suitable employment for Petitioner. (PX 7 at 32). Mr. Grzesik testified that the lack of a job search did not change his opinions. (PX 7 at 33). He further testified that his labor market survey was based on Dr. Rosseau's restrictions. (PX 7 at 49).

Mr. Grzesik testified that whether Petitioner wanted to return to work was not relevant to him determining what Petitioner's potential earnings could be. (PX 7 at 53). Mr. Grzesik testified that he based Petitioner's potential earnings on the vocational profile. (PX 7 at 53). Mr. Grzesik testified that a labor market survey establishes what a person can earn. (PX 7 at 77). It is not relevant as to whether the person wants to return to work since the labor market survey is based on the person's vocational profile. (PX 7 at 77).

Petitioner's Testimony regarding permanency

Petitioner testified that since May 28, 2008 he has not sustained and accidents involving his right shoulder. He has not received any medical treatment from Dr. Rosseau for his right shoulder since April 2016.

Petitioner testified that he experiences pain in his right shoulder every day. He testified that the pain is like a toothache and never goes away. The pain is worse on some days than other days. The pain is located over the AC joint. Petitioner testified that he has difficulty showering and shaving because he is right handed. He used his left hand more than his right hand. Petitioner testified that since the accident, he does not garden, cut the grass or wash the car. Petitioner testified that he experiences pain in his shoulder when he drives a car. Petitioner testified that he cannot perform those activities because he experiences too much pain. Petitioner takes Ibuprofen and use cream for the pain.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "L," nature and extent of the injury, the Arbitrator concludes as follows:

Petitioner seeks an award pursuant to Section 8(d)1. The Arbitrator finds that Petitioner is entitled to wage differential benefits pursuant to Section 8(d)1 of the Act in the amount of $576.60 per week effective November 25, 2008 for the duration of the disability. In support of her finding, the Arbitrator relies on the credible and unrebutted testimony of Petitioner, the medical records and opinions of Dr. Rosseau and the vocational opinions of Mr. Grzesik. The Arbitrator finds it significant that the medical opinions of Dr. Giannoulias, Respondent's Section 12 physician, were consistent with the opinions of Dr. Rosseau. The Arbitrator notes that a wage differential award is the preferred method of compensation in workers' compensation claims. *See Gallianetti v. Industrial Commission*, 315 Ill.App.3d 721, 734 N.E.2d 482 (3d Dist. 2000).

The Arbitrator awards wage differential benefits effective November 25, 2008, the date on which Dr. Rosseau stated that Petitioner reached maximum medical improvement and released Petitioner to return to work with permanent restrictions. The Arbitrator finds that Petitioner had not reached maximum medical improvement prior to November 25, 2008. Since Petitioner reached maximum medical improvement on November 25, 2008, the Arbitrator declines to award wage differential benefits prior to that date.

To qualify for a wage differential award, a petitioner must establish: 1) that he is partially incapacitated from pursuing his usual and customary line of employment; and 2) an impairment of earnings. *Copperweld Tubing Products, Co. v. Workers' Compensation Com'n*, 402 Ill.App.3d 630, 931 N.E.2d 762 (1st Dist. 2010). To establish an impairment of earnings, the Commission considers the amount that the claimant "is earning or is able to earn in some suitable employment or business after the accident." *Id.*

Usual and Customary Line of Employment

The Arbitrator finds that Petitioner's usual and customary line of employment was that of a union laborer. The Arbitrator relies on the credible and unrebutted testimony of Petitioner and the vocational opinions of Mr. Grzesik in finding that Petitioner's usual and customary line of employment was a union laborer. Petitioner's usual and customary line of employment was undisputed.

Partial Incapacity

The Arbitrator finds that Petitioner has established that he is partially incapacitated from pursuing his usual and customary line of employment. The Arbitrator relies on Petitioner's credible and unrebutted testimony, the medical records and opinions of Dr. Rosseau and the vocational opinions of Mr. Grzesik in support of her finding. The Arbitrator notes that Respondent's Section 12 physician, Dr. Giannoulias, agreed that Petitioner

would not be unable to return to work as a laborer in his current condition and that the restrictions of Dr. Rosseau were reasonable. Respondent's defense to the wage differential is that Petitioner should have undergone surgery to cure his current condition of ill-being. The Arbitrator finds that it was reasonable that Petitioner elected not to undergo the recommended surgery. The Arbitrator will address that issue later in this Decision.

As a result of the work-related accident of May 28, 2008, Petitioner sustained an injury to his right shoulder. Petitioner was provided permanent restrictions by Dr. Rosseau. Dr. Rosseau set forth that Petitioner could return to work with the permanent restrictions of no lifting, pushing or pulling greater than five (5) pounds and no repetitive overhead work. Dr. Rosseau recommended the permanent restrictions on November 25, 2008. Accordingly, the Arbitrator finds that Petitioner was partially incapacitated from performing his pre-injury employment on November 25, 2008, the date that Dr. Rosseau recommended permanent restrictions and found that Petitioner had reached maximum medical improvement.

Respondent's argues that Petitioner should have undergone an FCE to determine the permanent restrictions. Respondent's argument was based on the testimony of Dr. Giannoulias. However, Dr. Giannoulias testified that the FCE is one tool for determining restrictions. He agreed that Petitioner would not be able to return to his pre-injury employment in his current condition and that the restrictions set forth by Dr. Rosseau were reasonable. Further, Dr. Giannoulias acknowledged that the work restriction of no pushing or pulling greater than five (5) pounds and avoidance of overhead which he set forth in his report were valid. Accordingly, the Arbitrator relies on the permanent restrictions set forth by Dr. Rosseau in finding that Petitioner was partially incapacitated from returning to his pre-injury employment as a union laborer. The Arbitrator further acknowledged that all of the medical evidence supports a finding that Petitioner was partially incapacitated from returning to his pre-injury employment.

Mr. Grzesik also testified that based on the work restrictions of Dr. Rosseau, Petitioner's physical capabilities fell below the job duties of a laborer. He testified that based on the permanent restrictions, Petitioner would not be able to return to his pre-injury employment. The Arbitrator also notes that the work restrictions fall below the job duties of a union laborer as testified to by Petitioner. Accordingly, the Arbitrator finds that Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a union laborer.

Impairment of Earnings

Earnings in Petitioner's Pre-Injury Employment

The Arbitrator finds that Petitioner has also established an impairment of earnings. The Arbitrator finds that Petitioner would be earning $1,320 per week in the full performance of his job as a laborer. The Arbitrator relies on the stipulated Section 10 wages in finding Petitioner's earnings in the full performance of his pre-injury employment. In support of this finding, the Arbitrator relies on *Franklin v. Peabody Coal Company*, 7 IWCC 1402, 2007 WL 4099250 (IWCC Oct. 9, 2007) (holding that the claimant can establish earnings in his pre-injury employment through the Section 10 average weekly wage).

Earnings in Suitable Employment

The Arbitrator further finds that Petitioner would be earning $11.50 per hour in suitable employment as a gate guard, or security guard. Over a forty (40) hour week, this would equate to weekly earnings of $460 per week. The Arbitrator relies on the vocational opinions of Mr. Grzesik in finding support of her findings.

In finding that Petitioner is entitled to a wage differential award, Petitioner need not prove actual employment; rather, Petitioner must establish that suitable employment is available and what Petitioner would earn in the suitable employment. *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st)

160002WC, 73 N.E.3d 654 (1st Dist. 2017). Where a claimant has not returned to work in suitable employment, the Commission should calculated the "average amount which [the employee] is able to earn in some suitable employment or business after the accident.'" *Id.* In *Crittenden v. Illinois Workers' Compensation Commission*, the court held that to calculate the amount a claimant could earn in suitable employment where the claimant has not returned to work in suitable employment, the Commission "must identify, based on the evidence in the record, an occupation that the claimant is able and qualified to perform, and apply the average wage for that occupation to the wage for that occupation to the wage differential calculation." *Id.*

In the instant case, Mr. Grzesik specifically found that Petitioner would be employable as a security guard. He stated that based on Petitioner's vocational profile, the job of security guard constitutes suitable employment. Mr. Grzesik also testified regarding the average wage of a security guard. He set forth that the average earnings of a security guard in 2008 was $11.39 per hour. Currently, the wage range for a security guard is between $10 and $13 per hour, with the median wage being $11.50. Mr. Grzesik's vocational opinions were unrebutted. The Arbitrator relies on the amount that Petitioner would currently be earning in calculating the wage differential since the wage differential benefit is being calculated and awarded at the date of hearing. The Arbitrator further notes that the earning of $11.50 per hour falls within the range of earnings of a security guard in 2008. Accordingly, the Arbitrator finds that Petitioner was employable as a security guard earning $11.50 per hour, or $460 per week, in suitable employment.

Respondent argues that since Petitioner failed to engage in a job search, he is not entitled to receive wage differential benefits. The Arbitrator does not find this argument persuasive. First, Mr. Grzesik based his opinions about Petitioner's employability and earning capacity on a labor market survey and Petitioner's vocational profile. Petitioner's lack of a job search was not a factor in his opinions. Second, Petitioner is not required to engage in a job search to be entitled to receive a wage differential award. *See Gallianetti v. Industrial Commission*, 315 Ill.App.3d 721 (holding that a diligent job search is not required to establish an entitlement to a wage differential benefit). The Arbitrator further finds it irrelevant that Petitioner retired from his employment after his employment was terminated by Respondent. *Copperweld Tubing Products, Co. v. Workers' Compensation Com'n*, 402 Ill.App.3d 630 (holding that a claimant's voluntary decision to remove himself from the work force does not preclude a wage differential award).

The Arbitrator notes that Petitioner returned to work for Respondent as a gate guard in 2008. Petitioner testified regarding his job duties when he returned to work for Respondent. The job duties were different than those of a laborer. Mr. Grzesik testified that based on the job duties that Petitioner was actually performing when he returned to work for Respondent, Petitioner was employed as a gate guard, or security guard. The Arbitrator finds it significant that Petitioner was able to return to work as a gate guard. This supports her finding that the job of a gate guard constitutes suitable employment.

The Arbitrator relies on the holding in *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 142431WC, 47 N.E.3d 1167 (1st Dist. 2016), in support of her finding that Petitioner sustained an impairment of earning in the suitable employment of a security or gate guard. In *Jackson Park Hospital*, the claimant established that she sustained was partially incapacitated from performing her pre-injury job as a stationary engineer. *Id.* However, the employer provided her with employment within her restrictions as a public safety officer paying her the same wage that she would have earned as a stationary engineer. *Id.* The claimant was not qualified to perform the job of public safety officer. *Id.* Additionally, the vocational evidence established that the earnings of a public safety office were well below the earnings of a stationary engineer. *Id.*

The appellate court held that the claimant's earning capacity in suitable employment should be based on the claimant's capacity to earn and not the actual wages earned where other evidence can show that the "actual earnings do not fairly reflect the claimant's capacity." *Id.* citing A. Larson & L. Larson, *Larson's Workers' Compensation Law* Sec. 81.03[1] (2005). Therefore, whether the claimant sustained an impairment of earnings should be based on the nature of the post-injury employment in comparison to the wages the claimant

could earn in a competitive job market in the post-injury employment. *Id.* The court acknowledged that there was a danger that the claimant could receive a wage differential award while also earning the same wages as prior to the accident. *Id.* However, the court found that under the Act, the claimant is entitled to a wage differential if there has been an impairment of earning capacity. *Id.* The court specifically found that income is not synonymous with earning capacity. *Id.* Moreover, the court found that a claimant could not be denied a wage differential award because the employer pays the claimant an inflated wage in an employer-controlled job that does not otherwise exist in the labor market. *Id; see also Smith v. Industrial Commission,* 308 Ill.App.3d 260, 719 N.E.2d 329 (1999).

In the instant case, the Arbitrator finds that the vocational evidence established that Petitioner earned inflated wages when he returned to work for Respondent in 2008. Petitioner's testimony and the opinions of Mr. Grzesik establish that the job provided to him by Respondent was that of a gate guard, or security guard. Petitioner did not perform the job duties of a laborer. Rather, he performed the job duties of a gate guard. Although Petitioner was paid $34.75 for the job of a gate guard, the vocational testified established that the labor market for a security guard in 2008 was $11.39 per hour and the entry level earning for a security guard were $8.33 per hour. Mr. Grzesik found that the wages paid by Respondent were artificially inflated for the job duties that Petitioner was performing and that the labor market did not support the wages paid to Petitioner by Respondent for the job he was performing. Accordingly, the Arbitrator finds that Petitioner was paid artificially inflated when he returned to work for Respondent. Petitioner has established that he sustained an impairment of earnings based on the vocational evidence and Petitioner's credible testimony.

Accordingly, Petitioner has established an impairment of earnings since Petitioner would earn $460 per week in suitable employment and Petitioner would have been earning $1,324.90 per week in the full performance of his job as a laborer.

Calculation of the Wage Differential

Petitioner is entitled to a wage differential award based on 2/3 of the difference between what he could have been earning in his former occupation as a laborer ($1,324.90 per week) and what he would be earning in suitable employment as a security guard ($460 per week). This would amount to a wage differential benefit of $576.60 per week. The Arbitrator finds that Petitioner is entitled to wage differential benefits in the amount of $576.60 per week for the duration of the disability effective November 25, 2008, the date of MMI, since Petitioner has established that he is partially incapacitated from pursuing his usual and customary line of employment and that he sustained an impairment of earnings.

In support of the Arbitrator's decision relating to "O," whether Petitioner was noncompliant in medical treatment pursuant to Section 19(d),the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner was complaint in his medical treatment when he elected to not undergo the surgical procedure recommended by his treating physician, Dr. Rosseau. The Arbitrator relies on the credible and unrebutted testimony of Petitioner. The Arbitrator finds it reasonable that Petitioner did not undergo the surgery recommended by Dr. Rosseau for the right shoulder condition.

Section 19(d) sets forth that "if any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit such, medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee." 820 ILCS 305/19(d). In *Rockford Clutch Division, Borgwarner Corporation v. Industrial Commission,* 34 Ill.2d 240, 215 N.E.2d 209 (1966), the Illinois Supreme Court held that "if a claimant's response to an offer of treatment is within the bounds of reason, his freedom of choice should be preserved even when an operation might mitigate the employer's damages." The Act "is designed for employees with divergent personalities, beliefs, and fears." *Id.* Further, the court found that "the record