STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert A Talbott,
Petitioner,

vs. NO: 15 WC 37649
20 IWCC 424

City of Springfield,
Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

This matter comes before the Commission on Petitioner's motion to correct a clerical error in the Decision and Opinion on Review of the Commission filed July 30, 2020. After reviewing the Decision on Review, the Commission recalls the Decision for the purposes of correcting the clerical error.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision dated July 30, 2020, is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision shall be issued simultaneously with this Order.

DATED: SEP 0 1 2020
DLS/rm

Deborah L. Simpson
Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT TALBOTT,

Petitioner,

vs. NO: 15 WC 37649
20 IWCC 424

CITY OF SPRINGFIELD,

Respondent.

CORRECTED 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 temporary total disability, the benefit rates, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part thereof.

I. Findings of Fact

Petitioner was a captain on Respondent's fire department. On April 11, 2015, Petitioner responded to an emergency medical call involving a dog attack on a child. When Petitioner arrived on the scene, he thought the child had already passed away due to her general appearance and the severity of her wounds. Petitioner testified that the child had been scalped and had bite marks on her arms, legs, thoracic cavity, chest, and scalp. Petitioner's crew provided active treatment to the child before an ambulance arrived two minutes later.

Petitioner testified that as his crew traveled back to the station, he was upset, sad, and mad all at once. He then put his crew out of service, because he believed that they could not go out on another call that day. Although Petitioner thereafter finished his shift, he indicated that he felt sad and withdrawn. He testified that after his shift, he crawled into his bed at home and cried for five hours, which he had never done before.

Thereafter, on August 27, 2015, Petitioner was back at work responding to a house fire

when he collapsed in the front yard. He was taken by ambulance to Memorial Medical Center and treated for an anxiety attack. Petitioner testified that as he was being cared for by the paramedics, he was crying, nervous, shaking, and unaware of what was going on.

Between the April and August incidents, Petitioner had similar episodes of unexplained crying. He testified that he was constantly on edge and nervous, had extremely high emotions, cried over almost anything, had no energy, and did not care. Petitioner further indicated that he was withdrawn and began having dreams replaying the dog attack call.

Petitioner first presented to Vincent Flammini, a licensed clinical social worker, for therapy between the two incidents on July 2, 2015. Mr. Flammini reported that since the April accident, Petitioner had flashbacks, nightmares, and other intrusive thoughts of both the dog attack call and several other calls from his career that had not previously interfered with his life. Petitioner's other symptoms included abnormal fears, anxiousness, concentration problems, depressed mood, guilt, hopelessness, isolation, panic attacks, sleep issues, somatic complaints, tearfulness, and feelings of worthlessness. Petitioner continued to undergo therapy for PTSD with Mr. Flammini through the hearing date. Throughout his therapy session notes, Mr. Flammini indicated that Petitioner was wrestling with whether or not to go back to work with his symptoms.

While still in the early stages of his therapy, on July 20, 2015, Petitioner presented to Memorial Medical Center complaining of intermittent chest pain and stress. A heart catherization was performed after an abnormal stress test revealed inferior wall myocardial ischemia. Petitioner was discharged on July 22, 2015 with the diagnoses of non-cardiac chest pain, hypertension, mild coronary artery disease, and dyslipidemia. Petitioner then followed up with his primary care physician, Dr. Cara Vasconcelles, on July 29, 2015. At that time, Dr. Vasconcelles started Petitioner on Prozac after noting that he was emotional, cried easily, and had short term memory loss with poor concentration.

On August 5, 2015, Mr. Flammini recommended that Petitioner either decrease or stop working at his second job at Butler Funeral Homes. Mr. Flammini noted that Petitioner was experiencing significantly increased anxiety at this job, even though it was a low risk activity. Petitioner testified that he had started working at Butler Funeral Homes in February of 2001 but stopped working there from September of 2015 to February of 2018 due to his emotions.

On September 8, 2015, Dr. Vasconcelles diagnosed Petitioner with PTSD, anxiety, depression, and sleep disturbances. She referred him to Dr. Phillip Pan, a psychiatrist, and continued his medication. The following day, on September 9, 2015, Mr. Flammini indicated that it did not make sense for Petitioner to return to work for Respondent considering his anxiety regarding his ability to perform during a crisis and the risk of his PTSD symptoms returning.

When Petitioner thereafter presented to Dr. Pan on September 15, 2015, he was started on prazosin for his sleeping problems. Petitioner continued to regularly treat with Dr. Pan through August 15, 2017, at which time Dr. Pan told Petitioner to follow up with Dr. Vasconcelles since he was leaving the clinic. Throughout this period, Dr. Pan continued and adjusted Petitioner's medications for PTSD, nightmares, and panic attacks. At his March 3, 2016 visit, Petitioner told Dr. Pan that he was working on determining if he was ready to return to work or retire.

On March 17, 2016, Dr. Pan authored a letter stating that Petitioner's PTSD diagnosis was a direct result of his firefighter duties for Respondent. Dr. Pan recommended that Petitioner not return to active duty as a firefighter given his lingering issues with PTSD and the likelihood of a relapse. Thereafter, on April 28, 2016, Dr. Pan filled out a medical form indicating that Petitioner was off work indefinitely.

At Respondent's request, Petitioner then presented for a §12 neuropsychological examination with Dr. Ronald Ganellen on November 28, 2016. Dr. Ganellen opined that Petitioner had developed PTSD in response to the dog attack call. He further found that Petitioner's symptoms were consistent with a single episode of major depression of moderate severity that had developed following the events of 2015. Dr. Ganellen also opined that Petitioner was not able to return to work as a firefighter, although he encouraged Petitioner to pursue a meaningful new career. He believed that it would be positive for Petitioner's emotional state, sense of self-worth, and outlook to resume involvement in the workforce in another field.

On January 5, 2017, Dr. Pan noted that Petitioner would run out of his sick time in March and would then need to make a decision regarding retirement. Thereafter, on March 2, 2017, Petitioner informed Dr. Pan that his disability benefits had not been worked out and there was confusion as to his active duty versus retirement. Also on March 2, 2017, Dr. Pan authored a report stating that Petitioner had been unable to work since September 15, 2015 and would remain unable to return to full duty as a firefighter or in emergency medical services indefinitely.

On May 17, 2017, Petitioner presented for another §12 examination with Dr. Terry Killian at the request of the Springfield Firefighters Pension Fund in response to Petitioner's application for a line of duty disability pension. Dr. Killian opined that Petitioner's PTSD symptoms were caused by his repetitive exposure to work trauma over the years. He opined that Petitioner had been totally disabled from his firefighter position since September of 2015 as a result of his PTSD. Dr. Killian indicated that returning to firefighting work would be increasingly unlikely as time progressed, and as such, Petitioner should be considered permanently disabled from his firefighter position as consistent with Dr. Pan's opinion.

On June 30, 2017, Petitioner was awarded a line of duty disability pension in the amount of $5,285.56 per month by the Springfield Firefighters Pension Board. The Board's Final Administrative Decision stated that Petitioner had been examined by three doctors, Dr. Ganellen, Dr. Pan, and Dr. Killian, who had all agreed that Petitioner was disabled and unable to return to service in the fire department.

On July 31, 2017, Elizabeth Skyles, a certified rehabilitation counselor, authored a vocational report following her in-person assessment of Petitioner on May 24, 2017. Ms. Skyles opined that there were employment positions available within Petitioner's labor market area that fit his current profile and could provide him with substantial gainful employment. On August 23, 2017, Ms. Skyles performed a labor market survey that identified ten appropriate alternative positions within Petitioner's labor market area with a yearly pay range of $35,000 to $110,000.

Respondent thereafter wrote a letter to Petitioner on November 15, 2017 enclosing a job

description for a position that Respondent was planning to offer. On November 21, 2017, Petitioner's counsel responded that Petitioner could not accept the job, because doing so would cause Petitioner to lose his disability pension. He explained that any position within the fire department also required one to be ready to respond to emergency calls in full turnout gear. As such, Petitioner's counsel stated that Petitioner would be performing the duties of a full-time firefighter and would thus lose his disability pension benefits. He further expressed concern that the position would require Petitioner to participate in emergency calls and fire suppression duties.

On December 13, 2017, Respondent's Human Resources Director, Jim Kuizin, wrote a letter to Petitioner's counsel that attached a job description and offer for a fire inspector/public educator position. This was the same job description that had been previously sent to Petitioner by Respondent's counsel. Mr. Kuizin wrote that this position did not require Petitioner to respond to emergency calls, participate in fire suppression, or perform firefighter duties. In the attached job description, it stated that the applicant should sustain the rank of captain or battalion chief.

On December 19, 2017, the President of the Springfield Firefighters Local 37 Union, Gary Self, filed a grievance alleging that the creation of this new position had violated the Collective Bargaining Agreement. He sought to immediately bargain over the position and wanted Respondent to file a new unit clarification application with the Illinois Labor Relations Board. At the hearing, Mr. Self testified that the job description was for a position that had never been on the fire department during his tenure. Mr. Self testified that at the time of the hearing, the position remained unfilled, and as far as he knew, no longer existed. Mr. Self further testified that the offered position was in Division II and those jobs were not generally related to firefighting. Nevertheless, he recalled two instances where individuals from Division II had been called into action and involved in firefighting activities.

After the grievance was filed, on January 12, 2018, Respondent wrote a letter to Petitioner stating that it was clear that Petitioner did not intend to accept the job offer. Respondent indicated that it was therefore terminating Petitioner's temporary total disability benefits with no further checks issued after January 6, 2018.

On January 22, 2018, Stephanie Barton, Respondent's labor relations manager, sent an e-mail to Mr. Self stating that although she disagreed with the grievance, the issue was now moot as the position was no longer being filled. Ms. Barton testified at the hearing that once Petitioner refused the job offer, Respondent took the stance that they were no longer filling the position and it was management's right to fill or not fill it. Ms. Barton testified that although she was not directly involved in the decision to create the position, it was her understanding that Respondent had created it to specifically accommodate Petitioner. She opined that it was purely a management right to create such positions and disagreed with the Union's position that it was collective bargaining work.

Jeph Bassett, Respondent's deputy division chief of operations, also testified at the hearing regarding the job offer. Mr. Bassett testified that with the offered position, Petitioner would not be exposed to any emergency situations and would instead be performing fire inspections, which were separate from fire investigations. Nevertheless, Mr. Bassett testified that in 2011, the acting mayor moved three inspectors out of working in fire safety and placed them back into operations.

He explained that a grievance was filed, but it did not go to arbitration, as a new mayor was elected who reinstated those three positions back into fire safety. Mr. Bassett testified that there had also been an incident where a power plant exploded and Respondent contacted several fire inspectors to have them come to the firehouse to unlock it, use radios to assist volunteers, and ride on rigs.

Petitioner eventually returned to work at his second job with Butler Funeral Homes on February 18, 2018 after obtaining clearance from Mr. Flammini. Thereafter, on April 8, 2018, Dr. Vasconcelles reported that Petitioner had been offered a desk job, but due to its requirements, he could not take that position.

At the request of Petitioner's counsel, Dr. Vasconcelles then authored a report on August 1, 2018 indicating that Petitioner's permanent disability from his fireman's job due to his PTSD symptoms also prevented him from taking a desk job with the fire department. Dr. Vasconcelles indicated that Petitioner was under good control as long as he was not exposed to any triggers, which include any activities that reminded him of his fireman job. Nevertheless, she stated that she was not equipped as a primary care physician to render decisions on the job descriptions she was asked to review and suggested that Dr. Pan weigh in.

On August 2, 2018, Dr. Pan wrote a letter to Petitioner's counsel indicating that he no longer worked for Memorial Physician Services and had not treated Petitioner since August 15, 2017. Nevertheless, Dr. Pan opined that it would not be prudent for Petitioner to accept the fire inspector/ public educator position, because being on the scene and investigating the aftermath of fires would likely still trigger his PTSD. However, he anticipated that Petitioner would be able to perform any of the other positions listed in the labor market survey.

On September 11, 2018, Petitioner was sent an e-mail from Therese O'Brien, the account coordinator of IPPFA benefits. Ms. O'Brien wrote that she was unable to sign off on Petitioner's direct rollover request, because he needed to be officially separated from service to do so. Ms. O'Brien explained that when she had reached out to Springfield to confirm his termination date, she was told that Petitioner was neither retired nor officially terminated from his position yet.

Petitioner testified that he did not return to work for Respondent in any capacity after the August 27, 2015 incident. However, he testified that he was not retired as of May 21, 2017 and still considered himself to be Respondent's employee at the time of the hearing. Petitioner testified that he based that on Respondent's refusal to give him his deferred compensation money because he was not a separated employee. Petitioner testified that although he felt like a separated employee after his disability pension was approved, he was not separated according to the e-mail that he had received from Respondent.

Petitioner further testified that when Respondent previously offered him temporary light duty, Dr. Pan still recommended that he not be anywhere around the firehouse. He testified that Dr. Pan did not feel that the firehouse triggers of constantly hearing sirens, seeing the rigs go out, and listing to the calls would be beneficial to Petitioner. Petitioner did not know exactly when he turned down the light duty position, but he guessed that it was in the fall of 2015 or spring of 2016. He testified that he did not think he could have done light duty at that time, because being at the firehouse would have aggravated his stress and anxiety.

Petitioner further testified that in addition to his current position at Butler Funeral Homes, he and his wife had a secondhand antique business with a small booth in the Sangamon Antique Mall that buys and sells glassware. Petitioner still takes fluoxetine and prazosin every day as well as Xanax as needed for his anxiety. He testified that prior to April 11, 2015, he had not required any long or short-term psychological or psychiatric care.

Petitioner's wife, Jane Talbott, also testified that she noticed a change in her husband after the April 11, 2015 incident. Mrs. Talbott testified that after the accident, Petitioner had trouble sleeping, became withdrawn, and was easily agitated. She explained that before the accident, they talked about their future plans and what it would be like to retire, but now they just live one day at a time. They also no longer attend a lot of functions, because Petitioner cannot be in large groups.

Following the hearing on September 25, 2018, the Decision of the Arbitrator awarded Petitioner 50% loss of use of man as a whole as well as temporary total disability benefits from January 6, 2018 to February 11, 2018. The Decision of the Arbitrator further gave Respondent a credit for the temporary total disability benefits that had been paid for the awarded time period.

II. Conclusions of Law

Following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to clarify that Respondent is not entitled to any temporary total disability credit for payments made to Petitioner through his line of duty disability pension.

Petitioner was unanimously determined to be medically unable to return to work as a firefighter by Dr. Ganellen, Dr. Pan, and Dr. Killian. He was thus awarded a line of duty disability pension on June 30, 2017, as his PTSD symptoms prevented him from returning to employment with Respondent. Due to his anxiety, Petitioner also stopped working at his second job with Butler Funeral Homes from September of 2015 until February 18, 2018 upon Mr. Flammini's recommendation. As the record shows that Petitioner was kept off work by several medical professionals for the claimed temporary total disability period of January 6, 2018 to February 11, 2018, the Commission affirms the Arbitrator's award of temporary total disability benefits.

The Commission further finds that there was no evidence in the record to show that Petitioner retired from employment with Respondent and voluntarily removed himself from the workforce. Although Petitioner expressed concerns as to whether he should retire to Mr. Flammini, there was no indication that he began a formal retirement process.

Additionally, the Commission finds that Petitioner's decision to decline Respondent's job offer does not affect his entitlement to temporary total disability benefits, because none of his doctors had determined that Petitioner would be medically able to pursue this position. Instead, Dr. Pan opined that it would not be prudent for Petitioner to accept the fire inspector/ public educator position, because being on the scene to investigate the aftermath of fires would likely trigger his PTSD. Although such Division II positions were not generally involved in firefighting activities, Mr. Bassett and Mr. Self both discussed occasions when employees in Division II had been put back on rigs and involved in firefighting duties. Thus, the offered position does not

constitute an adequate accommodation, as Petitioner's treatment records show that anything related to being a firefighter could induce his PTSD symptoms.

However, although the Commission agrees with the awarded period of temporary total disability benefits, it finds that Respondent is not entitled to a credit for the payments Petitioner received through his line of duty disability pension that commenced on June 30, 2017. In contemplating the award of firefighters' disability pensions, 40 ILCS 5/4-114.2(a) states:

> "Whenever a person is entitled to a disability or survivor's benefit under this Article and to benefits under the Workers' Compensation Act [820 ILCS 305/1 et seq.] or the Workers' Occupational Diseases Act [820 ILCS 310/1 et seq.] for the same injury or disease, the benefits payable under this Article shall be reduced by an amount computed in accordance with subsection (b) of this Section. There shall be no reduction, however, for any of the following: payments for medical, surgical and hospital services, non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this State and for artificial appliances; payments made for scheduled losses for the loss of or permanent and complete or permanent and partial loss of the use of any bodily member or the body taken as a whole under subdivision (d)2 or subsection (e) of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; payments made for statutorily prescribed losses under subdivision (d)2 of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; and that portion of the payments which is utilized to pay attorneys' fees and the costs of securing the workers' compensation benefits under either the Workers' Compensation Act [820 ILCS 305/1 et seq.] or Workers' Occupational Diseases Act [820 ILCS 310/1 et seq.]" 40 ILCS 5/4-114.2(a).

The Commission finds that 40 ILCS 5/4-114.2 does not relieve Respondent of its obligation to pay temporary total disability benefits once a line of duty pension is awarded. As such, the Commission modifies the Decision of the Arbitrator to clarify that Respondent is not entitled to a credit toward the temporary total disability award for any payments made by the Springfield Firefighters Pension Board. The Decision of the Arbitrator is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated July 22, 2019 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not entitled to a temporary total disability credit for any payments made by the Springfield Firefighters Pension Board as related to Petitioner's line of duty disability pension. Respondent is only entitled to a temporary total disability credit for any payments it made to Petitioner under his workers' compensation claim as related to the April 11, 2015 work accident.

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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 0 1 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O: 6/4/20
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

20 IWCC0424

TALBOTT, ROBERT
Employee/Petitioner

Case# **15WC037649**
15WC037650

CITY OF SPRINGFIELD
Employer/Respondent

On 7/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX ST
PALATINE, IL 60067

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

20 I W CC0424

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Robert Talbott
Employee/Petitioner
v.
City of Springfield
Employer/Respondent

Case # **15** WC **37649**

Consolidated cases: **15 WC 37650**

An *Application for Adjustment 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 **Urbana**, on **9/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [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. [ ] Were 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 **4/11/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**97,269.58**; the average weekly wage was $**1,873.95**.

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 for TTD benefits paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,248.95/week for 5 2/7 weeks, commencing 1/6/18 through 2/11/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for temporary total disability benefits that have been paid for the 5 2/7 weeks awarded herein.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$721.66**/week for **250** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **50% loss of the person as whole.**

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

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

Signature of Arbitrator

7/12/19
Date

JUL 2 2 2019

ICArbDec p. 2

FINDINGS OF FACTS

Robert Talbott testified that his date of birth is 6/29/61, making him 57 years old on the date of the hearing. He indicated he was hired by Respondent's fire department on 4/16/90. He was hired in as an entry level firefighter. He next was a driver engineer and then a captain. He obtained an emergency medical certification in his first year of employment. Petitioner described his job duties as a captain to oversee and manage his crew. This would include fire suppression activities. He noted that part of the job would involve rescuing people from burning structures. Further, there would be the responsibility to perform emergency medical services if necessary. Petitioner also noted responding to auto accident scenes and emergency medical situations. He noted the fire department responds to all advanced life support calls.

On 4/11/15 he was a captain with the Springfield Fire Department. At approximately 12:15 p.m., they responded to an emergency medical call involving an animal assault of a child. They were the first dispatched to the scene. Petitioner indicated he was first off the rig and was met by an adult female at the front door of the house. She indicated that the injured person was in the back yard and the dog involved was in a back bedroom behind a closed door. Petitioner indicated that his driver engineer, his firefighter and Petitioner entered the backyard. The driver engineer was BJ Crawford and the firefighter was Bobby Murphy. Initially when walking out on the deck in the backyard, they did not see any victim. There was another young girl standing at the top of a hill in the backyard. Petitioner indicated that they proceeded in that direction to where the young lady was standing. As they were approaching, they saw a young girl lying on the ground. His first thought was that she had already passed away. This was based upon her general appearance and the wounds on her body. She was not moving and from that distance they could not see any movement in her chest. His driver and his firefighter knelt down and started to assess the girl and realized that she was actually still alive. Petitioner indicated the girl had bite marks on both arms, both legs, and on her chest. She also had a very large laceration in her scalp. There did not appear to be any ongoing bleeding. The blood appeared to be all dry. The girl did not have any clothes on and the clothes were found strewn around the backyard and apparently ripped off by the dog. After a couple of minutes, the ambulance arrived. They moved quickly to transport the girl to the hospital. The ambulance crew and his crew did most of the preparation for transport of the little girl. Petitioner indicated he was just holding her head while she was loaded onto a backboard and then onto a stretcher.

On the way back to the station, the Petitioner noted knots in his stomach, and he was very upset, sad and mad at the same time. It was one of the worst calls Petitioner thought he had ever seen. He noted that the driver engineer showed symptoms of emotional upset. He was crying as he was driving the rig. Petitioner had the driver pull over and stop. He also put the rig out of service. They did go back to the station and he finished the shift that day. During the remainder of the shift, he was very sad and very withdrawn. He spent most of the rest of the shift by himself in a side office. Upon return to the station, he called the battalion chief and told him what had happened. He also contacted his wife. Petitioner indicated his driver engineer did not finish the day.

Petitioner noted that after he finished his shift following the 4/11/15 incident, he went home and crawled into bed and cried for five hours, something he had never done before. His emotions were high, and he would cry over almost anything. He had no energy and he did not care. He felt like he was just going through the motions. He started having nightmares. With regard to his personal life, he was very withdrawn. He did not want to do

anything, even with his family. Prior to the 4/11/15 incident, he had never had anything psychological or psychiatric care.

Petitioner noted that on 7/16/15, he went to the Memorial Hospital emergency room. Earlier he had been crying in a movie attended with his wife and daughter. At home later on he had some chest pains. Petitioner indicated they could not figure out exactly what was going on in the ER. A cardiologist was called in. While waiting in the emergency room, Petitioner indicated he was crying and did not have control of his emotions.

On 8/27/15, there were two fires that he and his crew worked. One of them was about dinner time, 5:00-6:00 p.m. They arrived at the scene at the same time as another rig. He directed his firefighter to pull a hose line. They went in the house and found the fire and started to work on extinguishing it. After working inside the building, he apparently became hot and was overcome. He indicated he was told he collapsed in the front yard. He received medical treatment at the scene and then by an ambulance crew that took him to the ER. When he was being cared for by the paramedics, he was very nervous and shaking and did not know what was going on with him. He was also crying maybe just because of his nerves being totally shot. Petitioner noted that he had had episodes of unexplained crying between 4/11/15 and 8/27/15.

On 8/27/15 he was transported to Memorial Medical Center. After he sat in the waiting room for two hours, the ER doctor gave him a bag of fluids for dehydration. She said he apparently suffered a heat episode. He was sent home to rest. Petitioner did not complete his shift on 8/27/15 after being taken to the Memorial Medical Center ER. In fact, he did not return to work for the City Fire Department in any capacity after that date.

After his ER treatment on the 8/27/15 date, he followed up with his family doctor, Dr. Vasconcelles. She did a general assessment for the emotions and nerves and everything and started him on a prescription of Fluoxetine. She thought he needed to see a psychiatrist and set him up to see Dr. Pan. Dr. Pan assessed the situation. He agreed to continue the Fluoxetine but at an increased amount. He also prescribed Prazosin, which was supposed to help with the dreams. Petitioner indicated that he still takes the Fluoxetine and the Prazosin every day. He also was prescribed Xanax for anxiety which he is to take as needed. He stopped seeing Dr. Pan a year ago or more.

In addition to seeing Dr. Pan, he is seeing a psychotherapist, Vincent Flammini. He still sees Dr. Flammini, having last seen him on 9/17/18. Initially he saw him twice a week and now sees him about once a month.

With regard to his condition, Petitioner indicated that any situation that he is unfamiliar with such as being in court could act as a trigger to his condition. He also mentioned hearing sirens on the streets, especially if they are close. This causes him to flash back to that day. In his personal life, he has become very guarded. He used to be outgoing. Now he just sits around, and his wife does the talking. He indicated he has to be careful of the TV shows he watches.

Petitioner indicated that he did talk to Flammini about his status, whether he was retired, whether he was disabled, whether he was on disability. Petitioner indicated that he was not retired. He was an employee with the

City Fire Department as of 5/21/17. In attempting to transfer his deferred compensation from the City account into a personal IRA, he was told he was not a separated employee.

Early on, maybe in the fall of 2015 or the spring of 2016, he was offered a light duty job by the City. This was offered by Mark Hart, who was a chief of Division 1. Dr. Pan thought this was a bad idea. Subsequently, the City offered a permanent position which he did not accept. That was in November or December of 2017. Before being offered that position, he said he believed he had heard of that position. He indicated that the position is filled. He assumed that the position the City was offering him represented a new position. The title and description they gave him was for the exact same position in our department, in our labor contract that was already filled and there was only one position. The union did object to the City offering the position.

Beginning in February of 2001, he has worked for Butler Funeral Home as a part-time staff member assisting on days of either a visitation or a funeral. Basically, he was meeting and greeting families and lining up cars. In approximately September of 2015, he stopped working for them until February of 2018. He indicated he stopped working for them because of his emotions, and he could not do the job. He could not meet and greet people and talk to them. He just could not handle the stress. He noted that the job can be stressful. Petitioner indicated that he returned to work for the funeral home on 2/18/18. Petitioner indicated that he finally got the clearance from Vincent Flammini, who thought it would be great if Petitioner could start going back to work. He called the funeral home and asked if his job was still available and they said it was. At some point after going back to work at the funeral home, he tried to go full time there. The added duties included courier duties as well as odd jobs in the office.

With regard to talking to Flammini in May of 2017, Petitioner indicated he was not stressed about his retirement, he was stressed about his PTSD. Petitioner did agree that on 8/17/17 he told Flammini that this is not how I planned to retire. In addition to his work at Butler, Petitioner indicated that he and his wife have a small antique second hand business at an antique mall. He noted that he buys and sells small glassware.

Petitioner agreed that as of his 25 year anniversary with the fire department, April 16, 2015, he made $92,924.34 annually. Petitioner noted that in addition to the base salary there are additions that can add to that base. With regard to his status with the City, Petitioner indicated he thought he was separated because after he received the duty disability pension, the City promoted and replaced employees in his place. Petitioner indicated he was told by deferred comp that he had to be a separated employee, which he was not.

Gary Self has been with the Springfield Fire Department for 18 ½ years. He has been president of the local union for three years. In December of 2017, he learned about a job offer to Petitioner by a call from Petitioner's attorney's office. He indicated that he reviewed the job description and felt that it was not a job that was currently or had been a position with the Springfield Fire Department. He immediately filed grievances over the non-bargaining and demanded to bargain with the City. The grievance process went through three steps and there was no resolution. Therefore, the union filed for arbitration and arbitration is currently set aside pending this hearing. The position is unfilled as of today and no longer exists. The job offer indicated there were no firefighting duties assigned with the position. Self noted there were two instances where individuals from Division II, which is fire safety, have been called into action. Division II is the same division in which this job offered to Petitioner is. One was when there was an explosion at the power plant. The other was when the interim mayor moved three investigators out of fire safety Division II and put them back on rigs. Self indicated

that the union has instructed its attorney not to file for arbitration in this case due to the fact that the job offer was rescinded. The grievance process was concluded but the next step has not been taken.

Jane Talbott is married to Petitioner. She indicated that she noticed a change in her husband after the 4/11/15 incident. She went to the station house after the incident and noted that Petitioner was visibly shaken up. He indicated that he had just had the worst call he has ever seen involving a little girl. When he came home the next morning, he went to bed and cried all day. At that point, he did not know if the little girl had survived. She indicated that Petitioner was worried about the girl and her future. Mrs. Talbott did indicate that the little girl did survive and that she is a healthy young lady now. Mrs. Talbott indicated that Petitioner had a lot of trouble sleeping and that it involved nightmares. Petitioner became very withdrawn and did not want to do a lot. He became agitated very easily. He tried to cover everything up. At the time of the first visit with the psychiatrist, Petitioner was shaking and near tears in the waiting room and throughout the entire appointment. Mrs. Talbott indicated that they do not attend a lot of functions. She indicated Petitioner cannot be in large groups of people.

Jeph Bassett is a Deputy Division Chief of Operations with the Springfield Fire Department. He has been in that position about six months. Prior to that for about three years he was Deputy Division Chief of Technical Services. Before that he was Deputy Division Chief of Fire Safety for about a year. With regard to the job description and position offered to Petitioner, Petitioner would not be exposed to any emergency situations whether it be fires or accidents or emergency situations such as a heart attack. He would be doing fire inspections. The Division II fire safety has four functions, which are plan review, fire inspections, fire investigations and public education. The job description for Petitioner was written to address fire inspections and public education. A fire inspector goes out and looks for code violations and code enforcement within buildings. Investigators go to a fire scene to figure out the origin. Going to a fire scene was not in the job description for Petitioner. The duties in the job description are all duties done by firemen. The previously noted figure of $92,924.34 would have been the same for this job description. There is the potential to make more with certain education requirements. With regard to Mayor Edwards moving three inspectors back to operations, this was unusual and a grievance was filed. It did not go to arbitration. There was an election and a new mayor reinstated the three back into fire safety. Edwards was an interim mayor for a few months. Division II works out of the Municipal Center West on the third floor, where most of the people are. There is also on the south side of town out by the university something called the Children's Safety Village where the senior public education officer works. There would be a uniform for the position, the same as what everyone wears. With the advent of cell phones, radios are not really used as much anymore. Fire safety is assigned to channel four. Operations calls are not dispatched over that channel. If a fire investigation was requested, that would come over that channel. Where there is an extremely large incident like the power plant explosion, someone from Division II could be called into an operational mode. The inspectors in Division II have a job description which is different than that given to Petitioner.

Stephanie Barton was employed by the City of Springfield as a labor relations manager. She was previously employed in the Attorney General's office in the Employment and Labor Law Bureau. She was also at the Department of Corrections as the Chief of Labor Relations. Then she became Deputy General Counsel over CMS labor relations, responsible for the negotiation of all state contracts. With the City of Springfield she was involved with negotiating contracts including the Collective Bargaining Agreement with firefighters. There were 23 Collective Bargaining Agreements at the City of Springfield. Last December she was familiar with the job that

was offered to Petitioner. She talked with the now-retired fire chief at that time. Contract negotiations were still ongoing then. She is familiar with the grievances filed by the union. The position being created for Petitioner was run by her from a collective bargaining standpoint. She gave her opinion that it is purely a management right to create positions. The City had the right to create a position even under the Illinois Labor Relations Act. The Union took the position that it was collective bargaining work and the City thought the opposite. Ms. Barton indicated that the union could start the process of filing a petition. The City had no obligation to bargain over it until the Labor Relations Board had certified that this was a position under the Collective Bargaining Agreement. Nothing was ever filed with the Illinois Labor Relations Board. Once Petitioner had refused the job, the City took the position that they were no longer filling the position. This was the management right to fill or not to fill. Her position was that it was then a moot issue once Petitioner rejected the job offer. Her understanding was that the City created the position to specifically accommodate Petitioner with whatever accommodations he needed. The City position was that the demand to bargain was moot because the Petitioner rejected the position and there was nothing to bargain over.

The records from Vincent Flammini (PX9) reflect that Petitioner was first seen on 7/02/15. The history was that Petitioner reported feeling a number of symptoms since April 2015 after a firefighter call when he encountered a young girl who had been attacked by a dog. Petitioner reported numerous flashbacks, nightmares, and other intrusive thoughts about the call as well as other calls from his career that had not affected him until after this April call. Petitioner reported withdrawal, increased irritability, and decreased frustration tolerance. Flammini's diagnosis was PTSD-moderate tending toward severe. At the time of the next visit on 7/15/15, the agreement was that Flammini would call Dr. Vasconcelles, Petitioner's personal physician, to prescribe medication. As of 7/29/15, Flammini noted that Petitioner's PTSD was negatively impacting all areas of his life. Flammini continued to see Petitioner on approximately once a week basis at least through the end of the year. As of 11/16/15, Flammini reported that Petitioner's symptoms were lessening but that he was still easily triggered by novel situations. As of 2/18/16, Flammini did not think it made sense for Petitioner to return to work since he was still having significant anxiety regarding his ability to perform during a crisis and was having anxiety regarding the risk of intense PTSD symptoms returning. Petitioner indicated he was leaning more toward retiring versus the risk of returning to work and experiencing significant PTSD again. As of 5/25/17, Flammini indicated that Petitioner had significantly more stress related to legal issues re PTSD and retirement. At the next visit on 8/17/17, Flammini again noted stress related to legal issues re PTSD and retirement. At that visit, Petitioner indicated to Flammini that he had an okay summer in which he did some lawn work at home and helped out a few friends in the neighborhood. Petitioner indicated this is not how I planned to retire (PX9).

Petitioner first saw Dr. Pan on 9/15/15, on referral from Dr. Vasconcelles. At that time, Petitioner described the incident occurring on 4/11/15 and how it affected him. He indicated to Dr. Pan that he had been seeing Vincent Flammini. Petitioner continued to see Dr. Pan until August 15, 2017. As of 3/17/16, Dr. Pan indicated that his recommendation was that Petitioner not return to active duty for the fire department. On 3/02/17, Petitioner reported to Dr. Pan that he was receiving temporary total disability benefits. There were still some issues to be worked out and he was frustrated by the lack of resolution. He was also frustrated that on TTD he could not work otherwise. Dr. Pan's impression was that Petitioner was doing well at that time. In a letter dated 3/02/17, Dr. Pan indicated that Petitioner had made a great deal of improvement and was reasonably stable with treatment. It remained the doctor's opinion that Petitioner should not return to work as a firefighter. He felt that the inability to return to full duties as a firefighter or in emergency medical situations was indefinite

(PX7). Dr. Pan indicated in a letter to Petitioner's attorney dated 8/02/18 that he did not feel Petitioner should accept the position as fire inspector/public educator because being on the scene and investigating fires would likely trigger his PTSD. He did note that Petitioner would be able to perform any of the positions listed on pages 8 and 9 of the labor market survey from Elizabeth Skyles (PX8).

Dr. Vasconcelles, in response to an inquiry from Petitioner's attorney, indicated that on perusing the job description, she did not see any that would be a clear concern for flaring up Petitioner's PTSD. She went on to indicate that she had not specifically reviewed them with the patient to see if he would foresee a problem. The doctor noted that Petitioner was physically capable of doing the jobs, but that it would depend upon his ability to emotionally handle the situations (Joint Exhibit 1).

Petitioner was seen for an independent medical evaluation by Dr. Ganellen on 11/28/16. Dr. Ganellen reviewed medical records and talked with Petitioner. His opinion was that Petitioner should not return to work as a firefighter. He thought it would be a good idea for Petitioner to resume involvement in the work force and would encourage Petitioner's efforts to pursue a new career (RX1). With respect to Petitioner's claim for disability pension benefits, he was evaluated by Dr. Terry Killian on 5/17/17. Dr. Killian talked to Petitioner and reviewed medical records. He essentially agreed with Dr. Pan and Dr. Ganellen. He indicated that Petitioner should be considered permanently disabled from his position as a firefighter (PX12).

Petitioner was evaluated by Elizabeth Skyles, a vocational consultant, in 2017. Her initial report with regard to her evaluation of Petitioner was dated 7/31/17. She felt that Petitioner was employable and that positions were available for him (RX2). Elizabeth Skyles also performed a labor market survey and issued a report dated 8/23/17. In the course of that evaluation, Petitioner indicated that he likely would have the opportunity to return to work at the funeral home. He indicated that it was to be determined whether he would be able to work full time there, which would depend upon how much work they had. Petitioner advised that this definitely could be a good possibility and option for him. Petitioner also reported to Elizabeth Skyles that he had independently built three houses for himself. He further reported that he bought, renovated, repaired and flipped homes as well. He noted that he had acted as a general contractor and performed all the labor. He did state that he had subcontracted out some plumbing and sewer work (RX3).

CONCLUSIONS

Issue (G): What were Petitioner's earnings?

In addition to the testimony about earnings, Respondent offered into evidence wage records which include Petitioner's actual earnings from the Fire Department in the 52 weeks preceding the accident (RX9). In addition, Petitioner entered into evidence wage records which include Petitioner's actual earnings from Butler Funeral Home in the 52 weeks preceding the accident (PX14).

For the Fire Department, Petitioner's average pay period was 100 hours and forty eight minutes, or 100.8 hours every two weeks. 100.8 ÷ 2 = 50.4 hours per week. From 4/11/14 through 2/28/15, 46 2/7 weeks, Petitioner earned $34.3939 per hour. From 3/1/15 through 4/10/15, 5 6/7 weeks, Petitioner earned $34.9098 per hour.

\$34.3939 x 50.4 hours per week = \$1,733.45 x 46 2/7 weeks = 80,232.85. \$34.9098 x 50.4 hours per week = \$1,759.45 x 5.857 = \$10,305.12. Therefore, Petitioner's straight time earnings in the 52 weeks preceding the accident were \$90,537.97.

The Arbitrator notes that Petitioner earned overtime in 13 of the 26 pay periods preceding the accident. In 9 of the pay periods, including one after the pay increase, Petitioner worked 12.0 hours. In the other pay periods he worked 1.0, 8.0, 4.0, and 12.5 hours of overtime for a total of 25.5 hours for these periods. However, there is no evidence in the record which addresses whether the overtime was mandatory, therefore the Arbitrator declines to include these hours in the wage calculation.

There is also evidence in the record, including both parties questioning of Petitioner, to establish that during the 52 weeks prior to the accident Petitioner had concurrent employment with Butler Funeral Home. Petitioner's exhibit 14, which was admitted without objection, shows Petitioner earned \$6,880.50 in the 52 weeks preceding the accident. The Arbitrator finds that these earnings should be included in the wage calculation.

Therefore, the Arbitrator finds that in the 52 weeks preceding the accident Petitioner earned \$90,537.97 + \$6,880.50 = \$97,418.47 for an AWW of 1,873.43.

<u>Issue (K)</u>: What temporary benefits are in dispute?

Petitioner claims entitlement to TTD from 1/6/18 through 2/11/18 (5 2/7 weeks). This is the only period the parties placed in dispute at the hearing. Petitioner last worked for Respondent on 8/27/15. Petitioner stopped working for Butler Funeral Home in September of 2015 and did not return to work for them until 2/18/18. There is no evidence in the record to establish Petitioner performed any work within the period for which TTD is claimed. The Arbitrator therefore concludes Petitioner is entitled to the claimed 5 2/7 weeks of TTD.

Respondent shall pay Petitioner temporary total disability benefits of \$1,248.95/week for 5 2/7 weeks, commencing 1/6/18 through 2/11/18, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid for the 5 2/7 weeks awarded herein.

The Arbitrator notes that Respondent seeks credit for TTD benefits paid from 5/28/17 through 1/5/18. because in an office visits with his psychologist, on 5/27/17 Mr. Flammini notes "[s}ignificantly more stress related to legal issues re PTSD and retirement," and on 8/17/19 he notes "stress related to legal issuers PTSD and retirement," Petitioner considered himself retired as of 5/27/17. The totality of the evidence in the record clearly indicates that Petitioner had not retired on 5/27/17. In fact, Petitioner had applied for a line of duty disability pension from the Firefighters' Pension Board but did not have a hearing before that Board until 6/30/17. He was there after awarded the line of duty disability pension effective as of 6/30/17. There is absolutely no question Respondent is not entitled to any credit for benefits paid during the period of 5/28/17 through 6/29/17.

. With respect to the period of 6/30/17 through 1/5/18, firefighters' line of duty pensions are awarded pursuant to 40 ILCS 5/4 110 et seq. Specifically, 40 ILCS 5/4-114.2 deals with reduction in line of duty

disability benefits for corresponding benefits payable under the Workers' Compensation Act. Section 5/4-114.2 provides, in pertinent part:

> **(a)** Whenever a person is entitled to a disability or survivor's benefit under this Article and to benefits under the Workers' Compensation Act [820 ILCS 305/1 et seq.] or the Workers' Occupational Diseases Act [820 ILCS 310/1 et seq.] for the same injury or disease, the benefits payable under this Article shall be reduced by an amount computed in accordance with subsection (b) of this Section. There shall be no reduction, however, for any of the following: payments for medical, surgical and hospital services, non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this State and for artificial appliances; payments made for scheduled losses for the loss of or permanent and complete or permanent and partial loss of the use of any bodily member or the body taken as a whole under subdivision (d)2 or subsection (e) of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; payments made for statutorily prescribed losses under subdivision (d)2 of Section 8 of the Workers' Compensation Act [820 ILCS 305/8] or Section 7 of the Workers' Occupational Diseases Act [820 ILCS 310/7]; and that portion of the payments which is utilized to pay attorneys' fees and the costs of securing the workers' compensation benefits under either the Workers' Compensation Act [820 ILCS 305/1

40 ILCS 5/4-114.2(a). Clearly this provision does not contemplate elimination of obligation to pay TTD benefits otherwise payable based on the award of a line of duty disability pension.

Respondent next alleges that when Petitioner failed to accept a position offered by Respondent on 12/13/17 which was allegedly "within Petitioner's restrictions" he refused the offer and had voluntarily removed himself from the work force. The Arbitrator disagrees. No physician ever cleared Petitioner to return to work in that position. Dr. Vasconcelles, in response to any inquiry of 7/23/18, wrote:

> ...I have been managing Robert's medications for his PTSD. It is under good control as long as he is not exposed to any triggers that can exacerbate his PTSD symptoms. Unfortunately, that seems to be any activities that remind him of his job as a fireman and EMT. On perusing the jobs descriptions enclosed, I do not see any that would be a clear concern for flaring his PTSD but I have not specifically reviewed them with the patient to see if he foresees any concerns. He is physically capable of doing any of these positions but it will depend on whether he can emotionally handle the rigors. I am not equipped as a primary care doctor to render a decision in this regard....

(JX 1). The Arbitrator does not believe this to be an opinion that Petitioner was capable of returning to work in one or more of the offered positions. Instead, it is a fairly clear statement that the doctor is not qualified to render an opinion of the matter. Further, the statement was not rendered until many months after the last requested payment of TTD.

Respondent does not claim credit for any benefits paid during the requested benefit period of 5 2/7 weeks from 1/6/18 through 2/11/18.

Based upon the foregoing the Arbitrator concludes Respondent is not entitled to the credit claimed.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was a firefighter and described his job activities in great deal. The Petitioner testified that he is unable to perform his job activities given the level of psychological impairment he still feels to date. His symptoms and treatment thereof continue through the date of trial. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old as of the date of his workplace injury. Petitioner will likely live the rest of his life afflicted by the ongoing results of the psychological trauma sustained in this injury. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner is unable to work in any emergency field due to his psychological triggers from the trauma of the incident. The emergency service field was his chosen occupation and primary source of income to provide for himself and his family, that field as a whole is no longer available to Petitioner. The Arbitrator therefore gives *greater* 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 testified to the ongoing psychological problems he is enduring. Respondent did not offer any evidence or testimony to refute the testimony of Petitioner, nor did Respondent offer the testimony of any expert to refute the Petitioner's condition. The Arbitrator finds the Petitioner to have testified credibly and the medical records to corroborate his medical condition. Petitioner entered into evidence the report of Dr. Pan, who indicated that Petitioner is certified as permanently disabled from firefighter service as a result of cumulative effects of acts of duty as a firefighter. (PX 7). Also submitted into evidence are the medical records of Dr. Pan which indicate a history of medical treatment and exams given by Dr. Pan to Petitioner.

All of the treating medical records entered into evidence without objection from Respondent corroborate the symptoms and the impact on Petitioner in his personal life. The records of the treaters in this case indicate the protracted duration of recovery, if there is even any recovery to be had in this matter. Because the medical

records and evidence taken as a whole corroborate the Petitioner's complaints, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 50% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANK MIONI,

Petitioner,

20 IWCC0488

vs. NO: 13 WC 6168

ILLINOIS WORKERS' COMPENSATION COMMISSION and
F.E. MORAN FIRE PROTECTION,

Respondents.

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the Illinois Appellate Court, First District, Workers' Compensation Division. A history of these proceedings useful to the understanding of this Decision and Opinion follows.

The parties proceeded to a hearing pursuant to section 19(b) of the Illinois Workers' Compensation Act (Act) on February 25, 2014, May 20, 2014, November 25, 2014, and May 22, 2015. An arbitration decision was filed on August 12, 2015, in which the Arbitrator found that Petitioner proved that he suffered a work-related accident on January 22, 2013, when he slipped and fell while working for Respondent. The Arbitrator also ruled that Petitioner proved that he provided adequate notice of the accident to Respondent, and that there was a causal connection between the accident and Petitioner's current condition of ill-being of the right shoulder. The Arbitrator awarded Petitioner 75 weeks of temporary total disability benefits, and $122,244.53 in medical expenses. The parties stipulated to defer the issue of 8(j) credit.

Relevant to today's decision, the Commission observes that in so ruling, the Arbitrator found Petitioner's testimony credible, noting that Petitioner "was subjected to lengthy, pointed and well prepared cross examination on each and every assertion" and "answered forthrightly." The Arbitrator added: "Despite the Petitioner's sometimes strange and seemingly childish

behavior in the courtroom and his possible anger issue with another witness for disagreeing with him, the Arbitrator accepts his testimony regarding the actual facts of the accident."

Respondent sought review of the Decision of the Arbitrator. A majority of the Commission reversed, finding that Petitioner did not sustain his burden of proving that he sustained a compensable accident. The Commission stated that Petitioner's credibility was "the critical issue," noting that there were inconsistencies between Petitioner's testimony and his medical records, some internal inconsistencies in his testimony, and a failure to report the accident in compliance with Respondent's internal procedures.

In finding Petitioner's testimony was not credible, the Commission also relied upon testimony from witnesses Scott Acred (a field superintendent for Respondent) and Jeff Smith (a superintendent for Respondent who worked with Petitioner) when they were recalled to testify about an encounter with Petitioner that occurred after their initial testimony. Mr. Acred and Mr. Smith both testified that Petitioner attempted to intimidate them after their initial testimony, stating that his attorney had their names.[1] Petitioner was also recalled to testify about the encounter. The majority stated:

> "In addition, the Commission cites Petitioner's testimony regarding the encounter with the other witnesses after their testimony. Although that encounter is not explicitly relevant to the issues addressed here, Petitioner's testimony about that incident is clearly relevant regarding the determination of his overall credibility. Petitioner basically claimed that the witnesses apologized for their testimony but he told them not to worry because they were still 'union brothers.' However, he then admitted he could have said 'something else' as well because he 'was pretty upset.' Petitioner's testimony about the encounter is internally inconsistent, simply does not make sense intuitively, and is completely contradicted by the credible testimony of the other witnesses involved in the incident."

Petitioner sought administrative review in the Circuit Court of Cook County, which confirmed the Decision of the Commission. Petitioner then appealed to the Illinois Appellate Court.

On appeal, the appellate court ruled that Respondent should not have been allowed to present the latter testimony from Mr. Acred and Mr. Smith. *Mioni v. Illinois Workers' Compensation Comm'n*, 2018 IL App (1st) 180101WC-U, ¶ 39. The court observed that the encounter they had with Petitioner occurred after the conclusion of their initial testimony and thus was not relevant to that initial testimony. *Id.* ¶ 40. The court also ruled that the latter testimony was evidence of other wrongs or acts and thus inadmissible where the sole purpose was to show Petitioner was dishonest. *Id.* (citing Ill. R. Evid. 404(a)(3) (eff. January 1, 2011)).

---

[1] This testimony was admitted over Petitioner's objections. See *Mioni v. Illinois Workers' Compensation Comm'n*, 2018 IL App (1st) 180101WC-U, ¶¶ 20-21.

The court further noted that impeachment on a collateral matter is generally improper. *Mioni*, 2018 IL App (1st) 180101WC-U, ¶ 40 (citing *Adams Truck Lines v. Industrial Comm'n*, 193 Ill. App. 3d 814, 819 (1990)). The court additionally ruled that "the erroneous admission of evidence the trier of fact considered 'clearly relevant' to the 'fundamental' issue in the case cannot be harmless ***." *Mioni*, 2018 IL App (1st) 180101WC-U, ¶ 41. The court concluded that "[g]iven the state of the law and the record, we fail to see how a reasonable person could agree with the Commission. As such, an abuse of discretion occurred." *Id.*

Accordingly, the Illinois Appellate Court reversed the circuit court's judgment, vacated the Commission's decision, and remanded the matter to the Commission "so that the Commission may reconsider its decision while taking into account only appropriate evidence." *Id.* ¶ 43. The appellate court specifically directed the Commission to reconsider all issues but not evidence of the encounter among Petitioner, Acred, and Smith after they had initially testified. *Id.*

The Commission thus turns to reconsider this matter pursuant to the mandate of the Illinois Appellate Court. Timely Petition for Review under §19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator which is attached hereto and made part thereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision to the extent it does not conflict with the Illinois Appellate Court's opinion dated January 11, 2019. The Commission also incorporates by reference the Illinois Appellate Court's opinion, which delineates the relevant facts and analysis, attached hereto and made a part hereof. The Commission's incorporation of the Illinois Appellate Court's opinion specifically includes but is not limited to the facts stated in paragraphs 5 through 30 of the opinion. See *Mioni*, 2018 IL App (1st) 180101WC-U, ¶¶ 5-30. Any additional findings of fact in this Decision and Order on Remand will be specifically identified in the discussion of particular issues.

Having reviewed the Commission's prior decision and the record, and following the opinion and mandate of the Illinois Appellate Court, the Commission concludes that the Decision of the Arbitrator was correct. In finding Petitioner proved a work-related accident, the Arbitrator accepted the testimony of Petitioner and found it forthright, even though he characterized his behavior in the courtroom as childish and noted that he had some anger issues with another witness. The Arbitrator did not find the issue of whether he left a voice-mail message regarding the incident with Mr. Acred determinative because he accepted Petitioner's "testimony regarding

the actual facts of the accident as alleged along with how he as a long time tradesman on a busy construction site, handles such initial physical insults on a job site at the time they occur."[2]

Respondent argues that Petitioner was not credible because: his accident was unwitnessed; the accident occurred on his last day of work; Petitioner did not seek medical attention for a week; the medical records do not make any mention of an accident until the physical therapy records of February 19, 2013; Petitioner did not comply with company policy about reporting accidents even though he was a foreman; and Petitioner threatened Respondent's witnesses. Pursuant to the opinion and mandate of the appellate court, the Commission will not consider the alleged threat mentioned by Respondent.

Regarding Respondent's remaining points, Petitioner did not seek immediate medical attention, but as noted in paragraph 2 of our prior decision, Petitioner testified that this was because the accident date was his last day "for a couple of days" due to a lack of work and he hoped the pain would go away. Also, as noted in paragraph 12 of our prior decision, Petitioner testified that it was common for him to experience bumps and bruises in his job and he did not report all of them. Petitioner's treating physician, Dr. Dragisic, testified that Petitioner told him of the work-related injury during Petitioner's initial visit, explaining that his inexperience while transitioning to electronic records would account for the omission from the medical records. The Arbitrator found the doctor's testimony on this point credible. The Commission agrees. Petitioner may not have followed company policy in reporting the incident, but after excluding the improper testimony, the Commission does not find this omission of sufficient weight to reject Petitioner's testimony regarding the accident and its causal connection to Petitioner's current condition of ill-being.

For all of the aforementioned reasons, the Commission agrees with the Arbitrator and finds that Petitioner met his burden of proof that he sustained a work-related accident and a causal connection between the accident and his current condition of ill-being. The Commission therefore affirms and adopts the Decision of the Arbitrator, which is attached hereto and made part thereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued on August 12, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,320.33 for a period of 75 weeks, that being the period of temporary partial incapacity for work under §8(a) of the Act.

---

[2] The Commission's original decision in this matter doubted whether Petitioner left the voicemail with Mr. Acred, but inasmuch as the dispute primarily concerns notice, the Commission agrees with the Arbitrator that the question is not determinative.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $122,244.53 in medical expenses incurred to date, subject to the applicable medical fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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: SEP 1 - 2020

Barbara N. Flores

BNF-MP/dw
O-7/23/20
46

Marc Parker

Dissent

I respectfully dissent from the majority opinion in this matter. Upon reconsideration as mandated by the Appellate Court, I would have found that Petitioner did not sustain his burden of proving he sustained a compensable accident, affirmed the Commission's initial Decision and Opinion on Review reversing the Decision of the Arbitrator, and denied compensation.

In finding Petitioner proved a work-related accident, the Arbitrator accepted the testimony of Petitioner and found it forthright, even though he characterized his behavior in the courtroom as childish and noted that he had some anger issues with another witness. The Arbitrator did not find the issue of whether he left a voice-mail message to Mr. Acred determinative because he accepted Petitioner's "testimony regarding the actual facts of the accident as alleged along with how he as a long time tradesman on a busy construction site, handles such initial physical insults on a job site at the time they occur."

Respondent argues the Arbitrator erred because Petitioner was not credible. It cites that his accident was unwitnessed, the accident occurred on his last day of work, Petitioner did not seek medical attention for a week, the medical records do not make any mention of an accident until the physical therapy records of February 19, 2013, Petitioner did not comply with company policy about reporting accidents even though he was a foreman, and Petitioner threatened Respondent's witnesses.

Initially, it is established law that the Commission acts as the original trier of fact as does the Arbitrator. Therefore the Commission is not bound by the Arbitrator's assessment of the relative credibility of witnesses. In this matter, I find serious discrepancies between Petitioner's testimony and the medical record as well as internal inconsistencies within his testimony itself. Therefore, I do not find his testimony credible. I consider Petitioner's apparent failure to report the accident/injury to be more problematic than the Arbitrator apparently did. Especially being a foreman, Petitioner had specific knowledge of proper procedures to be followed. Although there was timely statutory notice, the lack of compliance with procedures certainly affects the credulity of his testimony.

Petitioner's testimony is somewhat vague about when exactly he allegedly made the call to Mr. Acred reporting the accident. However, he testified he made the call when he was supposed to return to work. He also testified that he did not call Mr. Acred again after Mr. Acred had not yet returned his call by January 25. Therefore, Petitioner's testimony indicates he called Mr. Acred prior to January 25th and therefore prior to his initial doctor appointment on January 29, 2013. Nevertheless, he testified that in his voice-mail message he informed Mr. Acred of his five-pound restriction. There would not have been any such medical restriction at that time because he had not seen a medical provider. In addition, as a foreman, Petitioner should have been aware of the importance of notifying Respondent about the accident quickly, even if he did not see the need to report it immediately. It also appears unlikely that Petitioner would not have called Mr. Acred again after he did not return the call. Finally, Petitioner's testimony about leaving a voice-mail message was specifically contradicted by Mr. Acred. Therefore, the I am not convinced that Petitioner actually called Mr. Acred and left him a voice-mail message regarding his alleged accident.

In addition, I do not find Dr. Dragisic's testimony persuasive. He testified that he had "somewhat" of a recollection that Petitioner mentioned a work accident; that he thought he remembered something about Petitioner mentioning a work accident, but he was not 100% certain. He then explained that there was probably no mention of that conversation in his records, because they had recently changed to electronic record keeping. That explanation is not very persuasive, especially considering that his testimony about Petitioner's report of an actual work accident was equivocal at best. In this regard, it is noteworthy that his initial January 29, 2013 treatment note indicated that Petitioner presented for a "checkup" without any indication in the record about any acute injury or condition. However, at that time Dr. Dragisic found impingement in the right shoulder, after which Petitioner probably understood the need for substantial prospective treatment.

Also of interest is Dr. Dragisic's treatment note of September 23, 2013. In that note, he wrote that Petitioner reported that it was the first time he could raise his arm over his head for three years. That notation certainly suggests that Petitioner had significant problems with his shoulder prior to the alleged accident. So the record strongly suggests that Petitioner had ongoing problems prior to the alleged accident of January 22, 2013 and the need for substantial treatment was confirmed by Dr. Dragisic's findings of January 29th. The Commission also finds relevant the fact that nowhere in the medical records does any doctor refer to Petitioner's shoulder condition as anything but degenerative; there is no indication whatsoever that Petitioner's pathology was acute or traumatic in nature. In my opinion, the Commission properly reversed the Decision of the Arbitrator based on the above cited factors irrespective of mentioning his alleged intimidation of Respondent's witnesses.

Accordingly, because Petitioner did not report his accident in a manner prescribed by company policy of which as foreman he was clearly aware, because there is no indication in the record that he made any mention of an alleged work accident until his initial physical therapy session almost a month after the alleged accident, because there is no indication in the medical records that Petitioner's pathology was anything but degenerative in nature, and because of discrepancies and inconsistencies in Petitioner's testimony, I conclude that Petitioner's testimony was not credible. Therefore, I would have found that Petitioner did not sustain his burden of proving he suffered a work-related accident on January 22, 2013, reversed the Decision of the Arbitrator as the Commission did previously, and denied compensation.

Deborah L. Simpson

Deborah L. Simpson

DLS/dw
46

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

20IWCC0488

MIONI, FRANK
Employee/Petitioner

Case# **13WC006168**

F E MORAN FIRE PROTECTION
Employer/Respondent

On 8/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% 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:

0391 THE HEALY LAW FIRM
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2284 COZZI GOGGIN-WARD
MARK ZAPF
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

20IWCC0488

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)

Frank Mioni
Employee/Petitioner

Case # **13** WC **6168**

v.

Consolidated cases: ______

F.E. Moran Fire Protection
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 **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **2/25/14, 5/20/14, 11/25/14, and 5/22/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ 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, **1/22/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**106,028.52**; the average weekly wage was $**2,039.01**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **2** dependent children.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**122,244.53**, as provided in Section 8(a) of the Act pursuant to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $**1,320.33**/week for **75** weeks, commencing 2/18/13 through 7/28/14, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner penalties of , as provided in Section 16 of the Act; , as provided in Section 19(k) of the Act; and $ as provided in Section 19(l) of the Act.

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

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

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

01 George Andros
Signature of Arbitrator

8-4-15
Date

ICArbDec19(b)

AUG 1 2 2015

Findings of Fact 13 WC 6168

The Petitioner testified that he has worked as a sprinkler fitter for 15 years. Sprinkler Fitters install overhead fire protections systems, using wrenches and drills to install pipes, valves, and fire pumps that weigh anywhere from a few pounds to several hundred pounds. Photographs depict the size and type of materials he uses. (2/25/14 Tr. P. 14-15, PX13). After carrying the sprinkler pipe into the building, the pipe is lifted up to the ceiling. (2/25/14 Tr. P. 9-10). A job description correlated the same (2/25/14 Tr. P. 13-14, PX12) He was a foreman the last 4 years with additional duties over a fitter. (2/25/14 Tr. P7 & 8-9).

Petitioner testified that he is right handed, and on January 22, 2013 he did not have any problems with his right shoulder. On January 22, 2013 Petitioner was working for Respondent at the premises of Abbot Labs installing a hose valve. He was carrying two 10' 6" long pipes when he slipped on ice and fell with his right arm extended. As he landed, he felt a jerk and pain in his right shoulder. Petitioner stopped working that day and was not scheduled to return to work for the next several days due to a lack of work. (2/25/14Tr. P16—20 plus 36-37).

As to medical care, he asserted that when his pain did not go away he treated with his primary care physician, Dr. Dragisic, one week later. (2/25/14 Tr. p. 19-22). Dr. Dragisic's notes confirm that on January 29, 2013, Petitioner complained of pain to the right shoulder. (Px. 4). After an examination that was positive for impingement, Dr. Dragisic prescribed an MRI, meds, and later a CT and PT by February 6,13.

As to Notice under section 6(c) , he testified that he left a voicemail message shortly after the accident for his superintendent, Scott Acred, that he injured his right shoulder at Abbott Labs. (2/25/14 Tr. P. 22-23, 35, 39). This was contra to the supervisors testimony but Respondent did receive notice within 45 days. None of the witnesses on either side provided testimony that any prejudice ensued under 6(c for late notice by statute or inference given all the forthright testimony by all witnesses; All witnesses seemed ill at ease testifying in contrary to some of the other witnesses recollection of the facts.

Petitioner began physical therapy February 19, 2013. February 25, Dr. Dragisic sent him to an rthopedic specialist, Dr. Jose Perez-Sans, and advised continued physical therapy. (PX4).

Petitioner's initial visit with Dr. Perez-Sanz was April 12, 2013. Tr. P. 24, PX1 Notes confirm that Petitioner presented to Midwest Orthopedic Consultants complaining of pain to the right shoulder as a result of an injury at work on January 23, 2013 when he slipped on ice while carrying pipe and fell on his right shoulder. (PX1). This well known doctor performed a cortisone injection, prescribed an MRI, and instructed Petitioner to remain off work. (PX1).

After an MRI on April 16 he returned to Dr. Perez-Sanz on May 6. Dr. Perez-Sanz proscribed continued PT. Petitioner was released to work light duty, no lifting greater than 5 lbs. (2/25/14 Tr. P. 26, PX1). Petitioner testified that his employer was unable to accommodate his restrictions. (Tr. P. 25, PX1).

Petitioner next saw Dr. Perez-Sanz on June 10, 2013. (2/25/14 Tr. P. 25, PX1). Dr. Perez-Sanz recommended surgery. (2/25/14 Tr. P. 25, PX1). On 6/10/13 the orthopedist recommended surgery which was performed July 2 at the Center for Minimally Invasive Surgery. The operative report reflects a dislocatable right shoulder with impingement. (PX1).

Petitioner returned to Dr. Dragisic on July 29, 2013 for a post-surgical follow up. (2/25/14 Tr. P. 27, PX1). Petitioner was informed that Dr. Perez-Sans performed a labrum repair at the time of surgery. (PX4). Petitioner next saw Dr. Perez-Sanz on September 11, 2013. (PX1). Dr. Perez-Sanz recommended physical therapy, medication, and light duty restrictions of no lifting greater than 10 lbs. Petitioner continued to see Dr. Perez-Sanz in October and November of 2013. During that time, Dr. Perez-Sanz ordered continued physical therapy. (2/25/14 Tr. P. 28, PX1).

Treatment notes of November 11, 2013 indicate that the Dr. Perez-Sanz prescribed a course of work hardening and light duty. (2/25/14 Tr. P. 28, PX1).

Petitioner testified that his January 6, 2014 doctor's appointment with Dr. Perez-Sanz was cancelled because his employer was not paying Petitioner's medical bills. (2/25/14 Tr. P. 29-30). He returned to Dr. Dragisic on January 29, 2014. (2/25/14 Tr. P. 30, PX4) who continued the prescriptions for Vicodin, ibuprofen and off work. (2/25/14 Tr. P. 31, PX4).
Petitioner testified he finished work hardening on February 18, 2014. (2/25/14 Tr. P. 28, PX). At the time of the February 25, 2014 hearing, Petitioner still had pain in the right shoulder and difficulty with overhead lifting. (2/25/14 Tr. P. 31-32).

On May 23, 2014, Dr. Dragisic prescribed an FCE due to Petitioner's request to try to return to work. (PX4) which was done on May 26. The therapist concluded this Petitioner put forth full effort. (PX4). Petitioner was noted to be able to safely lift 50 lbs. (PX4). The Arbitrator notes the absence of any assessment of whether this conclusion considered uneven ground, other body mechanics or a true picture of the body mechanics of a fast paced construction environment. On June 4, 2014 Dr. Dragisic was awaiting the results of the FCE and prescribed Norco for right shoulder pain. Eventually he prescribed additional work hardening to improve strength.

He returned to Dr. Dragisic on July 16, 2014 which was post therapy at which time his medications were refilled. Most importantly, he was released to return to work on July 28, 2014. (PX4).

Dr. Dragisic testified that included in the type of injuries he treats are patients with shoulder injuries. (PX14, P. 5). Dr. Dragisic testified Petitioner told him that he injured his right shoulder at work on January 22, 2013 at his initial visit, even though his office notes do not reflect that history. (PX14, P. 11-13, 27, 31). Dr. Dragisic testified he was relatively new to using electronic medical records which would account for the records not correctly reflecting Petitioner's initial history. (PX14, P. 12-13).

The Arbitrator carefully studied the testimony of Ryon Hennessey M.D. , Respondent section 12 examiner, who is a spinal fellow by his testimony but has a general orthopedic practice at Elmhurst and Gottlieb Hospital. They key in analyzing his straight forward opinions is as follows: If you believe that the worker told his treating doctor at the initial presentation that he hurt himself at work albiet to the shoulder, then causal connection is in the affirmative for the worker relative to surgery and diagnosis.

In fact, the Arbitrator so concludes that he did give the history to his doctor but as per Dr. Dragisic's credible testimony his unfamiliarity to electronic recordation was the cause of its omission.

Relative to causation in the case, Dr. Dragisic reviewed the "Sprinkler Fitter Job Elements" submitted as PX12 and stated that the document accurately reflected the work activities of Petitioner as described by Petitioner. Dr. Dragisic confirmed Petitioner's work activities as a sprinkler fitter caused or contributed to cause the injury to his right shoulder seen at the time of surgery. (PX14, P. 19-21).

Respondent's presented the testimony Scott Acred who testified he is a field superintendent for Respondent He confirmed that Petitioner was a field foreman. (P. 63).
Relative to notice under 6(c, while Mr. Acred denied receiving a voice message from Petitioner shortly after the accident, he confirmed that Respondent was notified of Petitioner's accident within 45 days of the January 22, 2013 accident. (2/25/14 Tr. P. 80-83, 89). Mr. Acred also testified that Respondent trusted Petitioner to be the owner's representative on the jobsite, run the work, and be responsible for the men and the material on the job. (2/25/14 Tr. P. 80-81).

Additionally, Mr. Jeff Smith testified that he is a superintendent for F.E. Moran. (2/25/14 Tr. P. 95). Mr. Smith testified that he saw Petitioner riding a motorcycle in June of 2013. (2/25/14 Tr. P. 99). Mr. Smith also confirmed that Respondent trusted Petitioner to be the owner's representative on the jobsite, run the work, and be responsible for the men and the material on the job. (2/25/14 Tr. P. 102-103). The Arbitrator sees no contraindication in any doctor record or FCE, or by inference, that he could have lifted in the field per job description. Mr. Smith said prior to 1/22/13 he worked with Petitioner conceding Petitioner did not have any problems performing his job duties nor problems with his right shoulder. (P. 115-116).

Respondent also presented the testimony Steve Melville, a private investigator for Gateway Investigations. (5/20/14 Tr. P. 123). Admitted into evidence over Petitioner's objection was

Respondent's video surveillance taken on June 22 and 23 of 2013. (5/20/14 Tr. P. 135, RX5).
Mr. Melville acknowledged that at no time did he see Petitioner working, performing yardwork, or installing overhead pipe. (5/20/14 Tr. P. 149-156). He also conceded he does not have any medical training. (5/20/14 Tr. P. 143). A review of the surveillance video indicates there are gaps in the footage. (RX5). Specifically, Mr. Melville conceded that the video does not accurately depict all of Petitioner's activities. (5/20/14 Tr. P. 158-161, 161-164, 164-167, 168-172, 172-173, 173-174, 175, 180-181, RX5). The June 22, 2013 surveillance shows Petitioner tossing a beanbag weighting 2-3 oz. for about 14 minutes underhand. (5/20/14 Tr. P. 178-180). The video does not show Petitioner performing any activities outside of Petitioner's restrictions. (RX5). Mr. Melville conceded that the video taken does not depict all of Petitioner's activities during the time that he was under surveillance. (5/20/14 Tr. P. 180-181). At no time does the surveillance show any strenuous activity, heavy lifting, working or performing activities outside of his restrictions. (RX5).

The testimony of the investigator was very weak about the necessity to stop and start the recordation. Despite these ranglings, no medical opinion asserts this worker violated his restrictions nor can any reasonable inference be made he is a symptom magnifier especially given the medical records content.

As to the issue of 8 (j credit as reflected in the stipulations, Respondent also presented the testimony of Joyce Ward, the comptroller of F.E. Moran. Ms. Ward was unable to testify whether the medical bills paid by Sprinkler Fitters' L.U. 281 plan would have been paid irrespective of any accidental injury under the Workers' Compensation Act. She testified essentially that the Respondent paid money on behalf of Mr. Mioni into the union health and welfare plan according to the collective bargaining agreement of which the Respondent is a signatory.

The Arbitrator inferred this witness did not and would not have any reason to know whether the 281 plan actually paid any given medical bill incurred by the above facts or in what amount. Ms. Ward was very accurate as to her knowledge of the payroll system along with the payroll and deductions for Mr. Moran.

Conclusions of Law

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

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

Based upon the totality of the evidence, the Arbitrator finds that this Petitioner sustained an accident in the course and scope of his employment as alleged in the case at bar.

The Arbitrator adopts the testimony of Mr. Mioni as to the facts of the accident in the case at bar. The worker was subjected to lengthy, pointed and well prepared cross examination on each and every assertion. He answered forthrightly.

The dispute regarding which witness was more accurate about a voice message that day is not determinative on the issue of accident. Despite the Petitioner's sometimes strange and seemingly childish behavior in the courtroom and his possible anger issue with another witness for disagreeing with him, the Arbitrator accepts his testimony regarding the actual facts of the accident as alleged along with how he as a long time tradesman on a busy construction site, handles such initial physical insults on a job site at the time they occur.

As to causation, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. In determining that an employee was entitled to compensation for aggravation of a preexisting injury the Commission in many prior cases noted that a petitioner was in good health prior to the fall, he had no restrictions prior to his fall, and following his accident I he suffered a marked decrease in his health and ability to function at work.

It is well settled that an injury is received in the course of employment if it occurs within a period of employment, at a place where the worker may reasonably be in the performance of his or her duties, and while fulfilling those duties or engaged in something incidental thereto. Saunders v. Industrial Commission, 189 Ill.2d 623, 727 N.E.2d 247, 244 Ill.Dec. 948 (2000).

Based upon the totality of the evidence in this protracted and contentious hearing , the Arbitrator finds that Petitioner's right shoulder injury is causally connected to his work accident on January 22, 2013. Specifically, the Arbitrator finds that Petitioner sustained an impingement and a labrum tear as a result of the work incident on January 22, 2013 that necessitated surgical repair. After all was said and done , no fraud or wrong doing by any participant was borne out; The video was basically useless on any issue. The Arbitrator adopts the opinions of both treating doctors. Petitioner testified that he did not have any problems with his right shoulder nor seek treatment to his right shoulder. The Arbitrator finds Petitioner's testimony to be persuasive despite his sometimes juvenile presentation.

Dr. Perez-Sans diagnosed Petitioner as suffering from an impingement and labral tear of the right shoulder. Dr. Dragisic testified that the right shoulder conditions were work related. (PX14). The Arbitrator notes that Petitioner's co-worker and supervisors confirmed Petitioner's testimony concerning his job activities and physical condition in January, 2013.

(D) What timely notice of the accident given to Respondent?

Illinois statute requires that a claimant must provide notice of an accident "to the employer as soon as practicable, but not later than 45 days after the accident." 820 ILCS 305/6(c). Section 6(c) further holds that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." Id. Illinois courts have liberally construed Section 6(c), stating that "a claim is only barred if no notice whatsoever has been given," and "[i]f some notice has been given, but the notice is defective or inaccurate, then the employer must show that he has been unduly prejudiced." Tolbert v. Ill. Workers' Compensation Commission, 2014 IL App (4th) 130523WC (2014).

There is no dispute that Petitioner filed his Application for Adjustment of Claim on February 25, 2013, within 45 days from the January 22, 2013 date of accident. Furthermore, Respondent's Superintendent Scott Acred admitted F.E. Moran was aware of the incident within 37 days of the accident.

Based upon the totality of the evidence and a clear reading of the statute 6(c, The Arbitrator finds that Petitioner gave proper notice of the claim of injury to Respondent.

(J) Were the medical services that were provided to Petitioner reasonable and necessary?

Petitioner submitted the following medical expenses without objection concerning reasonableness and necessity:

Exhibit 5 – Midwest Orthopedic Consultants: $2,518.00;
Exhibit 6 – Therapy Providers: $5,157;
Exhibit 7 – Dr. Peter Dragisic: $3,805;
Exhibit 8 – Advanced Orthopedic and Spine Care: $26,794.00;
Exhibit 10 – Center for Minimally Invasive Surgery: $49,300.00;
Exhibit 11 – Chicago Ridge Radiology: $1,061.00;
Exhibit 15 – Epic Surgical Solutions: $1,550.00;
Exhibit 16 – ATI Physical Therapy: $32,059.53.

The Arbitrator finds based upon the totality of the evidence Respondent is liable to the Petitioner his attorney under section 8 for medical expenses by the above providers per fee schedule.

(L) What amount of compensation is due for Temporary Total Disability?

Based upon the totality of the evidence, The Arbitrator finds that Respondent is liable to pay to the Petitioner and his attorney temporary total disability benefits from the date of Dr. Dragisic's initial off work slip, February 18, 2013, to July 28, 2014 when he was released to work by Dr. Dragisic in the amount of $1,320.33 per week for 75 weeks.

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

Artur Kustosz,

Petitioner,

20IWCC0489

vs.

NO: 18 WC 25095

Illinois Home Improvement DBA
Best Brickmasters,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employer/employee relationship, accident, benefit rates temporary disability and bills and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 10, 2019, is hereby affirmed and adopted with the changes noted above.

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

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

DATED: SEP 1 - 2020
o7/23/20
DLS/rm
46

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20 IWCC0489

KUSTOSZ, ARTUR Case# **18WC025095**
Employee/Petitioner

ILLINOIS HOME IMPROVEMENT DBA BEST BRICKMASTERS
Employer/Respondent

On 9/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4128 RUBENS KRESS & MULHOLLAND
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
SEAN ANTHONY PETERS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

20IWCC0489

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)

Artur Kustosz
Employee/Petitioner
v
Illinois Home Improvement DBA Best Brickmasters
Employer/Respondent

Case # **18 WC 025095**

An *Application for Adjustment 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 **March 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [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. [ ] 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

A. Kustosz v. Illinois Home Improvement, etc., 18 WC 025095

FINDINGS

On the date of accident, **8/11/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$21,810.00**; the average weekly wage was **$0**.

On the date of accident, Petitioner was **52** 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 $**5,600.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**5,600.00**.

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

ORDER

Claim for compensation denied. Petitioner failed to prove that he had an employee/employer relationship with Respondent.

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

September 9, 2019

Date

ICArbDec19(b)

SEP 10 2019

INTRODUCTION

At the beginning of the trial, Petitioner made a motion to amend the Application and name the Respondent as: Illinois Home Improvement DBA Best Brickmasters. The Motion was granted. A copy of the Amended Application was admitted as Arbitrator's Exhibit 2.

Respondent made an oral motion to dismiss the case based upon Petitioner's election to exclude himself from coverage under the Act under §3(20) of the Act. The motion was denied and the case proceeded to trial on the merits.

Petitioner testified via Polish/English interpreters.

The Arbitrator redacted Tax I.D. and bank account numbers from the following exhibits, in order to comply with Supreme Court Rule 138: PX 3, PX 4, RX 4 and RX 5.

FINDINGS OF FACT

Petitioner testified that he worked as a roofer exclusively for Best Brickmasters and Illinois Home Improvement beginning in December of 2017. In addition to performing work as a roofer, he protected materials from water damage, installed parapets and drains, demolished brick, and did carpentry work. Some of the jobs Petitioner worked on could be completed by himself, while other jobs required two or more people because of safety reasons and practicality. Petitioner testified he had an exclusive contractual agreement to only perform work for Respondent.

Petitioner testified he always reported to work at Respondent office, located at Elston and Cicero in Chicago, at 6:30 in the morning and punched in on a time card. Petitioner would then receive his work assignments for the day and would come back after finishing his work to punch out. Petitioner testified he kept a log sheet of the times and locations of the jobsites he worked on and sent picture updates of the work to Mr. Wrobel. Petitioner used Respondent's tools and machines that he could not transport himself, including 30 foot ladders, a break machine weighing approximately 400 pounds, drills, crowbars, paint, and brushes. Petitioner testified he was required to wear a shirt with Respondent's company logo on it. He also wore his own shirts at times. Petitioner was not allowed to speak with Respondent's clients at the job sites.

Petitioner testified he was never self-employed, never had employees, and never "had an incorporation," adding he was not able to do so without a car. Petitioner denied making Respondent aware that he had his own company. Instead, Petitioner testified he utilized an entity known as Artur Kustosz Construction for tax benefits only. The Arbitrator notes Petitioner provided three different responses as to when he opened a bank account for Artur Kustosz Construction. The Arbitrator finds that Petitioner established the Artur Kustosz Construction bank account three months before December of 2017, when he was driving trucks.

Petitioner testified that he was paid $30.00 an hour by Respondent and was compensated on a bi-weekly basis via checks made out to Artur Kustosz Construction. (PX 4) Petitioner testified that his paychecks were initially made out to Artur Kustosz, but Respondent later changed the payee to Artur Kustosz Construction. Petitioner stated taxes were not taken out of his paychecks at his request. Petitioner said he sometimes received cash that he described as "some chump change" and "some small amount of cash" in an envelope with his paycheck.

Petitioner thought the cash payments came from Peter Zieba; but also testified he never received cash from Mr. Zieba.

Petitioner denied he was the sole proprietor of Artur Kustosz Construcion. Respondent introduced Petitioner's tax forms and completed W-9 tax form for "Artur Kustosz Construction" stating Petitioner was the sole proprietor of this company and signed by him, under the penalties of perjury. (RX 4)

Petitioner identified his tax returns from 2015-2018. (RX 5) When questioned about his 2018 tax returns, Petitioner said he was not aware that he had listed his occupation as self-employed, and that this was incorrect. Petitioner testified he completed a Schedule C-EZ (Form 1040) for a sole proprietorship listing only himself as the proprietor, his home address for the business address, and "Construction" as his principal business. Petitioner further completed a Form 1040 for self-employment tax, a qualified business income component worksheet, and qualified business income deduction simplified worksheet for his construction company. Petitioner signed the tax forms. (RX 5)

Petitioner testified his entire income from the year 2018 came from Respondent, and that he completed the calculations himself because he did not receive any paperwork or a 1099 from Respondent. A 1099-MISC form that he received from Respondent listing nonemployee compensation in the amount of $24,535.00 paid to his sole proprietorship, Artur Kustosz Construction. (RX 5, RX 7) Petitioner admitted to declaring a net profit from his sole proprietorship of $40,000.00. Petitioner did not agree with the amount declared. He later estimated he made approximately this amount, believing the "chump change" he received in cash boosted his income to approximately $40,000.00. Petitioner also attached a 1099-MISC form from Peter Zieba Consulting, listing nonemployee compensation in the amount of $1,390.00 to his sole proprietorship, Artur Kustosz Construction. (RX 5) Petitioner initially testified he received this compensation. He later testified he never received a check from Peter Zieba Consulting. Petitioner acknowledged that he never received or completed a W-2 form for the 2018 tax year.

Regarding Petitioner's tax returns for the 2015, 2016, and 2017 years, Petitioner listed his occupation as self-employed, completed a Schedule C-EZ (Form 1040) for a sole proprietorship listing himself as the proprietor, his home address for his business address, "Construction" as his principal business, and completed a Form 1040 for Self-Employment Tax. Petitioner testified he worked for somebody in 2017, but he did not attach a W-2 or list any income received from employment wages for either of the three years. (RX 5)

Petitioner testified he was not requested by Respondent to obtain his own workers' compensation insurance. When provided with a copy of the policy listing his construction company and home address at trial, Petitioner initially testified that he had never seen these documents before. Petitioner testified the policy he paid for was sent to Respondent and not him. Petitioner denied stating on the policy that he was a sole proprietor of Artur Kustosz doing business as Artur Kustosz Construction. He denied that he excluded himself on said policy as a sole proprietor. Subsequently, Petitioner admitted he did in fact receive a copy of the policy at his home. The policy does show that Petitioner opted out of coverage for himself. (RX 3)

Petitioner testified that on August 11, 2018, he was using an approximately five foot ladder provided by Respondent to hang drywall, when the ladder broke underneath him causing him to fall. Petitioner testified that one of the supports on the ladder was broken, and the other one was barely attached. Petitioner was working with a co-worker at the time of the fall. Petitioner said that he injured his right leg when he fell.

After the fall, an ambulance was called and Petitioner presented to the Emergency Room at St. Francis Hospital. Petitioner remembered he was given pain medication that he described as "real strong," which affected his memory. He did remember asking for an interpreter which he said he did not receive. The medical records state Petitioner requested and then refused a language interpreter. (PX 1)

Petitioner discharged from St. Francis on August 17, 2018. On August 11, 2018, Petitioner was noted in the field to have hypotension with blood pressure 90/40. Petitioner reported he felt dizzy and then missed a step on the ladder which caused him to fall. Petitioner had an anemia evaluation the same day that documented a past medical history significant for hypertension and gout, for which Petitioner had been taking medication daily. Petitioner was said to endorse having some dizziness just prior to his fall from a ladder. There is no notation of a broken or defective ladder, other than it was said to be "old". (PX 1)

On August 13, 2018, Petitioner underwent right knee surgery by Dr. Saper. The procedures performed included a right bicondylar tibial plateau fracture open reduction and internal fixation, and a right lateral meniscus repair. (PX 1)

On August 16, 2018, Petitioner underwent a colonoscopy by Dr. Chorba. Dr. Chorba recorded a history that Petitioner was having trouble with his rectum and he knew about it for a couple months and had been feeling weak prior to his fall. (PX 1) Petitioner denied this history.

Subsequently, Petitioner treated with Dr. Saper between September 11, 2018 and February 12, 2019. (PX 2) Petitioner received one injection into his knee and has remained off work.

Petitioner testified that he has pain. He has difficulty standing up. He has difficulty walking. He did not complete PT, due to financial reasons. He can't afford PT. He has no health insurance. He has received $5,600.00 in payments of TTD, as is shown on ArbX 1. He had no prior injuries to his right knee and no subsequent injuries. He did have a prior foot injury.

Eric Wrobel testified that he has been the President of the Respondent for approximately 24 years, with job duties including day-to-day operations, meeting clients, creating estimates, and overseeing office tasks and payroll. (T. 115-116). Illinois Home Improvement specializes in exterior renovation of buildings, repairs of exterior walls, siding, windows, cornice repairs, and some minor roof repairs associated with masonry work. Wrobel said that Best Brickmasters is a division of the Respondent specializing in masonry work. Respondent has ten employees who are divided into different crews, some of whom specialize in brick and masonry work, and some of whom perform repairs on the outside of structures - - repairs of the roofing, some light framing, siding, and windows. Respondent also had sixteen independent subcontractors during the 2018 year. These independent contractors performed a number of tasks, including electrician work, plumbing, heating and cooling, painting, dry walling, masonry, and roofing.

Wrobel testified that he first met Petitioner when he interviewed him in March of 2018. During the interview process, Petitioner told Mr. Wrobel that he had approximately twenty years of experience in construction, listing off a number of skills, including framing, window installation, roof repairs, siding, drywall repairs, and painting. Mr. Wrobel testified Petitioner advised him that he owned his own construction company, Artur Kustosz Construction, under which he had been working as an independent subcontractor for many years. Wrobel testified that Petitioner and his construction company agreed to perform work for Respondent through a verbal agreement. This was not an exclusive working relationship and Petitioner was free to work for other

construction companies as well. Respondent had similar verbal contracts with other independent subcontractors.

Respondent requires independent subcontractors to have workers' compensation insurance. Wrobel stated that Petitioner provided him with documentation that his company, Artur Kustosz Construction, obtained workers' compensation insurance and a certificate of liability of insurance. (RX 3) Wrobel testified he did not direct Petitioner to a specific insurance company or offer to pay for half of the policy Petitioner obtained. Petitioner did testify that Wrobel agreed to pay for half of the premium.

According to Wrobel, Respondent utilized Artur Kustosz Construction for window installation, siding, roof repairs, painting, and light framing. According to Wrobel, some of the jobs Petitioner could perform on his own, but a majority of the jobs required more than one person for safety reasons and practicality. Petitioner never worked for Best Brickmasters, as he was not qualified as a mason. If Petitioner was looking for work, he would show up to Respondent's office in the morning and ride as a passenger in Respondent's vans to the jobsite. Wrobel said Petitioner did not have his own means of transportation to get to the jobsites because of his financial situation. Wrobel testified this was not uncommon, as Respondent also offered to assist in transporting other independent subcontractors to and from the jobsites from time to time. No one was required to ride in Respondent's vehicles to the jobs.

Wrobel testified that Respondent's employees were required to report for work when scheduled and, if they did not, they would be subject to reprimand or possible termination. Wrobel testified that, because Petitioner worked on an as needed basis, he was not subject to discipline if he did not show up for work. For example, Petitioner did not show up to the job site for a week or so and was not disciplined or terminated.

Mr. Wrobel testified that, in regard to a construction site, all of the work being performed by Respondent's employees and independent subcontractors required some supervision. A foreman was present on the job site to ensure that the work being completed was done correctly. Petitioner was assigned work with an end result in mind, but it was up to him to determine how to perform the work in order to achieve the end result, given his approximate twenty years of experience. If Petitioner completed work that did not meet the end result required, then Respondent would offer suggestions or input to help or assist Petitioner in completing the work. Mr. Wrobel testified that very often Petitioner offered his own advice on how to complete a job because of his experience, and Respondent would take this advice into consideration.

Wrobel testified that Petitioner was not required to wear an Illinois Home Improvement or Best Brickmasters uniform. Instead, Respondent handed out branded clothing regularly, and almost anyone could obtain a shirt with Respondent's name on it, including people who do not have any relation to the work place. Mr. Wrobel also testified Petitioner was required to bring his own hand tools and some select power tools to the job, as is expected on almost all job sites. Petitioner was not required to supply his own ladders, heavy machinery, paint, or drywall. Mr. Wrobel said these materials were also supplied to other independent subcontractors, and Respondent did not require anyone to transport these materials to the jobsite on their own.

Regarding compensation, Wrobel testified that during his initial interview with Petitioner, they reached an oral agreement that Petitioner would be compensated on an hourly basis and both parties would keep track of the hours worked to ensure Petitioner's time spent on a jobsite was accurate. Petitioner was paid on a bi-weekly basis at $28.00 an hour, checks were made out to Artur Kustosz Construction, and taxes were not withheld from the checks, per Petitioner's request. (RX 1; PX 4) Wrobel testified that Respondent paid its employees on a bi-weekly basis at a similar or lower rate than Petitioner, checks were made out to the employees themselves, and

taxes were withheld from their paychecks. Respondent issued employees a W-2 form. However, because Petitioner was an independent subcontractor, Respondent obtained a W-9 from Petitioner and issued him a 1099. (RX 4; RX 7)

Respondent rarely performed work on Saturdays; however, Petitioner requested to perform work on August 11, 2018, which was a Saturday, to finish a job that he had lasted several days. Specifically, Petitioner was requesting to finish up some drywall, painting touch-ups, and moving some equipment from the job site. For safety reasons, Wrobel sent one of Respondent's employees to drive their truck with Petitioner to the job site, and to help Petitioner load equipment onto the truck which sometimes required two people. Wrobel stated no one was on the job site to supervise the manner in which Petitioner was performing the work. It was up to Petitioner to determine how to complete the work in order to achieve the end result.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law that follow.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

At the beginning of his testimony, Petitioner was advised of the proper procedures utilized when testimony via an interpreter is elicited. He said that he understood. There were times where he was non-compliant and he had to be instructed to not volunteer and to answer the question that was asked. The Arbitrator does not find that Petitioner is unsophisticated. He was being evasive. Wrobel's testimony is found to be credible. To the extent that Petitioner's testimony differs from that of Mr. Wrobel and the medical records, the testimony of Wrobel and the medical records are believed by the finder of fact herein.

In support of the Arbitrator's decision relating to (A) Whether Respondent on August 11, 2018 was operating under the Illinois Workers' Compensation Act and (B): Whether the relationship between Petitioner and Respondent on that date was one of employee and employer, the Arbitrator finds:

Respondent was operating under the Act on the date of accident, per §§3(1), (2), (8) and (15) of the Act.

The Arbitrator is not impressed with the relationship that Petitioner and Respondent elected to structure for work performed by Petitioner for Respondent. Both Petitioner and Wrobel knew the consequences of the subcontractor/contractor relationship that they entered into. They both were trying to avoid the expenses of payroll taxes, unemployment taxes and wage and hour laws, along with workers' compensation insurance premiums in structuring their relationship as they did. Petitioner and Wrobel do have a level of sophistication regarding construction business relationships and that persuades the Arbitrator that neither took advantage of the other in their relationship. Shame on them both for not defining the relationship in a written agreement.

As to the issue of Employee/Employer, the Arbitrator finds that Petitioner failed to prove that he had an employee/employer relationship with Respondent.

A. Kustosz v. Illinois Home Improvement, etc., 18 WC 025095

According to the Supreme Court, an employment relationship is a prerequisite for an award of benefits under the Act. A fact specific inquiry is required to determine whether an employment relationship exists. The Parties designation of their relationship is not controlling, but may be considered, along with the following other factors: 1.) Respondent's right to control the manner in which Petitioner performs the work; 2.) Does Respondent dictate Petitioner's schedule? ; 3.) Is Petitioner paid hourly, or on a per job basis? ; 4.) Are taxes and social security withheld from the payments to Petitioner? ; 5.) Does Respondent's business encompass Petitioner's work? 6.) Can Petitioner be discharged at will? . Roberson v. The Industrial Commission, 225 Ill. 2d 159 (2007)

First, Petitioner's tax forms establish that he ran his own construction business since at least 2015. Petitioner established the bank account for Artur Kustosz Construction at least 3 months before entering into any relationship with Respondent. This is persuasive evidence that Petitioner was an independent contractor and that he intended to be so.

Regarding the issue of control of the manner of the work, the proofs do not show that Respondent dictated or controlled the manner in which Petitioner performed construction tasks. While Respondent supplied job materials, ladders and heavy equipment like a break press, this is more of the nature of the construction project. There was no evidence that Respondent was monitoring Petitioner's work in a detailed manner. Respondent's level of control over Petitioner's work does not persuade the Arbitrator that Petitioner was an employee of Respondent.

Petitioner's schedule was dictated by when he showed up for work at Respondent and whether there was work available. He was free to work on other jobs and was not disciplined for not showing up for work on any given day. This factor does not support an employment relationship.

Petitioner and Respondent agreed that Petitioner was paid hourly, with both Parties monitoring his hours. This factor does weigh in favor of Petitioner being an employee, but given the haphazard attendance requirements of the relationship, it will not persuade the Arbitrator that Petitioner was an employee (he could not be paid on a per job basis if it was not certain that he would show up to finish the work).

Petitioner and Respondent agreed that Artur Kustosz Construction received a Form 1099 from Respondent at the end of the year and that no taxes or Social security was deducted from payments to it. There was no testimony that Petitioner received employee benefits such as paid time off, vacation or health insurance from Respondent. Checks were made out to Artur Kustosz Construction and were apparently deposited in its bank account. This factor implies that there was no employment relationship.

Respondent's business certainly encompasses Petitioner's work, but Artur Kustosz Construction's primary business was said to be "construction". This factor is not persuasive on the issue of employee/employer, given the remainder of the evidence.

There was no evidence on the issue of whether Petitioner could be discharged at will. This should have been addressed in a written agreement. Given the lack of evidence, this factor is given no weight on the issue of employment relationship.

Petitioner was able to work elsewhere than at Respondent. This weighs against the existence of an employee/employer relationship.

Artur Kustosz Construction obtained workers' compensation insurance had a bank account, thus implying that it was a distinct entity from Petitioner and actually negating an employee/employer relationship with Respondent.

Petitioner has the burden of proof on the issue of employee/employer relationship and the Arbitrator finds that the preponderance of the evidence does not support a finding that such a relationship existed.

The claim for compensation is, therefore, denied.

REMAINING ISSUES

As the Arbitrator has found that Petitioner failed to prove that an employee/employer relationship existed between him and Respondent, the Arbitrator needs not decide the remaining issues of: Accident; Notice; Causal Connection; Wages; Incurred and prospective medical expenses; and TTD.

Regarding the issue of Average Weekly Wage, the Arbitrator calculated the AWW based upon Petitioner's tax forms. He was paid no wages. A claimant's business income should not be included in the calculation of the Average Weekly Wage. Cindy Mansfield v. The Illinois Workers' Compensation Comm'n , 2013 IL App (2d) 120909WC (2013) Thus, there was a failure of proof on the issue of wages.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF WILLIAMSON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM TAITT,

Petitioner,

20 IWCC0490

vs.

NO: 18 WC 5103

ARDENT MILLS,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission hereby incorporates by reference the findings of fact contained in the Decision of the Arbitrator. However, following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to find that Petitioner sustained a loss of 25% MAW based upon its analysis of the Section 8.1(b) statutory factors.

In reviewing permanent partial disability, the Commission must consider the Section 8.1(b) enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to 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 as corroborated by treating medical records. 820 ILCS 305/8.1b(b) (West 2014). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

Regarding criterion (i), Dr. Kevin Rutz used the AMA 6th Edition Guidelines to provide what he referred to as a "permanent partial impairment rating" or "permanent partial disability rating" of 5% of the whole body. Dr. Rutz conveyed this rating in his Section 12 report dated December 17, 2019 and not a separate AMA impairment report. The Commission assigns some weight to this factor.

Regarding criterion (ii), Petitioner was employed as a relief man on the accident date. Dr. Matthew Gornet released him to return to his full duty work with no restrictions as of August 12, 2019. However, Respondent let Petitioner go on the day he was returned back to work, because he had "pointed out" of their system in part due to his time off work for his injury. Petitioner thereafter began driving a forklift for a company called TG in September of 2019, but he left that job because bouncing in and out of the trailers caused bruising and was hard on his incision site. At the time of the arbitration hearing, Petitioner was employed by Stark Truss assembling walls. Petitioner testified that he was able to handle all the job duties in his current heavy demand level of this position. The Commission assigns moderate weight to this factor.

Regarding criterion (iii), Petitioner was 38 years old on the accident date and still has significant time left in the workforce. The Commission assigns intermediate weight to this factor.

Regarding criterion (iv), Petitioner's average weekly wage for Respondent was $1,071.63. However, in his current position at Stark Truss, Petitioner works 40 hours per week at a payrate of $11.00 per hour, an approximately 60% decrease in average weekly wage to $440.00. The Commission assigns significant weight to this factor.

Regarding criterion (v), Petitioner treated his low back condition with an anterior decompression and disc replacement surgery at L4-L5, injections, physical therapy, prescription medication, and time off work. Petitioner last treated with Dr. Gornet on December 2, 2019, at which time he was placed at maximum medical improvement. Dr. Gornet nevertheless indicated that Petitioner continued to have a low level of pain with increased activity that would likely be permanent. At the time of the arbitration hearing, Petitioner testified that he was able to return to most of his daily activities and no longer got Charley horses in his right leg or tingling. However, he still experienced low back soreness after a long day of work, when doing heavy overhead lifting, and when going for walks, climbs, or hikes with his daughter. To manage the soreness, Petitioner takes Ibuprofen three to four times a week and puts Icy Hot on each night before bed and indicated that his symptoms were related to his activity level in that the more he does, the worse it hurts. Petitioner further testified that he had only been fishing a couple times since his accident, because he has difficulty getting the boat into the lake and sitting on the boat for long periods of time. The Commission assigns intermediate weight to this factor.

Upon consideration of these factors, particularly Petitioner's age and associated work-life expectancy and drastic reduction in earnings as a result of "pointing out" which is related to the amount of sick time Petitioner was required to take off as a result of his accident at work, the Commission finds that Petitioner has sustained a loss of 25% MAW. The Commission modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 18, 2020, is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $642.98 per week for a period of 125 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused a loss of 25% MAW.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: SEP 1 - 2020

Barbara N. Flores

DLS/met
O- 8/6/20
46

Marc Parker

DISSENT

I respectfully dissent from the Decision of the majority and would have affirmed and adopted the Arbitrator's permanent partial disability award of 17.5% MAW.

Although Petitioner's current average weekly wage is substantially less than it was for Respondent, the record failed to establish that Petitioner's disability was the actual cause of a negative impact to his future earning capacity. Petitioner was released by Dr. Gornet to return to full duty work with no restrictions as of August 12, 2019 and thereafter found employment at Stark Truss in a heavy demand level position. As Petitioner testified that he can handle all of his current work duties, it does not appear that Petitioner's present disability level restricts his ability to find or maintain other work at the heavy demand level. Moreover, there was no evidence presented regarding any of Petitioner's job searches or the available labor market in order to properly evaluate Petitioner's earning capacity.

With no permanent work restrictions and no labor market survey to speak to Petitioner's earning potential, the record does not clearly establish that Petitioner's disability diminished his future earning capacity. The record also failed to explain what Respondent's point system entitled. As no details were provided as to how the points system worked, it is not clear how Petitioner's injury affected his points compared to his other hospitalization for diverticulitis.

Moreover, the treatment records show that Petitioner continually improved after undergoing his lumbar surgery. Shortly before Dr. Gornet returned him to full duty work,

Petitioner asked to be discharged from physical therapy on July 12, 2019, because he stated that he was completely comfortable returning to his work duties. At that time, Petitioner indicated that he felt therapy was no longer appropriate, as he was even more active outside of therapy.

At the arbitration hearing, Petitioner further characterized his surgery as successful. Although Petitioner experiences ongoing residual soreness with increased activity, he does not require any prescription medication. Petitioner further testified that he was able to get back to most of his daily activities, including walking with his daughter, going on hikes, working on his vehicles, and returning to his normal life.

In consideration of the above, I respectfully dissent from the majority's increase of Petitioner's permanent partial disability award and would have affirmed and adopted the Decision of the Arbitrator.

DLS/met
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 IWCC0490

TAITT, WILLIAM
Employee/Petitioner

Case# **18WC005103**

ARDENT MILLS
Employer/Respondent

On 2/18/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0000 WIEDNER & McAULIFFE LTD
JAMES A TELTHORST
8000 MARYLAND AV SUITE 550
ST LOUIS, MO 63105

20IWCC0490

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

William Taitt
Employee/Petitioner

Case # 18 WC 05103

v.

Consolidated cases: n/a

Ardent Mills
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on January 14, 2020. By stipulation, the parties agree:

On the date of accident, January 25, 2018, 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 $55,724.76; the average weekly wage was $1,071.63.

At the time of injury, Petitioner was 38 years of age, married, with 4 dependent child(ren).

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

Respondent shall be given a credit of $26,229.42 for TTD, $0.00 for TPD, $0.00 for maintenance, and $6,180.00 for other benefits (PPD advance), for a total credit of $32,409.42.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $642.98 per week for 87.5 because the injuries sustained caused 17 1/2% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from December 2, 2019, through January 14, 2020, and shall pay the remainder of the award, if any, in weekly payments.

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

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

William R. Gallagher, Arbitrator

February 8, 2020
Date

FEB 18 2020

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 by Respondent on January 25, 2018. According to the Application, Petitioner was "Pulling hose, stepped backwards into hole in floor" and sustained an injury to his "Low back, right leg, body as a whole" (Arbitrator's Exhibit 2). At trial, the only disputed issue was the nature and extent of disability. Petitioner and Respondent also stipulated Respondent had paid Petitioner advance payments of permanent partial disability in the amount of $6,180.00 and Respondent was entitled to a credit for same (Arbitrator's Exhibit 1).

This case was previously tried in a 19(b) proceeding on November 27, 2018. At that time, the only disputed issue was Petitioner's entitlement to continued temporary total disability benefits. The Arbitrator ruled in favor of Petitioner and his Decision was filed with the Commission on December 22, 2018. Respondent filed a review of the Arbitrator's Decision to the Commission. On September 30, 2019, the Commission entered its Decision and Opinion on Review which affirmed the Arbitrator's Decision awarding temporary total disability benefits to Petitioner (Petitioner's Exhibit 11).

As noted in the Commission's Decision, Petitioner's primary treating physician was Dr. Matthew Gornet, an orthopedic surgeon, who recommended Petitioner undergo disc replacement surgery at L4-L5. Respondent had Petitioner examined by Dr. Kevin Rutz, an orthopedic surgeon, who opined the back surgery recommended by Dr. Gornet was within the appropriate standard of care (Petitioner's Exhibit 11).

At the time Petitioner sustained the accident on January 25, 2018, he worked for Respondent as a relief man. Petitioner sustained the accident as he was in the process of attempting to unclog a flour pipe with an air hose. As Petitioner was unrolling the hose, it got caught and while Petitioner was pulling on it and walking backward, his left leg went through a hole in the floor.

As was noted in the Commission's Decision, Petitioner received conservative treatment including steroid injections. He also underwent numerous diagnostic tests (Petitioner's Exhibit 11).

Ultimately, Dr. Gornet performed back surgery on December 12, 2018. The procedure consisted of an anterior decompression and disc replacement at L4-L5 (Petitioner's Exhibit 8).

Following surgery, Petitioner continued to be treated by Dr. Gornet. When Dr. Gornet saw Petitioner on January 3, and January 24, 2019, he noted Petitioner was doing well. When Dr. Gornet saw Petitioner on March 25, 2019, he ordered physical therapy (Petitioner's Exhibit 5).

Petitioner received physical therapy from April 1, 2019, through July 12, 2019. During that time, Petitioner's symptoms gradually improved (Petitioner's Exhibit 3).

When Dr. Gornet saw Petitioner on August 5, 2019, Dr. Gornet noted Petitioner had continued to do well. He released Petitioner to return to work without restrictions effective August 12, 2019 (Petitioner's Exhibit 5).

Dr. Gornet subsequently saw Petitioner on December 2, 2019. Dr. Gornet noted Petitioner was released to return to work full duty effective August 12, 2019, but was informed his employment had been terminated. Dr. Gornet opined Petitioner was at MMI, but he also noted Petitioner still had a low level of pain with increased activities and that it would probably be permanent (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was again examined by Dr. Rutz on December 17, 2019. In connection with his examination of Petitioner, Dr. Rutz reviewed medical records which included Dr. Gornet's most recent medical records of December 2, 2019, which were provided to him by Respondent. On examination, Dr. Rutz noted Petitioner had some mild residual back pain, but no neurological deficits. He opined Petitioner could work without restrictions and was at MMI (Respondent's Exhibit 3).

Dr. Rutz also opined Petitioner had a permanent partial impairment rating of five percent (5%) based upon the AMA guides. Dr. Rutz also described this as a permanent partial disability rating (Respondent's Exhibit 3).

At trial, Petitioner acknowledged Dr. Gornet had released him to return to work without restrictions. However, Respondent terminated Petitioner's employment purportedly because of excessive absenteeism. Petitioner stated he was able to find employment driving a forklift. Petitioner testified he subsequently had to leave that job because the bouncing up and down while driving the forklift became too painful.

Petitioner was later able to find a job at Stark Truss where he is currently employed. Petitioner's job duties consist of building walls, some of which are very heavy. Petitioner testified the job at Stark Truss is physically demanding, but he has been able to perform all of his job duties. Petitioner is currently making $11.00 an hour and works 40 hours a week, $440.00 a week. While employed by Respondent, Petitioner's average weekly wage was $1,071.63.

At trial, Petitioner stated he still has symptoms in his low back, primarily on the right side. Petitioner's symptoms become more intense with activity. Petitioner does avoid taking any narcotic medication, but he does take over-the-counter medication on an as needed basis.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 17 1/2% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Rutz opined Petitioner had a permanent partial impairment rating of five percent (5%) based on the AMA guides. However, he also incorrectly characterized it as a permanent partial disability rating. Obviously, the permanent partial impairment rating does not take into consideration the physical demands of Petitioner's job and the fact Petitioner has increased symptoms with activity. The Arbitrator gives this factor minimal weight.

Petitioner was employed as a relief man at the time of the accident, but his employment was subsequently terminated by Respondent. Petitioner currently works building walls which he described as physically demanding. Although Petitioner continues to have low back symptoms, he has been able to work without restrictions. The Arbitrator gives this factor moderate weight.

Petitioner was 38 years of age at the time he sustained the accident. He will have to live with the effects of the injury for the remainder of his working and natural life. The Arbitrator gives this factor significant weight.

Petitioner earned $1,071.63 per week at the time he sustained the accident and presently earns substantially less, $440.00 per week. As noted herein, Petitioner was released to return to work without restrictions, but Respondent terminated his employment. Because of these circumstances, it is difficult to determine if Petitioner's current earnings are indicative of a decreased earning capacity. The Arbitrator gives this factor minimal weight.

Petitioner sustained an injury to his low back which required back surgery consisting of a decompression and disc replacement procedure at L4-L5. While Petitioner was released to return to work without restrictions, Dr. Gornet noted Petitioner still had a low level of pain with increased activity which would probably be permanent. Petitioner's testimony regarding his complaints was consistent with and corroborated by the preceding. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

Jackie Nash,

Petitioner,

vs. NO: 11 WC 36052

SIUE, 20IWCC0492

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 October 16, 2019, is hereby affirmed and adopted.

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

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

DATED: SEP 2 - 2020
TJT:yl
o 7/14/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NASH, JACKIE
Employee/Petitioner

Case# **11WC036052**
11WC036053
14WC027733

SIUE
Employer/Respondent

20IWCC0492

On 10/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 SHORT & DAUGHERTY PC
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

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

6147 ASSISTANT ATTORNEY GENERAL
CORI STEWART
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

OCT 16 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jackie Nash
Employee/Petitioner

v.

SIUE
Employer/Respondent

Case # 11 WC 36052

Consolidated cases: 11 WC 36053
14 WC 27733

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 27, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [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. [ ] Other _____

FINDINGS

On July 23, 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned $33,733.44; the average weekly wage was $648.72.

On the date of accident, Petitioner was 55 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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 paid under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusion of Law attached hereto, no permanent partial disability 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.

William R. Gallagher, Arbitrator

October 14, 2019
Date

OCT 16 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case number 11 WC 36052, on September 19, 2011, Petitioner filed an Application which alleged that on November 4, 2009, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist & neck" (Respondent's Exhibit 1). On March 7, 2019, Petitioner filed an Amended Application which alleged that on July 23, 2008, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist and neck" (Arbitrator's Exhibit 1).

In case number 11 WC 36053, on July 20, 2011, Petitioner filed an Application which alleged that on February 18, 2010, Petitioner sustained a repetitive trauma injury to "both wrists and elbows" (Respondent's Exhibit 3). On May 2, 2013, Petitioner filed an Amended Application which alleged that on February 18, 2010, Petitioner sustained an injury to the "Body as a whole" as a result of "chairs falling down". At trial, Petitioner's counsel made an oral motion to amend the date of accident to February 17, 2011. The motion was granted by the Arbitrator and the date of accident was changed by interlineation (Arbitrator's Exhibit 3).

In case number 14 WC 27733, on August 18, 2014, Petitioner filed an Application which alleged a date of accident of February 16, 2012, and Petitioner sustained "Repetitive trauma" to his "Bilateral Hands, Bilateral Elbows" (Respondent's Exhibit 5). On May 2, 2019, Petitioner filed an Amended Application which alleged "Repetitive trauma" to "Bilateral hands, bilateral elbows, cervical spine" (Arbitrator's Exhibit 4).

Petitioner sought final awards in all three cases. Respondent disputed liability in all three cases on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked as a maintenance person at the East St. Louis campus of Southern Illinois University - Edwardsville and began his employment with Respondent in April, 2004. At trial, Petitioner testified that on July 23, 2008, he walked into a classroom to determine why the lights were not working. At that time, Petitioner slipped in a puddle of water and fell backwards. When he did so, Petitioner testified he struck his right wrist and upper back/neck on a doorframe. Petitioner stated he informed George Johnson, his supervisor, of the accident and an accident report was prepared. At trial, there were no reports regarding the accident of July 23, 2008, tendered into evidence. While Respondent disputed accident and notice, Johnson did not testify at trial.

Following the accident, Petitioner was seen in the ER of Alton Memorial Hospital. According to the history in the hospital records, Petitioner slipped in a puddle of water and fell slamming his left wrist (not his right) on a door panel. X-rays were taken of Petitioner's left wrist, which were negative for fractures and Petitioner was diagnosed with a left wrist sprain. There was no reference in the hospital records regarding Petitioner having any upper back/neck symptoms (Respondent's Exhibit 18). At trial, Petitioner testified he only missed one day of work and returned to work to his regular job.

Petitioner subsequently sought medical treatment from Dr. David Brown, an orthopedic surgeon, who evaluated Petitioner on August 13, 2008. At that time, Petitioner informed Dr. Brown that he sustained an injury to his left wrist when he fell into a steel doorway and struck his left wrist on the doorframe. There was no reference to Petitioner having sustained a neck injury. Dr. Brown opined Petitioner had ulnar sided wrist pain and ordered an MRI scan (Respondent's Exhibit 15).

The MRI was performed on September 16, 2008. According to the radiologist, the MRI revealed a small protruding cyst with adjacent joint effusion (Respondent's Exhibit 15).

When Dr. Brown saw Petitioner on September 16, 2008, he reviewed the MRI scan and opined Petitioner had a traumatically induced ganglion cyst. He subsequently performed a surgical excision of the ganglion cyst on October 31, 2008 (Respondent's Exhibit 15).

Following surgery, Dr. Brown ordered four weeks of therapy. He discharged Petitioner from care on December 8, 2008. All of Dr. Brown's medical records provided to Petitioner's employer, "Cathy Meyers, SIU Edwardsville" (Respondent's Exhibit 15).

At trial, Tayanna Crowder testified for Respondent. Crowder is Respondent's Workers' Compensation Coordinator. Crowder testified she did a thorough search of computer databases to determine if an accident report was prepared for an accident sustained by Petitioner on July 23, 2008. Crowder stated she could find no evidence Petitioner reported an accident as having occurred on that date.

On cross-examination, Crowder was shown a medical report from Dr. David Brown dated August 13, 2008 (which, as noted herein, was Dr. Brown's initial visit with Petitioner). Crowder agreed it was directed to Cathy Meyers in Respondent's Benefits Administration Department. Crowder agreed it appeared Meyers had referred Petitioner to Dr. Brown for treatment related to an injury sustained by Petitioner on July 23, 2008, when Petitioner slipped in water and struck his wrist. Crowder conceded Dr. Brown's report was evidence Respondent had notice of Petitioner having sustained an accident on July 23, 2008.

Petitioner testified at length regarding his job duties. Petitioner performed maintenance tasks both outside on the grounds of the campus as well as building maintenance. Petitioner worked at the East St. Louis campus of SIU, an area of approximately 30 acres of ground. Petitioner's outside duties included trimming bushes, using both push and riding lawnmowers, using a backpack leaf blower, using a weed eater and, in the winter months, snow removal when necessary. Petitioner estimated that performing the aforementioned tasks would take eight to 10 hours a day. Petitioner's inside maintenance duties included moving classroom furniture, repairing equipment, various building maintenance tasks, etc. Respondent offered no testimony regarding Petitioner's job duties.

As noted herein, in case 14 WC 27733, the Amended Application alleged a date of accident (manifestation) of February 16, 2012, and Petitioner sustained repetitive trauma to his bilateral upper extremities (Arbitrator's Exhibit 4). Respondent tendered into evidence a Notice of Injury form completed and signed by Petitioner on November 16, 2010, which described repetitive

trauma to Petitioner's neck and hands and indicated the date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a Form 45 dated February 10, 2011, which was unsigned, but indicated Petitioner sustained repetitive trauma to his neck and noted the date of accident was November 4, 2009 (Respondent's Exhibit 7). Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner on March 2, 2011, which indicated Petitioner sustained "Repetitive Duty's" to his hand, fingers, wrist and upper forearm and noted the date of accident was February 18, 2010 (Respondent's Exhibit 8). Respondent tendered into evidence a Form 45 dated February 16, 2011, which was unsigned, but indicated Petitioner sustained "Repetitive Motion" to his wrist and carpal tunnel and noted the date of accident was February 18, 2010 (Respondent's Exhibit 9).

In regard to Petitioner's repetitive trauma injury to his arms/hands, Petitioner was initially seen by Dr. Michael Beatty, an orthopedic surgeon, on September 7, 2011. Petitioner informed Dr. Beatty he had complaints referable to both hands and he also advised Dr. Beatty he did a lot of weed eating and used power tools. Dr. Beatty opined Petitioner had bilateral carpal and ulnar neuropathy. Dr. Beatty noted he wanted to review Petitioner's job description (Petitioner's Exhibit 8).

At the direction of Respondent, Dr. Anthony Sudekum, a hand surgeon, examined Petitioner on January 26, 2012. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and data regarding Petitioner's job duties, the latter of which included a position description and "Demands of the Job" form. Dr. Sudekum opined Petitioner had bilateral carpal tunnel and cubital tunnel syndrome for which surgery was appropriate. In regard to causality, Dr. Sudekum opined Petitioner's job duties caused and/or aggravated Petitioner's carpal tunnel and cubital tunnel conditions (Petitioner's Exhibit 10).

Dr. Beatty subsequently performed right carpal and cubital tunnel and left carpal and cubital tunnel release surgeries on May 30, 2012, and June 27, 2012, respectively. Dr. Beatty also performed an excision of a ganglion cyst from Petitioner's right wrist on August 8, 2012 (Petitioner's Exhibit 8).

Dr. Beatty was deposed on December 6, 2011, and his deposition testimony was received into evidence at trial. Obviously, Dr. Beatty was deposed prior to his performing surgery on Petitioner. Dr. Beatty reaffirmed his opinion regarding his diagnosis of bilateral carpal and cubital tunnel syndrome and Petitioner was in need of surgery. In regard to causality, Dr. Beatty stated he had reviewed Petitioner's job description which was provided by Respondent and opined there was a causal relationship between Petitioner's job duties and the upper extremity conditions he diagnosed and treated (Petitioner's Exhibit 3; pp 15-23).

Respondent initially accepted Petitioner's carpal tunnel and cubital tunnel syndrome conditions as being compensable and paid medical bills and temporary total disability benefits. However, at trial, Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

In regard to Petitioner's neck/cervical spine condition, Petitioner testified he has had neck problems for a number of years. On September 30, 2001, Petitioner went to the ER of Alton

Memorial Hospital because of neck pain. X-rays were taken which revealed mild degenerative disc disease at C5 and C7, minimal marginal spurring and mild facet osteoarthritis (Respondent's Exhibit 18).

Petitioner was subsequently seen by Dr. Rajnikani Patel, an internist, on October 1, 2001. Dr. Patel diagnosed Petitioner as having sustained a neck muscle strain. Dr. Patel prescribed medication for both Petitioner's neck symptoms and depression (Respondent's Exhibit 14).

Petitioner was later seen by Dr. Daniel Scodary, a neurosurgeon, on February 8, 2010, for neck symptoms. At that time, Petitioner advised Dr. Scodary the symptoms had started three months prior. Dr. Scodary reviewed an MRI scan of Petitioner's cervical spine (the date of the scan was not indicated) and opined it revealed mild stenosis and degenerative disc disease. Dr. Scodary recommended Petitioner be referred to Dr. Gregory Stynowick, a pain management specialist (Petitioner's Exhibit 14).

Petitioner was seen by Dr. Patel on April 28, 2010, who evaluated him for both his carpal tunnel syndrome and neck symptoms. Dr. Patel opined Petitioner had cervical radiculopathy and that he should return to Dr. Scodary (Respondent's Exhibit 14).

Dr. Scodary saw Petitioner on April 29, 2010, and noted Petitioner had not been seen by Dr. Stynowick as he had recommended. He renewed his recommendation Petitioner go to Dr. Stynowick (Petitioner's Exhibit 14).

Dr. Stynowick saw Petitioner on May 6, 2010. At that time, Dr. Stynowick administered an epidural steroid injection at C7-T1. He also ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 15).

The MRI was performed on May 12, 2010. According to the radiologist, there were no disc herniations, but disc bulges at C3-C4, C5-C6 and C6-C7 (Petitioner's Exhibit 16).

Dr. Stynowick subsequently saw Petitioner in May/June, 2010 and administered additional epidural steroid injections as well as medial branch nerve blocks. Dr. Stynowick diagnosed Petitioner with cervical radiculitis and cervical spondylosis. He directed Petitioner to follow up with Dr. Scodary (Petitioner's Exhibit 15). However, Petitioner did not follow up with Dr. Scodary.

At trial, Petitioner testified that on February 18, 2011 (which he later said may have been February 17, 2011), he was pushing a wheeled cart that had a number of chairs stacked on it. Some chairs fell off of the cart striking Petitioner in the shoulder and neck area and caused him to fall to the ground.

As previously noted herein, Respondent tendered into evidence a Notice of Injury dated November 16, 2010, which noted Petitioner sustained repetitive trauma to his neck/arms and indicated that date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a First Report of Injury dated February 10, 2011, which indicated

Petitioner sustained "Repetitive Motion" to the neck and indicated a date of accident of November 4, 2009 (Respondent's Exhibit 7).

Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner dated March 7, 2011, which indicated Petitioner sustained an injury on February 17, 2011, when some "carts" fell on him causing him to sustain an injury to his right hand/wrist and right,. There was no reference to Petitioner having sustained a neck injury (Respondent's Exhibit 10).

Respondent tendered into evidence a witness statement dated February 17, 2011, of Edward Florian, one of Petitioner's co-workers. Florian noted Petitioner was moving chair haulers and that he slipped and fell forward. He provided assistance to Petitioner afterward and noted his wrist (he did not specify right or left) was swollen and bruised. Florian did not note Petitioner had sustained a neck injury (Respondent's Exhibit 11).

Petitioner sought medical treatment at the ER of Alton Memorial Hospital on February 17, 2011. According to the hospital record, Petitioner fell on his outstretched right hand. He was diagnosed with abrasions, a wrist sprain and chronic carpal tunnel syndrome. There was no reference in the record to Petitioner having any neck symptoms (Respondent's Exhibit 18).

At the direction of Respondent, Petitioner was examined by Dr. David Robson, an orthopedic surgeon, on September 6, 2012. In connection with his examination of Petitioner, Dr. Robson reviewed medical records provided to him by Respondent. Dr. Robson also reviewed information regarding Petitioner's work-related accidents. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner was walking into a classroom, slipped/fell in water and injured his left wrist and neck. Dr. Robson noted the First Report of Injury in which Petitioner claimed the repetitive motion required by his job caused him to sustain a neck injury on November 4, 2009. Dr. Robson also noted that on February 17, 2011, Petitioner was pushing chairs on a dolly and some of the chairs fell forward onto Petitioner's right arm/wrist (Petitioner's Exhibit 5; Deposition Exhibit 2).

Dr. Robson diagnosed Petitioner with cervical spondylosis. In regard to causality, Dr. Robson noted Petitioner had conflicting dates of injury as to which caused his neck symptoms. He noted Petitioner claimed his neck pain began on November 4, 2009, but the record indicated Petitioner first reported neck pain on July 23, 2008. Dr. Robson noted that, in regard to the February 17, 2011, accident, Petitioner only reported an injury to his right wrist/arm, nothing regarding the cervical spine. Dr. Robson opined Petitioner's cervical spine condition was not related to the repetitive motion of Petitioner's job (Petitioner's Exhibit 5; Deposition Exhibit 2).

On November 26, 2012, Petitioner was evaluated by Dr. David Raskas, an orthopedic surgeon. Petitioner informed Dr. Raskas that he sustained an accident in 2009 when he slipped and fell backwards and sustained an injury to his neck and shoulder (Petitioner was, in fact, apparently referring to the accident of July 23, 2008). Petitioner also informed Dr. Raskas that in 2011 a stack of chairs fell on him causing him to sustain injuries to his right wrist and neck (Petitioner's Exhibit 6).

When seen by Dr. Raskas, Petitioner complained of a decreased range of motion of his neck and shoulders. Dr. Raskas ordered x-rays of the cervical spine which revealed a spondylolisthesis at C7-T1, degenerative disc disease at C5-C6 and C6-C7 and retrolisthesis at C5-C6. Dr. Raskas opined Petitioner had C8 radiculopathy and recommended a CT myelogram of the cervical spine (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner on December 5, 2012, and reviewed the CT myelogram. He opined it revealed a herniated disc at C4-C5 with severe spinal stenosis, but that most of Petitioner's symptoms were coming from the C7-T1 level. He recommended Petitioner undergo some nerve root blocks at C5 and C8, but indicated he might recommend Petitioner undergoing a fusion at C4-C5 and C7-T1 (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Barry Feinberg, a pain management specialist, on December 17, 2012. Dr. Feinberg diagnosed Petitioner with cervical radiculopathy and administered a series of epidural steroid injections (Petitioner's Exhibit 7).

Dr. Raskas continued to treat Petitioner. On September 20, 2013, Dr. Raskas performed surgery which consisted of a partial vertebrectomy at C4 and C7, anterior discectomies and fusions at C5-C6 and C6-C7, a fusion at C7-T1 and plating from C4 to T1 (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner following surgery, but when he evaluated Petitioner on July 28, 2014, he opined the fusion had not fully healed. Ultimately, Dr. Raskas performed a second surgery on December 4, 2014, a fusion with instrumentation at C4-C5 (Petitioner's Exhibit 6; Petitioner's Exhibit 1, Deposition Exhibit 2).

Following the second surgery, Petitioner continued to be treated by Dr. Raskas and Dr. Feinberg. When Dr. Raskas saw Petitioner on April 20, 2015, he opined the fusion the solid, but recommended Petitioner continue treating with Dr. Feinberg (Petitioner's Exhibit 6).

Dr. Feinberg saw Petitioner and administered facet injections at C3-C4 from June, 2015, through February, 2016. Petitioner did experience some relief of his symptoms (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was again examined by Dr. Robson on June 2, 2015. Dr. Robson noted Petitioner had undergone two fusion procedures performed by Dr. Raskas since his prior examination. Petitioner continued to complain of pain of 5 out of 10 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Robson again opined as to causality. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner did not complain of any neck symptoms subsequent to the accident, only wrist pain. In regard to the repetitive trauma injury with the date of accident of November 4, 2009, Dr. Robson opined it was difficult to determine within a degree of medical certainty whether Petitioner sustained a neck injury because of repetitive trauma. He opined Petitioner had pre-existing cervical spondylosis which caused him to have neck pain (Petitioner's Exhibit 5; Deposition Exhibit 3).

On July 12, 2019, Dr. Raskas prepared a medical report in which he opined he had released Petitioner from care and Petitioner was at MMI. He also noted Petitioner would require pain management in the form of medications and/or injections because of Petitioner's chronic pain (Petitioner's Exhibit 28).

Petitioner's counsel had Petitioner evaluated by J. Stephen Dolan, a vocational rehabilitation expert on April 10, 2018. Dolan reviewed Petitioner's education/work history and various medical reports/records provided to him by Petitioner's counsel. He also administered a number of tests to Petitioner. Dolan noted Petitioner was subject to numerous restrictions, had poor academic skills and had worked primarily as a maintenance/groundskeeper but had previously worked as a truck driver. He opined Petitioner did not have access to a reasonably stable labor market (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Raskas was deposed on March 9, 2015, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Raskas' testimony was consistent with his medical records and he reaffirmed the opinions contained therein. When questioned about the history Petitioner provided to him, Dr. Raskas testified Petitioner advised that in 2009 he slipped and fell backwards on some liquid injuring his neck and shoulder. Petitioner also informed him that in 2010, but it was actually February 17, 2011, Petitioner had a stack of chairs fall on him. Dr. Raskas opined the accidents could have caused or aggravated the condition in Petitioner's cervical spine which led him to performing two surgeries (Petitioner's Exhibit 1; pp 6, 21-22).

On cross-examination, Dr. Raskas agreed that if the history of the accidents Petitioner provided to him and his condition prior to them was different than what Petitioner had advised, his opinion regarding causality might change. Dr. Raskas also testified he did not believe Petitioner had any treatment for cervical spine symptoms prior to 2009 (Petitioner's Exhibit 1; pp 29-30, 32).

Dr. Feinberg was deposed on June 3, 2016, and his deposition testimony was received into evidence at trial. In regard to the treatment provided to Petitioner, Dr. Feinberg's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Feinberg testified that when he initially evaluated Petitioner on December 12, 2012, Petitioner gave a history of slipping and falling on some water which caused him to hit his head, neck and shoulder on a doorframe. Petitioner also advised his condition worsened because of his job duties and was again injured when a stack of chairs fell on him (Petitioner's Exhibit 2; p 7).

In regard to causality, Dr. Feinberg testified the two accidents could have caused or contributed to Petitioner's neck condition. He based this on the history Petitioner provided to him and the symptoms Petitioner had for which he had treated him (Petitioner's Exhibit 2; p 21).

On cross-examination, Dr. Feinberg testified Petitioner initially informed him the accident occurred in July, 2008, and February, 2009, but he subsequently advised him the accident involving the chairs occurred in early 2011. Petitioner also informed him he had no neck problems prior to sustaining the slip and fall in the water (Petitioner's Exhibit 2; pp 24-25).

J. Stephen Dolan was deposed on July 18, 2018, and his deposition testimony was received into evidence at trial. Dolan's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, Dolan testified Petitioner was permanently and totally disabled from gainful employment (Petitioner's Exhibit 4; p 28).

Dr. Robson was deposed on January 10, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Robson's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Robson testified Petitioner had multiple level spondylosis in the neck at C4-C5, C5-C6 and C6-C7. He stated Petitioner informed him that he had sustained an injury on November 4, 2009, as a result of prolonged use of a weed eater, but had also sustained an accident on July 23, 2008, when he slipped. He noted that Petitioner had undergone an x-ray of the cervical spine in 2001 and, when Petitioner had an MRI performed on November 30, 2009, Petitioner indicated he had neck symptoms for six to eight months prior. Based upon the preceding, Dr. Robson could not attribute Petitioner's cervical spine symptoms to an accident of November 4, 2009 (Petitioner's Exhibit 5; p 11).

On cross-examination, Dr. Robson agreed that if Petitioner slipped and fell in water striking his head and back of his neck on the doorframe, this could aggravate the pre-existing spondylosis in the cervical spine. He also agreed that if Petitioner used a weed eater four to six hours a day during the summer that this could cause his spondylosis to become symptomatic (Petitioner's Exhibit 5; pp 14-15).

At trial, Petitioner testified he has not worked since October 20, 2012, primarily because of his neck symptoms. Petitioner apparently began to draw long term disability benefits (not temporary total disability) at that time. Petitioner testified that he was subsequently informed that those payments were going to be terminated and, for that reason, he made the decision to retire. The reason he gave was that he would have no other income. Respondent's counsel tendered into evidence a form (which was not signed by Petitioner) but which indicated a retirement date of July 1, 2018 (Respondent's Exhibit 17).

Petitioner testified he has not been released to return to work by any of his treating physicians. Petitioner still continues to complain of severe neck pain as well as numbness in both hands and forearms.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on July 23, 2008.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified he sustained a work-related accident on July 23, 2008, when he stepped in a puddle of water and fell backward. He stated he reported the accident to his supervisor, George Johnson, but Johnson did not testify when this case was tried.

When Petitioner was seen in the ER of Alton Memorial Hospital on July 23, 2008, he advised of the accident and that he had injured his left wrist. Petitioner also informed Dr. Brown of the circumstances of the accident of July 23, 2008, when he was initially evaluated by Dr. Brown on August 13, 2008.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner gave notice to Respondent of the accident of July 23, 2008, within the time prescribed by the Act.

As aforestated, Petitioner testified he informed his supervisor, George Johnson, of the accident of July 23, 2008, but Johnson did not testify at trial.

The Arbitrator notes that all of Dr. Brown's treatment records were provided to Cathy Meyers, SIU Edwardsville.

When Respondent's witness, Tayana Crowder, testified at trial, she conceded that a copy of Dr. Brown's report of August 13, 2008, was provided to Cathy Meyer (who she identified as Respondent's Benefits Administrator) and it was evidence Respondent had notice of Petitioner having sustained a work-related accident on July 23, 2008.

While the Amended Application erroneously states the injury was to the right hand, it is clear that Respondent had notice of Petitioner having sustained a work-related accident on July 23, 2008.

In regard to disputed issues (F) and (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being in regard to his left hand is not causally related to the accident of July 23, 2008, and there is no permanent partial disability to Petitioner's left hand as a result thereof.

In support of this conclusion the Arbitrator notes the following:

As a result of the accident of July 23, 2008, Petitioner sustained a left wrist sprain and a traumatically induced ganglion cyst.

As noted in case number 14 WC 27733, Petitioner subsequently sustained a repetitive trauma injury to both hands/elbows which required surgery.

There was no evidence Petitioner had any permanent partial disability attributable to the left wrist prior to his sustaining the repetitive trauma injury to both hands/elbows.

William R. Gallagher, Arbitrator

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

Jackie Nash,

Petitioner,

vs. NO: 11 WC 36053

20IWCC0493

SIUE,

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 October 16, 2019, is hereby affirmed and adopted.

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

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

DATED: SEP 2 - 2020
TJT:yl
o 7/14/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NASH, JACKIE
Employee/Petitioner

Case# **11WC036053**

11WC036052
14WC027733

SIUE
Employer/Respondent

20IWCC0493

On 10/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 SHORT & DAUGHERTY PC
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

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

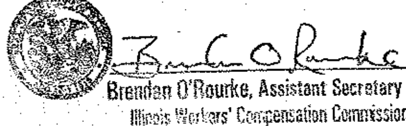
6147 ASSISTANT ATTORNEY GENERAL
CORI STEWART
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

OCT 16 2019



Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0493

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

Jackie Nash
Employee/Petitioner

v.

SIUE
Employer/Respondent

Case # 11 WC 36053

Consolidated cases: 11 WC 36052
14 WC 27733

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 27, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [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 February 17, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $33,733.44; the average weekly wage was $648.72.

On the date of accident, Petitioner was 58 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusion of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator
ICArbDec p. 2

October 14, 2019
Date

OCT 1 6 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case number 11 WC 36052, on September 19, 2011, Petitioner filed an Application which alleged that on November 4, 2009, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist & neck" (Respondent's Exhibit 1). On March 7, 2019, Petitioner filed an Amended Application which alleged that on July 23, 2008, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist and neck" (Arbitrator's Exhibit 1).

In case number 11 WC 36053, on July 20, 2011, Petitioner filed an Application which alleged that on February 18, 2010, Petitioner sustained a repetitive trauma injury to "both wrists and elbows" (Respondent's Exhibit 3). On May 2, 2013, Petitioner filed an Amended Application which alleged that on February 18, 2010, Petitioner sustained an injury to the "Body as a whole" as a result of "chairs falling down". At trial, Petitioner's counsel made an oral motion to amend the date of accident to February 17, 2011. The motion was granted by the Arbitrator and the date of accident was changed by interlineation (Arbitrator's Exhibit 3).

In case number 14 WC 27733, on August 18, 2014, Petitioner filed an Application which alleged a date of accident of February 16, 2012, and Petitioner sustained "Repetitive trauma" to his "Bilateral Hands, Bilateral Elbows" (Respondent's Exhibit 5). On May 2, 2019, Petitioner filed an Amended Application which alleged "Repetitive trauma" to "Bilateral hands, bilateral elbows, cervical spine" (Arbitrator's Exhibit 4).

Petitioner sought final awards in all three cases. Respondent disputed liability in all three cases on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked as a maintenance person at the East St. Louis campus of Southern Illinois University - Edwardsville and began his employment with Respondent in April, 2004. At trial, Petitioner testified that on July 23, 2008, he walked into a classroom to determine why the lights were not working. At that time, Petitioner slipped in a puddle of water and fell backwards. When he did so, Petitioner testified he struck his right wrist and upper back/neck on a doorframe. Petitioner stated he informed George Johnson, his supervisor, of the accident and an accident report was prepared. At trial, there were no reports regarding the accident of July 23, 2008, tendered into evidence. While Respondent disputed accident and notice, Johnson did not testify at trial.

Following the accident, Petitioner was seen in the ER of Alton Memorial Hospital. According to the history in the hospital records, Petitioner slipped in a puddle of water and fell slamming his left wrist (not his right) on a door panel. X-rays were taken of Petitioner's left wrist, which were negative for fractures and Petitioner was diagnosed with a left wrist sprain. There was no reference in the hospital records regarding Petitioner having any upper back/neck symptoms (Respondent's Exhibit 18). At trial, Petitioner testified he only missed one day of work and returned to work to his regular job.

Petitioner subsequently sought medical treatment from Dr. David Brown, an orthopedic surgeon, who evaluated Petitioner on August 13, 2008. At that time, Petitioner informed Dr. Brown that he sustained an injury to his left wrist when he fell into a steel doorway and struck his left wrist on the doorframe. There was no reference to Petitioner having sustained a neck injury. Dr. Brown opined Petitioner had ulnar sided wrist pain and ordered an MRI scan (Respondent's Exhibit 15).

The MRI was performed on September 16, 2008. According to the radiologist, the MRI revealed a small protruding cyst with adjacent joint effusion (Respondent's Exhibit 15).

When Dr. Brown saw Petitioner on September 16, 2008, he reviewed the MRI scan and opined Petitioner had a traumatically induced ganglion cyst. He subsequently performed a surgical excision of the ganglion cyst on October 31, 2008 (Respondent's Exhibit 15).

Following surgery, Dr. Brown ordered four weeks of therapy. He discharged Petitioner from care on December 8, 2008. All of Dr. Brown's medical records provided to Petitioner's employer, "Cathy Meyers, SIU Edwardsville" (Respondent's Exhibit 15).

At trial, Tayanna Crowder testified for Respondent. Crowder is Respondent's Workers' Compensation Coordinator. Crowder testified she did a thorough search of computer databases to determine if an accident report was prepared for an accident sustained by Petitioner on July 23, 2008. Crowder stated she could find no evidence Petitioner reported an accident as having occurred on that date.

On cross-examination, Crowder was shown a medical report from Dr. David Brown dated August 13, 2008 (which, as noted herein, was Dr. Brown's initial visit with Petitioner). Crowder agreed it was directed to Cathy Meyers in Respondent's Benefits Administration Department. Crowder agreed it appeared Meyers had referred Petitioner to Dr. Brown for treatment related to an injury sustained by Petitioner on July 23, 2008, when Petitioner slipped in water and struck his wrist. Crowder conceded Dr. Brown's report was evidence Respondent had notice of Petitioner having sustained an accident on July 23, 2008.

Petitioner testified at length regarding his job duties. Petitioner performed maintenance tasks both outside on the grounds of the campus as well as building maintenance. Petitioner worked at the East St. Louis campus of SIU, an area of approximately 30 acres of ground. Petitioner's outside duties included trimming bushes, using both push and riding lawnmowers, using a backpack leaf blower, using a weed eater and, in the winter months, snow removal when necessary. Petitioner estimated that performing the aforementioned tasks would take eight to 10 hours a day. Petitioner's inside maintenance duties included moving classroom furniture, repairing equipment, various building maintenance tasks, etc. Respondent offered no testimony regarding Petitioner's job duties.

As noted herein, in case 14 WC 27733, the Amended Application alleged a date of accident (manifestation) of February 16, 2012, and Petitioner sustained repetitive trauma to his bilateral upper extremities (Arbitrator's Exhibit 4). Respondent tendered into evidence a Notice of Injury form completed and signed by Petitioner on November 16, 2010, which described repetitive

trauma to Petitioner's neck and hands and indicated the date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a Form 45 dated February 10, 2011, which was unsigned, but indicated Petitioner sustained repetitive trauma to his neck and noted the date of accident was November 4, 2009 (Respondent's Exhibit 7). Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner on March 2, 2011, which indicated Petitioner sustained "Repetitive Duty's" to his hand, fingers, wrist and upper forearm and noted the date of accident was February 18, 2010 (Respondent's Exhibit 8). Respondent tendered into evidence a Form 45 dated February 16, 2011, which was unsigned, but indicated Petitioner sustained "Repetitive Motion" to his wrist and carpal tunnel and noted the date of accident was February 18, 2010 (Respondent's Exhibit 9).

In regard to Petitioner's repetitive trauma injury to his arms/hands, Petitioner was initially seen by Dr. Michael Beatty, an orthopedic surgeon, on September 7, 2011. Petitioner informed Dr. Beatty he had complaints referable to both hands and he also advised Dr. Beatty he did a lot of weed eating and used power tools. Dr. Beatty opined Petitioner had bilateral carpal and ulnar neuropathy. Dr. Beatty noted he wanted to review Petitioner's job description (Petitioner's Exhibit 8).

At the direction of Respondent, Dr. Anthony Sudekum, a hand surgeon, examined Petitioner on January 26, 2012. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and data regarding Petitioner's job duties, the latter of which included a position description and "Demands of the Job" form. Dr. Sudekum opined Petitioner had bilateral carpal tunnel and cubital tunnel syndrome for which surgery was appropriate. In regard to causality, Dr. Sudekum opined Petitioner's job duties caused and/or aggravated Petitioner's carpal tunnel and cubital tunnel conditions (Petitioner's Exhibit 10).

Dr. Beatty subsequently performed right carpal and cubital tunnel and left carpal and cubital tunnel release surgeries on May 30, 2012, and June 27, 2012, respectively. Dr. Beatty also performed an excision of a ganglion cyst from Petitioner's right wrist on August 8, 2012 (Petitioner's Exhibit 8).

Dr. Beatty was deposed on December 6, 2011, and his deposition testimony was received into evidence at trial. Obviously, Dr. Beatty was deposed prior to his performing surgery on Petitioner. Dr. Beatty reaffirmed his opinion regarding his diagnosis of bilateral carpal and cubital tunnel syndrome and Petitioner was in need of surgery. In regard to causality, Dr. Beatty stated he had reviewed Petitioner's job description which was provided by Respondent and opined there was a causal relationship between Petitioner's job duties and the upper extremity conditions he diagnosed and treated (Petitioner's Exhibit 3; pp 15-23).

Respondent initially accepted Petitioner's carpal tunnel and cubital tunnel syndrome conditions as being compensable and paid medical bills and temporary total disability benefits. However, at trial, Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

In regard to Petitioner's neck/cervical spine condition, Petitioner testified he has had neck problems for a number of years. On September 30, 2001, Petitioner went to the ER of Alton

Memorial Hospital because of neck pain. X-rays were taken which revealed mild degenerative disc disease at C5 and C7, minimal marginal spurring and mild facet osteoarthritis (Respondent's Exhibit 18).

Petitioner was subsequently seen by Dr. Rajnikani Patel, an internist, on October 1, 2001. Dr. Patel diagnosed Petitioner as having sustained a neck muscle strain. Dr. Patel prescribed medication for both Petitioner's neck symptoms and depression (Respondent's Exhibit 14).

Petitioner was later seen by Dr. Daniel Scodary, a neurosurgeon, on February 8, 2010, for neck symptoms. At that time, Petitioner advised Dr. Scodary the symptoms had started three months prior. Dr. Scodary reviewed an MRI scan of Petitioner's cervical spine (the date of the scan was not indicated) and opined it revealed mild stenosis and degenerative disc disease. Dr. Scodary recommended Petitioner be referred to Dr. Gregory Stynowick, a pain management specialist (Petitioner's Exhibit 14).

Petitioner was seen by Dr. Patel on April 28, 2010, who evaluated him for both his carpal tunnel syndrome and neck symptoms. Dr. Patel opined Petitioner had cervical radiculopathy and that he should return to Dr. Scodary (Respondent's Exhibit 14).

Dr. Scodary saw Petitioner on April 29, 2010, and noted Petitioner had not been seen by Dr. Stynowick as he had recommended. He renewed his recommendation Petitioner go to Dr. Stynowick (Petitioner's Exhibit 14).

Dr. Stynowick saw Petitioner on May 6, 2010. At that time, Dr. Stynowick administered an epidural steroid injection at C7-T1. He also ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 15).

The MRI was performed on May 12, 2010. According to the radiologist, there were no disc herniations, but disc bulges at C3-C4, C5-C6 and C6-C7 (Petitioner's Exhibit 16).

Dr. Stynowick subsequently saw Petitioner in May/June, 2010 and administered additional epidural steroid injections as well as medial branch nerve blocks. Dr. Stynowick diagnosed Petitioner with cervical radiculitis and cervical spondylosis. He directed Petitioner to follow up with Dr. Scodary (Petitioner's Exhibit 15). However, Petitioner did not follow up with Dr. Scodary.

At trial, Petitioner testified that on February 18, 2011 (which he later said may have been February 17, 2011), he was pushing a wheeled cart that had a number of chairs stacked on it. Some chairs fell off of the cart striking Petitioner in the shoulder and neck area and caused him to fall to the ground.

As previously noted herein, Respondent tendered into evidence a Notice of Injury dated November 16, 2010, which noted Petitioner sustained repetitive trauma to his neck/arms and indicated that date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a First Report of Injury dated February 10, 2011, which indicated

Petitioner sustained "Repetitive Motion" to the neck and indicated a date of accident of November 4, 2009 (Respondent's Exhibit 7).

Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner dated March 7, 2011, which indicated Petitioner sustained an injury on February 17, 2011, when some "carts" fell on him causing him to sustain an injury to his right hand/wrist and right,. There was no reference to Petitioner having sustained a neck injury (Respondent's Exhibit 10).

Respondent tendered into evidence a witness statement dated February 17, 2011, of Edward Florian, one of Petitioner's co-workers. Florian noted Petitioner was moving chair haulers and that he slipped and fell forward. He provided assistance to Petitioner afterward and noted his wrist (he did not specify right or left) was swollen and bruised. Florian did not note Petitioner had sustained a neck injury (Respondent's Exhibit 11).

Petitioner sought medical treatment at the ER of Alton Memorial Hospital on February 17, 2011. According to the hospital record, Petitioner fell on his outstretched right hand. He was diagnosed with abrasions, a wrist sprain and chronic carpal tunnel syndrome. There was no reference in the record to Petitioner having any neck symptoms (Respondent's Exhibit 18).

At the direction of Respondent, Petitioner was examined by Dr. David Robson, an orthopedic surgeon, on September 6, 2012. In connection with his examination of Petitioner, Dr. Robson reviewed medical records provided to him by Respondent. Dr. Robson also reviewed information regarding Petitioner's work-related accidents. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner was walking into a classroom, slipped/fell in water and injured his left wrist and neck. Dr. Robson noted the First Report of Injury in which Petitioner claimed the repetitive motion required by his job caused him to sustain a neck injury on November 4, 2009. Dr. Robson also noted that on February 17, 2011, Petitioner was pushing chairs on a dolly and some of the chairs fell forward onto Petitioner's right arm/wrist (Petitioner's Exhibit 5; Deposition Exhibit 2).

Dr. Robson diagnosed Petitioner with cervical spondylosis. In regard to causality, Dr. Robson noted Petitioner had conflicting dates of injury as to which caused his neck symptoms. He noted Petitioner claimed his neck pain began on November 4, 2009, but the record indicated Petitioner first reported neck pain on July 23, 2008. Dr. Robson noted that, in regard to the February 17, 2011, accident, Petitioner only reported an injury to his right wrist/arm, nothing regarding the cervical spine. Dr. Robson opined Petitioner's cervical spine condition was not related to the repetitive motion of Petitioner's job (Petitioner's Exhibit 5; Deposition Exhibit 2).

On November 26, 2012, Petitioner was evaluated by Dr. David Raskas, an orthopedic surgeon. Petitioner informed Dr. Raskas that he sustained an accident in 2009 when he slipped and fell backwards and sustained an injury to his neck and shoulder (Petitioner was, in fact, apparently referring to the accident of July 23, 2008). Petitioner also informed Dr. Raskas that in 2011 a stack of chairs fell on him causing him to sustain injuries to his right wrist and neck (Petitioner's Exhibit 6).

When seen by Dr. Raskas, Petitioner complained of a decreased range of motion of his neck and shoulders. Dr. Raskas ordered x-rays of the cervical spine which revealed a spondylolisthesis at C7-T1, degenerative disc disease at C5-C6 and C6-C7 and retrolisthesis at C5-C6. Dr. Raskas opined Petitioner had C8 radiculopathy and recommended a CT myelogram of the cervical spine (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner on December 5, 2012, and reviewed the CT myelogram. He opined it revealed a herniated disc at C4-C5 with severe spinal stenosis, but that most of Petitioner's symptoms were coming from the C7-T1 level. He recommended Petitioner undergo some nerve root blocks at C5 and C8, but indicated he might recommend Petitioner undergoing a fusion at C4-C5 and C7-T1 (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Barry Feinberg, a pain management specialist, on December 17, 2012. Dr. Feinberg diagnosed Petitioner with cervical radiculopathy and administered a series of epidural steroid injections (Petitioner's Exhibit 7).

Dr. Raskas continued to treat Petitioner. On September 20, 2013, Dr. Raskas performed surgery which consisted of a partial vertebrectomy at C4 and C7, anterior discectomies and fusions at C5-C6 and C6-C7, a fusion at C7-T1 and plating from C4 to T1 (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner following surgery, but when he evaluated Petitioner on July 28, 2014, he opined the fusion had not fully healed. Ultimately, Dr. Raskas performed a second surgery on December 4, 2014, a fusion with instrumentation at C4-C5 (Petitioner's Exhibit 6; Petitioner's Exhibit 1, Deposition Exhibit 2).

Following the second surgery, Petitioner continued to be treated by Dr. Raskas and Dr. Feinberg. When Dr. Raskas saw Petitioner on April 20, 2015, he opined the fusion the solid, but recommended Petitioner continue treating with Dr. Feinberg (Petitioner's Exhibit 6).

Dr. Feinberg saw Petitioner and administered facet injections at C3-C4 from June, 2015, through February, 2016. Petitioner did experience some relief of his symptoms (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was again examined by Dr. Robson on June 2, 2015. Dr. Robson noted Petitioner had undergone two fusion procedures performed by Dr. Raskas since his prior examination. Petitioner continued to complain of pain of 5 out of 10 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Robson again opined as to causality. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner did not complain of any neck symptoms subsequent to the accident, only wrist pain. In regard to the repetitive trauma injury with the date of accident of November 4, 2009, Dr. Robson opined it was difficult to determine within a degree of medical certainty whether Petitioner sustained a neck injury because of repetitive trauma. He opined Petitioner had pre-existing cervical spondylosis which caused him to have neck pain (Petitioner's Exhibit 5; Deposition Exhibit 3).

On July 12, 2019, Dr. Raskas prepared a medical report in which he opined he had released Petitioner from care and Petitioner was at MMI. He also noted Petitioner would require pain management in the form of medications and/or injections because of Petitioner's chronic pain (Petitioner's Exhibit 28).

Petitioner's counsel had Petitioner evaluated by J. Stephen Dolan, a vocational rehabilitation expert on April 10, 2018. Dolan reviewed Petitioner's education/work history and various medical reports/records provided to him by Petitioner's counsel. He also administered a number of tests to Petitioner. Dolan noted Petitioner was subject to numerous restrictions, had poor academic skills and had worked primarily as a maintenance/groundskeeper but had previously worked as a truck driver. He opined Petitioner did not have access to a reasonably stable labor market (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Raskas was deposed on March 9, 2015, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Raskas' testimony was consistent with his medical records and he reaffirmed the opinions contained therein. When questioned about the history Petitioner provided to him, Dr. Raskas testified Petitioner advised that in 2009 he slipped and fell backwards on some liquid injuring his neck and shoulder. Petitioner also informed him that in 2010, but it was actually February 17, 2011, Petitioner had a stack of chairs fall on him. Dr. Raskas opined the accidents could have caused or aggravated the condition in Petitioner's cervical spine which led him to performing two surgeries (Petitioner's Exhibit 1; pp 6, 21-22).

On cross-examination, Dr. Raskas agreed that if the history of the accidents Petitioner provided to him and his condition prior to them was different than what Petitioner had advised, his opinion regarding causality might change. Dr. Raskas also testified he did not believe Petitioner had any treatment for cervical spine symptoms prior to 2009 (Petitioner's Exhibit 1; pp 29-30, 32).

Dr. Feinberg was deposed on June 3, 2016, and his deposition testimony was received into evidence at trial. In regard to the treatment provided to Petitioner, Dr. Feinberg's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Feinberg testified that when he initially evaluated Petitioner on December 12, 2012, Petitioner gave a history of slipping and falling on some water which caused him to hit his head, neck and shoulder on a doorframe. Petitioner also advised his condition worsened because of his job duties and was again injured when a stack of chairs fell on him (Petitioner's Exhibit 2; p 7).

In regard to causality, Dr. Feinberg testified the two accidents could have caused or contributed to Petitioner's neck condition. He based this on the history Petitioner provided to him and the symptoms Petitioner had for which he had treated him (Petitioner's Exhibit 2; p 21).

On cross-examination, Dr. Feinberg testified Petitioner initially informed him the accident occurred in July, 2008, and February, 2009, but he subsequently advised him the accident involving the chairs occurred in early 2011. Petitioner also informed him he had no neck problems prior to sustaining the slip and fall in the water (Petitioner's Exhibit 2; pp 24-25).

J. Stephen Dolan was deposed on July 18, 2018, and his deposition testimony was received into evidence at trial. Dolan's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, Dolan testified Petitioner was permanently and totally disabled from gainful employment (Petitioner's Exhibit 4; p 28).

Dr. Robson was deposed on January 10, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Robson's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Robson testified Petitioner had multiple level spondylosis in the neck at C4-C5, C5-C6 and C6-C7. He stated Petitioner informed him that he had sustained an injury on November 4, 2009, as a result of prolonged use of a weed eater, but had also sustained an accident on July 23, 2008, when he slipped. He noted that Petitioner had undergone an x-ray of the cervical spine in 2001 and, when Petitioner had an MRI performed on November 30, 2009, Petitioner indicated he had neck symptoms for six to eight months prior. Based upon the preceding, Dr. Robson could not attribute Petitioner's cervical spine symptoms to an accident of November 4, 2009 (Petitioner's Exhibit 5; p 11).

On cross-examination, Dr. Robson agreed that if Petitioner slipped and fell in water striking his head and back of his neck on the doorframe, this could aggravate the pre-existing spondylosis in the cervical spine. He also agreed that if Petitioner used a weed eater four to six hours a day during the summer that this could cause his spondylosis to become symptomatic (Petitioner's Exhibit 5; pp 14-15).

At trial, Petitioner testified he has not worked since October 20, 2012, primarily because of his neck symptoms. Petitioner apparently began to draw long term disability benefits (not temporary total disability) at that time. Petitioner testified that he was subsequently informed that those payments were going to be terminated and, for that reason, he made the decision to retire. The reason he gave was that he would have no other income. Respondent's counsel tendered into evidence a form (which was not signed by Petitioner) but which indicated a retirement date of July 1, 2018 (Respondent's Exhibit 17).

Petitioner testified he has not been released to return to work by any of his treating physicians. Petitioner still continues to complain of severe neck pain as well as numbness in both hands and forearms.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on February 17, 2011, but that his current condition of ill-being in regard to his cervical spine is not causally related to same or his work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner previously sought treatment for cervical spine symptoms in 2001, which was prior to his being employed by Respondent in 2004.

It is extremely difficult to determine with any certainty what Petitioner is claiming to be the work-related cause of his cervical spine condition, the accident of July 23, 2008, the accident of February 17, 2011, repetitive trauma with an undetermined date of manifestation or some combination of the preceding.

The onset of Petitioner's cervical spine condition while employed by Respondent cannot be determined with any certainty. However, the medical records for the treatment Petitioner received after the accident of July 23, 2008, only make reference to Petitioner having left wrist pain. There was no reference to Petitioner having any neck symptoms.

While Dr. Raskas testified the accident of 2009 when Petitioner slipped and fell in water (actually referring to the accident of July 23, 2008) could have aggravated Petitioner's cervical spine condition. This opinion is undermined by the fact Petitioner sought no treatment for cervical spine complaints immediately or shortly after the accident of July 23, 2008.

The preceding analysis is also applicable to the opinion of Dr. Feinberg regarding causality.

Petitioner sought medical treatment for cervical spine symptoms in February, 2010, which Petitioner noted started some three months prior. This may be the basis for Petitioner, at one point in time, alleging a date of accident of November 4, 2009.

Petitioner testified he sustained an injury on February 17, 2011, while he was pushing a wheeled cart that had chairs stacked on it and a number of chairs fell off striking him. Petitioner subsequently completed/signed a Notice of Injury on March 7, 2011, which described the accident. A witness to the accident, Edward Florian, a co-worker, completed a statement describing the accident.

In both the Notice of Injury and Florian's statement, the only injury noted was to Petitioner's right hand/wrist. There was no reference to Petitioner sustaining an injury to his neck.

In the medical records for treatment Petitioner received shortly after the accident of February 17, 2011, there was no reference to Petitioner having any neck symptoms.

Dr. Raskas testified the accident of February 17, 2011, could have caused or aggravated Petitioner's cervical spine condition; however, this opinion is undermined by the fact Petitioner only complained of right hand pain shortly afterward and did not complain of any neck symptoms, in spite of the fact of his having received treatment for neck symptoms in 2010.

The preceding analysis is also applicable to the opinion of Dr. Feinberg regarding causality.

Dr. Raskas did not opine whether Petitioner's cervical spine condition was related to Petitioner's repetitive work duties.

When Dr. Robson, Respondent's Section 12 examiner, was deposed, he agreed on cross-examination that if Petitioner slipped and fell in water striking the back of his head and neck this could have aggravated the pre-existing spondylosis in the cervical spine. However, as with Dr.

Raskas, this opinion is undermined by the lack of any neck symptoms shortly after the accident of July 23, 2008.

On cross-examination, Dr. Robson did agree Petitioner's weed eating for four to six hours a day during the summer months could make his spondylosis "symptomatic." However, this opinion only suggests that this specific activity could have caused some increase in symptoms, but it does not state whether this would have been a permanent aggravation of same.

Based upon the preceding, the Arbitrator concludes Petitioner's cervical spine condition is not work-related.

In regard to disputed issues (E) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)	☐ 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie Nash,

Petitioner,

vs. NO: 14 WC 27733

20 IWCC0494

SIU-E,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, TTD, medical expenses, prospective medical expenses and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator, as stated herein, all else otherwise affirmed and adopted, said decision being attached hereto and made a part hereof.

The Arbitrator found that "... Petitioner sustained a repetitive trauma injury to his right and left elbows and hands arising out of and in the course of his employment by Respondent and his current condition of ill-being in regard to his right and left elbows and hands is causally related to same." (Arb.Dec.[Addendum] 14WC27733, p.8). The Arbitrator noted that "... the date of manifestation alleged in the Amended Application is February 16, 2012; however, it is not possible to determine how this was the appropriate date of manifestation. The Arbitrator does note that in [companion claim] 11 WC 36053, the initial Application alleged a date of accident (manifestation) of February 18, 2010, consisting of repetitive trauma to both wrist and elbows, but this was subsequently amended to allege an injury to the body as a whole when Petitioner was struck by falling chairs. The preceding makes it difficult to determine what the appropriate date of manifestation should be; however, it is clear that Petitioner's bilateral hand and elbow conditions are work-related, as noted by both Dr. Beatty and Dr. Sudekum." (Id., p.9).

While the Commission agrees that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment and that a causal relationship existed between said accident and Petitioner's bilateral carpal and cubital tunnel syndrome conditions, we disagree with the Arbitrator's decision to utilize February 16, 2012 as the date of accident or manifestation in this case. The Commission notes that there is no evidence to support the use of said date, and that the more appropriate date of

manifestation – or the date on which both the fact of the injury and the causal relationship of the injury to the employment would have become plainly apparent to a reasonable person – was February 16, 2010, the date on which Petitioner underwent an EMG/nerve conduction study which revealed findings consistent with bilateral median nerve compression at the wrists.

As such, the Commission modifies the decision of the Arbitrator to find that Petitioner sustained accidental injuries arising out of and in the course of his employment and that said accidental injuries manifested themselves on or about February 16, 2010.

Finally, the Commission corrects a computational error at page 2 of the Arbitrator's Form decision, in the Order section, to show that the number of weeks of permanency awarded is equal to 104.25 weeks (not 101.25), based on 10% loss of use of both hands (.2[205 weeks] = 41 weeks) and 12.5% loss of use of both arms (.25[253 weeks] = 63.25 weeks).

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/16/19 is modified as stated herein, all else otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $389.23 per week for a period of 104.25, for the reason that the injuries sustained caused the loss of use of 10% of the right hand, 10% loss of use of the left hand, 12.5% loss of use of the right arm and 12.5% loss of use of the left arm, as provided in §8(e)9 and §8(e)10 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

DATED: SEP 2 - 2020
o:7/14/20
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NASH, JACKIE
Employee/Petitioner

Case# **14WC027733**

11WC036052
11WC036053

SIU E
Employer/Respondent

20IWCC0494

On 10/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 SHORT & DAUGHERTY PC
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

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

6147 ASSISTANT ATTORNEY GENERAL
CORI STEWART
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

OCT 16 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jackie Nash
Employee/Petitioner

v.

SIUE
Employer/Respondent

Case # 14 WC 27733

Consolidated cases: 11 WC 36052
11 WC 36053

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 27, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [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. [ ] Other _____

FINDINGS

On February 16, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $33,733.44; the average weekly wage was $648.72.

On the date of accident, Petitioner was 59 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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 paid under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $389.23 per week for 101.25 weeks because the injuries sustained caused the 10% loss of use of the right hand, 10% loss of use of the left hand, 12 1/2% loss of use of the right arm and 12 1/2% loss of use of the left arm, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

October 14, 2019
Date

OCT 16 2019

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged he sustained accidental injuries arising out of and in the course of his employment by Respondent. In case number 11 WC 36052, on September 19, 2011, Petitioner filed an Application which alleged that on November 4, 2009, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist & neck" (Respondent's Exhibit 1). On March 7, 2019, Petitioner filed an Amended Application which alleged that on July 23, 2008, Petitioner "slipped on spilled water" and sustained an injury to his "Right wrist and neck" (Arbitrator's Exhibit 1).

In case number 11 WC 36053, on July 20, 2011, Petitioner filed an Application which alleged that on February 18, 2010, Petitioner sustained a repetitive trauma injury to "both wrists and elbows" (Respondent's Exhibit 3). On May 2, 2013, Petitioner filed an Amended Application which alleged that on February 18, 2010, Petitioner sustained an injury to the "Body as a whole" as a result of "chairs falling down". At trial, Petitioner's counsel made an oral motion to amend the date of accident to February 17, 2011. The motion was granted by the Arbitrator and the date of accident was changed by interlineation (Arbitrator's Exhibit 3).

In case number 14 WC 27733, on August 18, 2014, Petitioner filed an Application which alleged a date of accident of February 16, 2012, and Petitioner sustained "Repetitive trauma" to his "Bilateral Hands, Bilateral Elbows" (Respondent's Exhibit 5). On May 2, 2019, Petitioner filed an Amended Application which alleged "Repetitive trauma" to "Bilateral hands, bilateral elbows, cervical spine" (Arbitrator's Exhibit 4).

Petitioner sought final awards in all three cases. Respondent disputed liability in all three cases on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked as a maintenance person at the East St. Louis campus of Southern Illinois University - Edwardsville and began his employment with Respondent in April, 2004. At trial, Petitioner testified that on July 23, 2008, he walked into a classroom to determine why the lights were not working. At that time, Petitioner slipped in a puddle of water and fell backwards. When he did so, Petitioner testified he struck his right wrist and upper back/neck on a doorframe. Petitioner stated he informed George Johnson, his supervisor, of the accident and an accident report was prepared. At trial, there were no reports regarding the accident of July 23, 2008, tendered into evidence. While Respondent disputed accident and notice, Johnson did not testify at trial.

Following the accident, Petitioner was seen in the ER of Alton Memorial Hospital. According to the history in the hospital records, Petitioner slipped in a puddle of water and fell slamming his left wrist (not his right) on a door panel. X-rays were taken of Petitioner's left wrist, which were negative for fractures and Petitioner was diagnosed with a left wrist sprain. There was no reference in the hospital records regarding Petitioner having any upper back/neck symptoms (Respondent's Exhibit 18). At trial, Petitioner testified he only missed one day of work and returned to work to his regular job.

Petitioner subsequently sought medical treatment from Dr. David Brown, an orthopedic surgeon, who evaluated Petitioner on August 13, 2008. At that time, Petitioner informed Dr. Brown that he sustained an injury to his left wrist when he fell into a steel doorway and struck his left wrist on the doorframe. There was no reference to Petitioner having sustained a neck injury. Dr. Brown opined Petitioner had ulnar sided wrist pain and ordered an MRI scan (Respondent's Exhibit 15).

The MRI was performed on September 16, 2008. According to the radiologist, the MRI revealed a small protruding cyst with adjacent joint effusion (Respondent's Exhibit 15).

When Dr. Brown saw Petitioner on September 16, 2008, he reviewed the MRI scan and opined Petitioner had a traumatically induced ganglion cyst. He subsequently performed a surgical excision of the ganglion cyst on October 31, 2008 (Respondent's Exhibit 15).

Following surgery, Dr. Brown ordered four weeks of therapy. He discharged Petitioner from care on December 8, 2008. All of Dr. Brown's medical records provided to Petitioner's employer, "Cathy Meyers, SIU Edwardsville" (Respondent's Exhibit 15).

At trial, Tayanna Crowder testified for Respondent. Crowder is Respondent's Workers' Compensation Coordinator. Crowder testified she did a thorough search of computer databases to determine if an accident report was prepared for an accident sustained by Petitioner on July 23, 2008. Crowder stated she could find no evidence Petitioner reported an accident as having occurred on that date.

On cross-examination, Crowder was shown a medical report from Dr. David Brown dated August 13, 2008 (which, as noted herein, was Dr. Brown's initial visit with Petitioner). Crowder agreed it was directed to Cathy Meyers in Respondent's Benefits Administration Department. Crowder agreed it appeared Meyers had referred Petitioner to Dr. Brown for treatment related to an injury sustained by Petitioner on July 23, 2008, when Petitioner slipped in water and struck his wrist. Crowder conceded Dr. Brown's report was evidence Respondent had notice of Petitioner having sustained an accident on July 23, 2008.

Petitioner testified at length regarding his job duties. Petitioner performed maintenance tasks both outside on the grounds of the campus as well as building maintenance. Petitioner worked at the East St. Louis campus of SIU, an area of approximately 30 acres of ground. Petitioner's outside duties included trimming bushes, using both push and riding lawnmowers, using a backpack leaf blower, using a weed eater and, in the winter months, snow removal when necessary. Petitioner estimated that performing the aforementioned tasks would take eight to 10 hours a day. Petitioner's inside maintenance duties included moving classroom furniture, repairing equipment, various building maintenance tasks, etc. Respondent offered no testimony regarding Petitioner's job duties.

As noted herein, in case 14 WC 27733, the Amended Application alleged a date of accident (manifestation) of February 16, 2012, and Petitioner sustained repetitive trauma to his bilateral upper extremities (Arbitrator's Exhibit 4). Respondent tendered into evidence a Notice of Injury form completed and signed by Petitioner on November 16, 2010, which described repetitive

trauma to Petitioner's neck and hands and indicated the date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a Form 45 dated February 10, 2011, which was unsigned, but indicated Petitioner sustained repetitive trauma to his neck and noted the date of accident was November 4, 2009 (Respondent's Exhibit 7). Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner on March 2, 2011, which indicated Petitioner sustained "Repetitive Duty's" to his hand, fingers, wrist and upper forearm and noted the date of accident was February 18, 2010 (Respondent's Exhibit 8). Respondent tendered into evidence a Form 45 dated February 16, 2011, which was unsigned, but indicated Petitioner sustained "Repetitive Motion" to his wrist and carpal tunnel and noted the date of accident was February 18, 2010 (Respondent's Exhibit 9).

In regard to Petitioner's repetitive trauma injury to his arms/hands, Petitioner was initially seen by Dr. Michael Beatty, an orthopedic surgeon, on September 7, 2011. Petitioner informed Dr. Beatty he had complaints referable to both hands and he also advised Dr. Beatty he did a lot of weed eating and used power tools. Dr. Beatty opined Petitioner had bilateral carpal and ulnar neuropathy. Dr. Beatty noted he wanted to review Petitioner's job description (Petitioner's Exhibit 8).

At the direction of Respondent, Dr. Anthony Sudekum, a hand surgeon, examined Petitioner on January 26, 2012. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and data regarding Petitioner's job duties, the latter of which included a position description and "Demands of the Job" form. Dr. Sudekum opined Petitioner had bilateral carpal tunnel and cubital tunnel syndrome for which surgery was appropriate. In regard to causality, Dr. Sudekum opined Petitioner's job duties caused and/or aggravated Petitioner's carpal tunnel and cubital tunnel conditions (Petitioner's Exhibit 10).

Dr. Beatty subsequently performed right carpal and cubital tunnel and left carpal and cubital tunnel release surgeries on May 30, 2012, and June 27, 2012, respectively. Dr. Beatty also performed an excision of a ganglion cyst from Petitioner's right wrist on August 8, 2012 (Petitioner's Exhibit 8).

Dr. Beatty was deposed on December 6, 2011, and his deposition testimony was received into evidence at trial. Obviously, Dr. Beatty was deposed prior to his performing surgery on Petitioner. Dr. Beatty reaffirmed his opinion regarding his diagnosis of bilateral carpal and cubital tunnel syndrome and Petitioner was in need of surgery. In regard to causality, Dr. Beatty stated he had reviewed Petitioner's job description which was provided by Respondent and opined there was a causal relationship between Petitioner's job duties and the upper extremity conditions he diagnosed and treated (Petitioner's Exhibit 3; pp 15-23).

Respondent initially accepted Petitioner's carpal tunnel and cubital tunnel syndrome conditions as being compensable and paid medical bills and temporary total disability benefits. However, at trial, Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

In regard to Petitioner's neck/cervical spine condition, Petitioner testified he has had neck problems for a number of years. On September 30, 2001, Petitioner went to the ER of Alton

Memorial Hospital because of neck pain. X-rays were taken which revealed mild degenerative disc disease at C5 and C7, minimal marginal spurring and mild facet osteoarthritis (Respondent's Exhibit 18).

Petitioner was subsequently seen by Dr. Rajnikani Patel, an internist, on October 1, 2001. Dr. Patel diagnosed Petitioner as having sustained a neck muscle strain. Dr. Patel prescribed medication for both Petitioner's neck symptoms and depression (Respondent's Exhibit 14).

Petitioner was later seen by Dr. Daniel Scodary, a neurosurgeon, on February 8, 2010, for neck symptoms. At that time, Petitioner advised Dr. Scodary the symptoms had started three months prior. Dr. Scodary reviewed an MRI scan of Petitioner's cervical spine (the date of the scan was not indicated) and opined it revealed mild stenosis and degenerative disc disease. Dr. Scodary recommended Petitioner be referred to Dr. Gregory Stynowick, a pain management specialist (Petitioner's Exhibit 14).

Petitioner was seen by Dr. Patel on April 28, 2010, who evaluated him for both his carpal tunnel syndrome and neck symptoms. Dr. Patel opined Petitioner had cervical radiculopathy and that he should return to Dr. Scodary (Respondent's Exhibit 14).

Dr. Scodary saw Petitioner on April 29, 2010, and noted Petitioner had not been seen by Dr. Stynowick as he had recommended. He renewed his recommendation Petitioner go to Dr. Stynowick (Petitioner's Exhibit 14).

Dr. Stynowick saw Petitioner on May 6, 2010. At that time, Dr. Stynowick administered an epidural steroid injection at C7-T1. He also ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 15).

The MRI was performed on May 12, 2010. According to the radiologist, there were no disc herniations, but disc bulges at C3-C4, C5-C6 and C6-C7 (Petitioner's Exhibit 16).

Dr. Stynowick subsequently saw Petitioner in May/June, 2010 and administered additional epidural steroid injections as well as medial branch nerve blocks. Dr. Stynowick diagnosed Petitioner with cervical radiculitis and cervical spondylosis. He directed Petitioner to follow up with Dr. Scodary (Petitioner's Exhibit 15). However, Petitioner did not follow up with Dr. Scodary.

At trial, Petitioner testified that on February 18, 2011 (which he later said may have been February 17, 2011), he was pushing a wheeled cart that had a number of chairs stacked on it. Some chairs fell off of the cart striking Petitioner in the shoulder and neck area and caused him to fall to the ground.

As previously noted herein, Respondent tendered into evidence a Notice of Injury dated November 16, 2010, which noted Petitioner sustained repetitive trauma to his neck/arms and indicated that date of accident of November 4, 2009 (Respondent's Exhibit 6). Respondent tendered into evidence a First Report of Injury dated February 10, 2011, which indicated

Petitioner sustained "Repetitive Motion" to the neck and indicated a date of accident of November 4, 2009 (Respondent's Exhibit 7).

Respondent tendered into evidence a Notice of Injury completed/signed by Petitioner dated March 7, 2011, which indicated Petitioner sustained an injury on February 17, 2011, when some "carts" fell on him causing him to sustain an injury to his right hand/wrist and right,. There was no reference to Petitioner having sustained a neck injury (Respondent's Exhibit 10).

Respondent tendered into evidence a witness statement dated February 17, 2011, of Edward Florian, one of Petitioner's co-workers. Florian noted Petitioner was moving chair haulers and that he slipped and fell forward. He provided assistance to Petitioner afterward and noted his wrist (he did not specify right or left) was swollen and bruised. Florian did not note Petitioner had sustained a neck injury (Respondent's Exhibit 11).

Petitioner sought medical treatment at the ER of Alton Memorial Hospital on February 17, 2011. According to the hospital record, Petitioner fell on his outstretched right hand. He was diagnosed with abrasions, a wrist sprain and chronic carpal tunnel syndrome. There was no reference in the record to Petitioner having any neck symptoms (Respondent's Exhibit 18).

At the direction of Respondent, Petitioner was examined by Dr. David Robson, an orthopedic surgeon, on September 6, 2012. In connection with his examination of Petitioner, Dr. Robson reviewed medical records provided to him by Respondent. Dr. Robson also reviewed information regarding Petitioner's work-related accidents. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner was walking into a classroom, slipped/fell in water and injured his left wrist and neck. Dr. Robson noted the First Report of Injury in which Petitioner claimed the repetitive motion required by his job caused him to sustain a neck injury on November 4, 2009. Dr. Robson also noted that on February 17, 2011, Petitioner was pushing chairs on a dolly and some of the chairs fell forward onto Petitioner's right arm/wrist (Petitioner's Exhibit 5; Deposition Exhibit 2).

Dr. Robson diagnosed Petitioner with cervical spondylosis. In regard to causality, Dr. Robson noted Petitioner had conflicting dates of injury as to which caused his neck symptoms. He noted Petitioner claimed his neck pain began on November 4, 2009, but the record indicated Petitioner first reported neck pain on July 23, 2008. Dr. Robson noted that, in regard to the February 17, 2011, accident, Petitioner only reported an injury to his right wrist/arm, nothing regarding the cervical spine. Dr. Robson opined Petitioner's cervical spine condition was not related to the repetitive motion of Petitioner's job (Petitioner's Exhibit 5; Deposition Exhibit 2).

On November 26, 2012, Petitioner was evaluated by Dr. David Raskas, an orthopedic surgeon. Petitioner informed Dr. Raskas that he sustained an accident in 2009 when he slipped and fell backwards and sustained an injury to his neck and shoulder (Petitioner was, in fact, apparently referring to the accident of July 23, 2008). Petitioner also informed Dr. Raskas that in 2011 a stack of chairs fell on him causing him to sustain injuries to his right wrist and neck (Petitioner's Exhibit 6).

When seen by Dr. Raskas, Petitioner complained of a decreased range of motion of his neck and shoulders. Dr. Raskas ordered x-rays of the cervical spine which revealed a spondylolisthesis at C7-T1, degenerative disc disease at C5-C6 and C6-C7 and retrolisthesis at C5-C6. Dr. Raskas opined Petitioner had C8 radiculopathy and recommended a CT myelogram of the cervical spine (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner on December 5, 2012, and reviewed the CT myelogram. He opined it revealed a herniated disc at C4-C5 with severe spinal stenosis, but that most of Petitioner's symptoms were coming from the C7-T1 level. He recommended Petitioner undergo some nerve root blocks at C5 and C8, but indicated he might recommend Petitioner undergoing a fusion at C4-C5 and C7-T1 (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Barry Feinberg, a pain management specialist, on December 17, 2012. Dr. Feinberg diagnosed Petitioner with cervical radiculopathy and administered a series of epidural steroid injections (Petitioner's Exhibit 7).

Dr. Raskas continued to treat Petitioner. On September 20, 2013, Dr. Raskas performed surgery which consisted of a partial vertebrectomy at C4 and C7, anterior discectomies and fusions at C5-C6 and C6-C7, a fusion at C7-T1 and plating from C4 to T1 (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner following surgery, but when he evaluated Petitioner on July 28, 2014, he opined the fusion had not fully healed. Ultimately, Dr. Raskas performed a second surgery on December 4, 2014, a fusion with instrumentation at C4-C5 (Petitioner's Exhibit 6; Petitioner's Exhibit 1, Deposition Exhibit 2).

Following the second surgery, Petitioner continued to be treated by Dr. Raskas and Dr. Feinberg. When Dr. Raskas saw Petitioner on April 20, 2015, he opined the fusion the solid, but recommended Petitioner continue treating with Dr. Feinberg (Petitioner's Exhibit 6).

Dr. Feinberg saw Petitioner and administered facet injections at C3-C4 from June, 2015, through February, 2016. Petitioner did experience some relief of his symptoms (Petitioner's Exhibit 7).

At the direction of Respondent, Petitioner was again examined by Dr. Robson on June 2, 2015. Dr. Robson noted Petitioner had undergone two fusion procedures performed by Dr. Raskas since his prior examination. Petitioner continued to complain of pain of 5 out of 10 (Petitioner's Exhibit 5; Deposition Exhibit 3).

Dr. Robson again opined as to causality. In regard to the accident of July 23, 2008, Dr. Robson noted Petitioner did not complain of any neck symptoms subsequent to the accident, only wrist pain. In regard to the repetitive trauma injury with the date of accident of November 4, 2009, Dr. Robson opined it was difficult to determine within a degree of medical certainty whether Petitioner sustained a neck injury because of repetitive trauma. He opined Petitioner had pre-existing cervical spondylosis which caused him to have neck pain (Petitioner's Exhibit 5; Deposition Exhibit 3).

On July 12, 2019, Dr. Raskas prepared a medical report in which he opined he had released Petitioner from care and Petitioner was at MMI. He also noted Petitioner would require pain management in the form of medications and/or injections because of Petitioner's chronic pain (Petitioner's Exhibit 28).

Petitioner's counsel had Petitioner evaluated by J. Stephen Dolan, a vocational rehabilitation expert on April 10, 2018. Dolan reviewed Petitioner's education/work history and various medical reports/records provided to him by Petitioner's counsel. He also administered a number of tests to Petitioner. Dolan noted Petitioner was subject to numerous restrictions, had poor academic skills and had worked primarily as a maintenance/groundskeeper but had previously worked as a truck driver. He opined Petitioner did not have access to a reasonably stable labor market (Petitioner's Exhibit 4; Deposition Exhibit 2).

Dr. Raskas was deposed on March 9, 2015, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Raskas' testimony was consistent with his medical records and he reaffirmed the opinions contained therein. When questioned about the history Petitioner provided to him, Dr. Raskas testified Petitioner advised that in 2009 he slipped and fell backwards on some liquid injuring his neck and shoulder. Petitioner also informed him that in 2010, but it was actually February 17, 2011, Petitioner had a stack of chairs fall on him. Dr. Raskas opined the accidents could have caused or aggravated the condition in Petitioner's cervical spine which led him to performing two surgeries (Petitioner's Exhibit 1; pp 6, 21-22).

On cross-examination, Dr. Raskas agreed that if the history of the accidents Petitioner provided to him and his condition prior to them was different than what Petitioner had advised, his opinion regarding causality might change. Dr. Raskas also testified he did not believe Petitioner had any treatment for cervical spine symptoms prior to 2009 (Petitioner's Exhibit 1; pp 29-30, 32).

Dr. Feinberg was deposed on June 3, 2016, and his deposition testimony was received into evidence at trial. In regard to the treatment provided to Petitioner, Dr. Feinberg's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Feinberg testified that when he initially evaluated Petitioner on December 12, 2012, Petitioner gave a history of slipping and falling on some water which caused him to hit his head, neck and shoulder on a doorframe. Petitioner also advised his condition worsened because of his job duties and was again injured when a stack of chairs fell on him (Petitioner's Exhibit 2; p 7).

In regard to causality, Dr. Feinberg testified the two accidents could have caused or contributed to Petitioner's neck condition. He based this on the history Petitioner provided to him and the symptoms Petitioner had for which he had treated him (Petitioner's Exhibit 2; p 21).

On cross-examination, Dr. Feinberg testified Petitioner initially informed him the accident occurred in July, 2008, and February, 2009, but he subsequently advised him the accident involving the chairs occurred in early 2011. Petitioner also informed him he had no neck problems prior to sustaining the slip and fall in the water (Petitioner's Exhibit 2; pp 24-25).

J. Stephen Dolan was deposed on July 18, 2018, and his deposition testimony was received into evidence at trial. Dolan's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, Dolan testified Petitioner was permanently and totally disabled from gainful employment (Petitioner's Exhibit 4; p 28).

Dr. Robson was deposed on January 10, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Robson's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Robson testified Petitioner had multiple level spondylosis in the neck at C4-C5, C5-C6 and C6-C7. He stated Petitioner informed him that he had sustained an injury on November 4, 2009, as a result of prolonged use of a weed eater, but had also sustained an accident on July 23, 2008, when he slipped. He noted that Petitioner had undergone an x-ray of the cervical spine in 2001 and, when Petitioner had an MRI performed on November 30, 2009, Petitioner indicated he had neck symptoms for six to eight months prior. Based upon the preceding, Dr. Robson could not attribute Petitioner's cervical spine symptoms to an accident of November 4, 2009 (Petitioner's Exhibit 5; p 11).

On cross-examination, Dr. Robson agreed that if Petitioner slipped and fell in water striking his head and back of his neck on the doorframe, this could aggravate the pre-existing spondylosis in the cervical spine. He also agreed that if Petitioner used a weed eater four to six hours a day during the summer that this could cause his spondylosis to become symptomatic (Petitioner's Exhibit 5; pp 14-15).

At trial, Petitioner testified he has not worked since October 20, 2012, primarily because of his neck symptoms. Petitioner apparently began to draw long term disability benefits (not temporary total disability) at that time. Petitioner testified that he was subsequently informed that those payments were going to be terminated and, for that reason, he made the decision to retire. The reason he gave was that he would have no other income. Respondent's counsel tendered into evidence a form (which was not signed by Petitioner) but which indicated a retirement date of July 1, 2018 (Respondent's Exhibit 17).

Petitioner testified he has not been released to return to work by any of his treating physicians. Petitioner still continues to complain of severe neck pain as well as numbness in both hands and forearms.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury to his right and left elbows and hands arising out of and in the course of his employment by Respondent and his current condition of ill-being in regard to his right and left elbows and hands is causally related to same.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner testified at length regarding the repetitive nature of his job duties which included using a weed eater, operating a backpack leaf blower, trimming bushes, snow removal, etc. Petitioner's testimony in regard to his job duties was unrebutted.

Both Petitioner's primary treating physician, Dr. Beatty, and Respondent's Section 12 examiner, Dr. Sudekum, opined Petitioner's elbow and hand conditions were related to his repetitive work duties. Further, both Dr. Beatty and Dr. Sudekum based their causality opinions, in part, on data regarding Petitioner's job duties provided by Respondent.

The Arbitrator notes the date of manifestation alleged in the Amended Application is February 16, 2012; however, it is not possible to determine how this was the appropriate date of manifestation. The Arbitrator does note that in 11 WC 36053, the initial Application alleged a date of accident (manifestation) of February 18, 2010, consisting of repetitive trauma to both wrist and elbows, but this was subsequently amended to allege an injury to the body as a whole when Petitioner was struck by falling chairs.

The preceding makes it difficult to determine what the appropriate date of manifestation should be; however, it is clear that Petitioner's bilateral hand and elbow conditions are work-related, as noted by both Dr. Beatty and Dr. Sudekum.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner gave notice to Respondent that he sustained a repetitive trauma injury arising out of and in the course of his employment by Respondent within the time prescribed by the Act.

As noted herein, the Arbitrator is unable to determine a precise date of manifestation. However, Respondent initially accepted Petitioner's bilateral hand/elbow injuries as being compensable and paid both medical bills and temporary total disability benefits. While the Arbitrator acknowledges that payment of said benefits is not an admission of liability on the part of Respondent, the fact that Respondent paid both medical bills and temporary total disability benefits indicates Respondent had notice Petitioner was claiming to have sustained a work-related injury.

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 right hand, 10% loss of use of the left hand, 12 1/2% loss of use of the right arm and 12 1/2% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner not Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner worked as a maintenance person, a job which required extensive repetitive use of both upper extremities. The Arbitrator gives this factor significant weight.

Petitioner was 59 years old at the time of the alleged manifestation. The Arbitrator gives this factor minimal weight.

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

Petitioner underwent carpal tunnel and cubital tunnel release surgeries on right and left hands and right and left elbows, respectively. Petitioner also underwent an excision of a ganglion cyst from his right wrist. While most of Petitioner's current complaints were in regard to his neck and cervical spine, at trial, Petitioner did complain of numbness in both hands and elbows. The Arbitrator gives this factor moderate weight.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alberta Sampson,

Petitioner,

20IWCC0491

vs.

NO: 19 WC 2250

Paige Bus Enterprises,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, medical expenses and evidentiary and procedural rulings and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 14, 2020, 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.

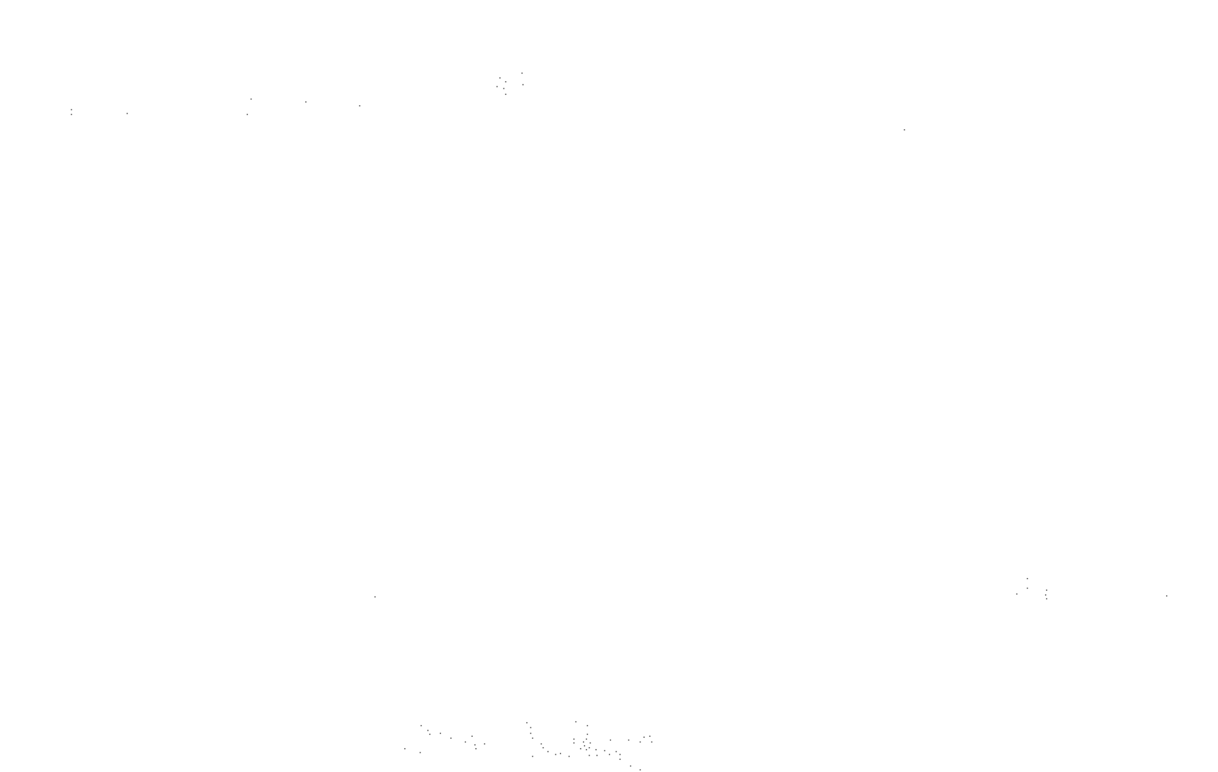
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 - 2020
o8/20/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker



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

20IWCC0491

SAMPSON, ALBERTA
Employee/Petitioner

Case# **19WC002250**

PAIGE BUS ENTERPRISES
Employer/Respondent

On 1/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6184 GERALD F O'CONNOR LAW OFFICES
222 W MERCHANDISE MART
SUITE 1225
CHICAGO, IL 60603

0208 GALLIANI DOELL & COZZI LTD
ROBERT COZZI
77 W WASHINGTON ST SUITE 1600
CHICAGO, IL 60602

20IWCC0491

20IWCC0491

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)/8(a)

ALBERTA SAMPSON
Employee/Petitioner

Case # **19** WC **02250**

v.

Consolidated cases: ____

PAIGE BUS ENTERPRISES
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 **Chicago**, on **August 13, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. [x] Was there an employee-employer relationship?

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

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

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

F. [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, **January 23, 2019**, 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 $**10,131.85**; the average weekly wage was $**203.46**.

On the date of accident, Petitioner was **69** 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 $**0** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of her employment on January 23, 2019. The Arbitrator further finds that the Petitioner sustained a closed head injury, coccyx contusion and cervical and lumbar strains that are causally related to the accident, but that she had no treatment for the head condition after her emergency room visit, and that she reached maximum medical improvement relative to her cervical and lumbar spine as of March 18, 2019.

Respondent shall pay Petitioner temporary total disability benefits of $203.46 per week for 7-5/7 weeks, commencing January 24, 2019 through March 18, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $13,167.73, as provided in Sections 8(a) and 8.2 of the Act.

Prospective medical treatment is denied.

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

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

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

Signature of Arbitrator

January 10, 2020
Date

JAN 14 2020

STATEMENT OF FACTS

Petitioner has worked for Respondent as a bus monitor since March 2013. She testified that she was in an employee-only parking lot at 6:30 a.m. on 1/23/19 when she slipped and fell on ice. Her testimony was that the lot was not open to the general public and that it was dark at the time. To get to her bus she had to walk through the lot, testifying she did this four times per day. Petitioner testified she had chest, back and posterior head pain after she fell, and that she was brought to the hospital via ambulance.

At the Ingalls Memorial Hospital ER on 1/23/19, the Petitioner reported an occipital headache and coccyx pain following a slip and fall on ice that morning. She denied other complaints or loss of consciousness. There were no focal neurologic deficits on exam, no cervical tenderness, normal movement of the extremities, an unremarkable CT scan of the head and normal x-rays of the lumbar spine and coccyx. The lumbar x-ray report does note anterolisthesis of L5 on S1, no acute fracture and moderate multilevel degenerative disc disease with moderate/severe facet arthropathy. Petitioner was discharged, prescribed ibuprofen and advised to return to work on 1/25/19 and to follow up with her own physician. (Px1).

Petitioner testified that she followed up with Dr. Najera on 1/25/19. The records submitted into evidence indicate she went to the South Holland Medical Center (also known as AMCI) on 1/25/19 and saw chiropractor Dr. Hooton. The report states that Petitioner was working as a bus monitor on 1/23/19 and was walking to a bus when she slipped on a patch of ice in the parking lot, causing her to fall backwards and strike her head and back on the ground. She reported ongoing 8 out of 10 (8/10) pain throughout the spine and that she had been unable to work. Petitioner was diagnosed with cervical, thoracic and lumbar strains and a coccyx contusion that were noted to be causally related to the fall. Petitioner was taken off work, physical therapy and a home exercise program were recommended, and she was advised to follow up with Dr. Foreman. (Px2).

Petitioner saw Dr. Foreman on 1/29/19 at South Holland Medical Center. He noted her primary complaints were neck and back pain with pain into both posterior legs at times. Following examination and review of the prior lumbosacral x-rays, Dr. Foreman noted the same diagnoses that were made on 1/25/19, adding lumbar radiculitis and spondylolisthesis, and noted possible exacerbation of previously asymptomatic degenerative disease. Prescribed were physical therapy, home exercise, Naprosyn, Cyclobenzaprine and Omeprazole. Petitioner was also held off work pending 2/26/19 reevaluation. (Px2).

Chiropractic evaluations were performed along with physical therapy on 2/1/19, 2/4/19, 2/6/19, 2/8/19, 2/11/19, 2/14/19, 2/16/19, 2/19/19 and 2/21/19 at South Holland. Each of these reports are either identical or virtually identical to each other, and all note that the Petitioner reported feeling the same despite treatment. On 2/22/19, chiropractor Dr. Hooton reported that Petitioner's symptoms had improved somewhat, noting 3 of 6 therapy goals had been achieved or partially achieved while the other three were not yet achieved. (Px2).

On 2/25/19, at the request of the Respondent pursuant to Section 12, Petitioner was examined by orthopedic surgeon by Dr. Julie Wehner. She reported a consistent history of the 1/23/19 accident and that she was referred to South Holland Medical Center by her attorney. Petitioner told Dr. Wehner she was about 50% improved with

treatment to date, with 7/10 low back pain, right greater than left, and no pain or numbness into the legs. Dr. Wehner indicated Petitioner did not report any neck pain that day. Petitioner stated she had no prior back problems. Following examination and review of Petitioner's medical records, Dr. Wehner diagnosed Petitioner with soft tissue injuries/contusions including a lumbar strain and head contusion, noting it was possible she also suffered a cervical strain but that Petitioner's said her headaches resolved and she was not complaining of neck pain, only low back pain. Her review of radiologic studies indicated normal age-related degenerative findings and no acute findings. Dr. Wehner opined that the injuries were causally related to the 1/23/19 work accident and that Petitioner's treatment to date had been reasonable. Noting the Petitioner reported she had been discharged from care, Dr. Wehner also opined that the Petitioner had reached maximum medical improvement and was able to return to work full duty. Her clinical exam was normal, and she advised Petitioner to continue home exercise. (Rx7).

Also, on 2/25/19, the Petitioner was reevaluated by Dr. Foreman. His assessment reflected that Petitioner reported decreased pain, some reduction in medication use with treatment and functional improvement. However, she continued to report symptoms. Dr. Foreman believed Petitioner would likely benefit from a return to work program, and he prescribed a TENS unit, lumbar brace and changed medications to Meloxicam and Tramadol ER. Home exercise was to continue, and a functional capacity evaluation (FCE) was advised to assess job capacity and to guide a return to work program. A lumbar MRI was also recommended. He continued the Petitioner off work pending a 3/18/19 visit with Dr. Najera, stating the visit would be for "PMR/Interventional Pain consultation and further treatment and work recommendations. Disabled until cleared by Dr. Najera." (Px2).

Petitioner underwent an FCE at South Holland on 3/4/19. The results are unclear to the Arbitrator, and the therapist stated: "Job lifting requirements were not heavy enough to surpass the 10% tile required to generate a valid result" and that in some fashion the test was invalid. Dr. Najera, however, in reviewing the testing on 3/18/19 stated that the FCE "meets validity criteria." Petitioner's job was listed at the "medium" work level, though this appears to have been significantly based on her report of having to lift up to 30 pounds occasionally, as the rest of the job involved walking or sitting. It appears the test may be indicating the Petitioner could work at that level. (Px2).

The 3/11/19 lumbar MRI reflected multilevel spondylosis with facet arthrosis and ligamentum flavum hypertrophy. There were circumferential disc bulges with neuroforaminal and central canal stenosis at L3/4 (moderate), L4/5 (moderate to severe), L2/3 and L5/S1 (mild to moderate) and at L1/2 (mild). (Px3).

Petitioner presented for therapeutic massage on 3/5/19, 3/8/19 and 3/13/19. (Px2).

On 3/18/19, Petitioner presented to Dr. Najera at South Holland. While he states that the Petitioner reported some improvement with each of the conservative treatments she was receiving, she also was continuing to report 8/10 pain. Dr. Najera reviewed the lumbar MRI, noting it revealed multilevel disc bulges and facet arthropathy causing multilevel neuroforaminal and central stenosis. Dr. Najera recommended EMG, interventional pain procedures and consideration of surgical consultation if interventional procedures failed. Petitioner indicated she wanted to consider her options, including a second opinion, so she was referred to a spine specialist of her choice. His report states she was to remain "disabled until cleared by spine specialist or follow-up with me if she wishes to pursue interventional management. Discharged from care." She was advised to continue home exercise and to wean from oral narcotics. (Px2).

Dr. Najera issued an addendum on 3/18/19 after reviewing the 2/25/19 report of Dr. Wehner. He states: "I do not agree with the following opinions: 1. Dr. Wehner did not have the MRI report available, which shows multilevel extensive degeneration for the lumbar spine causing both multilevel stenosis and multilevel lumbar

stenosis. She is a candidate for interventional procedures and possibly surgery. 2. Because of the MRI findings I do not feel she is at MMI. A recent FCE was also done by Dr. Hooton on 3/4/19, which was ordered by Dr. Foreman. Please see the FCE report for full details. She did not meet all her goals." (Px2).

On 4/15/19, Dr. Wehner issued an addendum report following her review of the 3/11/19 lumbar MRI, noting again that there were normal age-related findings and stating that this did not change her previous opinions of 2/25/19. She stated: "These radiographic findings can cause neurologic claudication, which is pain with ambulation. This was not consistent with Ms. Sampson's description of her pain." (Rx8).

Petitioner testified she has continuing right lower back pain and she has not returned to work. She did not have these symptoms previous to the accident.

Petitioner was also questioned on cross-examination. She initially testified she did not recall receiving a company handbook but acknowledged she must have when she was shown a 3/26/13 receipt for same. (Rx2). She agreed she also signed for an update/addendum to the handbook (Rx3), and that it reflected rules for certain shoes for winter driving but testified she does not drive the bus. On the accident date she was wearing "winter Sketchers", testifying that she was advised that she could not wear a shoe with a toe or heel out and that "everyone wore gym shoes." Petitioner acknowledged she signed for the addendum in Rx4 on 8/18/17. Her understanding was that the winter dress code rules were no gym or running shoes. Asked if her Sketchers were a brand of gym shoes, she testified she didn't know. Petitioner acknowledged her attorney referred her to Dr. Najera. The only orthopedic physician she has seen thus far was Dr. Wehner. She had not seen Dr. Najera since March 2019 and has never seen any bills from him.

Ms. Felicia Bailey-Diggs testified on behalf of the Respondent. The operations manager overseeing day to day operations at the bus yard in Riverdale, Illinois, she testified the company is responsible for transporting children to and from school. She previously worked for Respondent as safety and compliance officer, which involved overseeing the safety of students and drivers, keeping driver records, dealing with bus accidents and forwarding workers' compensation claims to the corporate facility. She testified she remains involved with safety issues as the operations manager. Ms. Bailey-Diggs testified she is familiar with the employee handbook, identifying Rx1 as a copy. She verified Rx2 was the acknowledgement of receipt of the handbook signed by Petitioner. She noted that there have been addendums and supplements to the handbook (Rx3 and Rx4) and verified the Petitioner had signed in that she received them. She testified the addendum in Rx3 states that work style shoes were required to be worn, not gym or running shoes, and that the second addendum (Rx4) in August 2017 reflected the winter shoe wear requirement. Ms. Bailey-Diggs testified that the purpose of the rule prohibiting gym or running shoes in the winter is based on both driver and student safety. Bus monitors are required to help kids on and off the bus, so the rule is important for them to do their jobs properly. Ms. Bailey-Diggs testified that there are more falls in the winter without proper shoe wear, i.e. avoiding gym or running shoes.

On 1/23/19, Ms. Bailey-Diggs was contacted that someone had fallen so she went out to the parking lot. The Petitioner was lying on the ground when she arrived, and she noted the Petitioner was wearing gym shoes with flat soles, which she believed were Sketchers, that were not the proper footwear. She testified that, per the addendum, the Petitioner was supposed to be wearing work boots. She did not discuss this issue with the Petitioner at the time as the Petitioner had been injured and on the ground. Petitioner acknowledged that Ms. Bailey-Diggs came out to the lot in a van when she fell.

On cross exam, Ms. Bailey-Diggs agreed that the Rx4 addendum indicated employees were to wear "work shoe style." She acknowledged that the Petitioner has been a good employee working as a paraprofessional, i.e. bus monitor. She agreed the Petitioner would have to walk through the parking lot to get to the buses. Petitioner had

been issued no dress code violations prior to the accident. While she agreed the Petitioner had not faced any post-accident discipline because of her shoe wear, on redirect Ms. Bailey-Diggs testified that the Petitioner had not been back to work since the incident and that when she returned she would receive a verbal warning, which is the proper discipline for a first offense.

Respondent's current safety compliance officer, Tamika Cosper, testified that she is responsible for making sure all employees are working safely. She also deals with workers' compensation accidents, medical cards and keeping employee files up to date. Before that she was a driver/trainer, including doing pre-trip training for new hires and road safety. She had been working in this position on the accident date. Safety meetings/training would be performed bi-monthly, initially prior to the children returning to school, and at that time they would review the company rules. Ms. Cosper testified she is familiar with the rules in the employee handbook and addendums, including winter shoe wear. Rx4 included the rule in effect at the time of the accident, the use of work shoes/boots and no gym or running shoes. She indicated the reason for the rule was to avoid employees injuring themselves.

Testifying it is documented in Rx6, a safety meeting took place at Respondent's facility on 12/19/18. Petitioner was present for the meeting based on her signature on the sign in sheet. At that time all safety/ winter safety issues were discussed, as documented in her notes (Rx5), including winter shoe wear, radio calls, railroad crossing rules, etc. It was emphasized that the shoes worn had to be suitable for winter, i.e. boots.

At the safety meeting on 12/19/18 Petitioner testified she did not recall any discussion regarding the importance of not wearing gym shoes and a need to wear boots in winter, and that based on her understanding her Sketchers were proper shoes. She testified she had never been reprimanded by Respondent for wearing the wrong shoes.

Cross-examined, Ms. Cosper agreed that the term used in Rx4, "work shoe style", doesn't necessarily require the footwear to be boots. She testified that since Petitioner began her employment with Respondent in 2013, she had not been reprimanded for any employee code violations and acknowledged that part of her own daily routine was to walk through the lot to check on things.

Testifying in rebuttal, Petitioner disputed being told to wear boots at work and testified that employees were told they could wear a full shoe. She considered the Sketchers she was wearing to be consistent with an acceptable work shoe. She wears a summer Sketcher and a winter one with a thicker heel. She testified she has worn these shoes to work daily and had never been reprimanded for it. She testified that all she was told by her "PJ", Respondent's Keith Paige, and by Ms. Bailey-Diggs when she initially came to work for Respondent was to avoid shoes with an open toe or an extended heel. Ms. Bailey-Diggs denied this when she then testified in rebuttal, indicating she wasn't aware of any other Respondent representative saying this to employees. She testified she hadn't paid attention to whether Petitioner had worn sneakers to work prior to the accident date, and that if she had she would have said something to the Petitioner. The employee handbook is produced by the corporate department and as such Ms. Bailey-Diggs herself has no ability to change the shoe wear rules.

With regard to the employee handbook (Rx1), dated 2012, the section on shoes indicates: a) "All shoes must have enclosed heels and toes and possess a non-slip type of sole and heel, which are typically a type of shoe that will effectively resist slipping on wet or slippery surfaces", and b) "Shoes worn for winter driving must be appropriate for winter or cold weather work." Additionally, the appearance/dress code rules state that there should be no open toe sandals, sling back shoes, crocs or slippers, and that no shoes with soles or heels more than one inch in height or high heeled boots are acceptable. A first offense would involve a documented verbal warning, possibly being sent home, while offenses then escalate to a written warning and sent home, a three-day suspension and finally termination. (Rx1).

Rx2 is the Petitioner's signed acknowledgement of receipt of the handbook on 3/26/13. Rx3 is an Appearance and Dress Code addendum, also signed off on by Petitioner on 3/26/13, and is the same as the handbook except for the part about shoes in winter. This document states: "Shoes worn for winter driving must be a "work shoe" style, not a gym shoe or running shoe." An additional addendum, signed by Petitioner as received on 8/18/17, is essentially identical to the addendum in Rx3 with regard to shoe wear. (Rx4).

The safety meeting notes testified to by Ms. Cosper (Rx5), as to shoe wear, state: "Weather – Wear shoes that's good for rain, mud, snow." (Rx5). Petitioner signed in for the 12/19/18 safety meeting. (Rx6).

Petitioner's Exhibit 4 (Px4) contains the medical expenses Petitioner is claiming to be related to the accident and for which she argues the Respondent should be liable.

CONCLUSIONS OF LAW

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

Respondent maintains no compensable accident occurred because Petitioner was wearing gym shoes at the time of the accident in violation of company policy. Petitioner disputes this allegation, claiming she wore Sketcher style winter work shoes that were not in violation of company policy. The Arbitrator finds that the Petitioner sustained accidental injury arising out of and in the course of her employment on 1/23/19.

The Arbitrator notes that the Petitioner was clearly \in the course of her employment when she slipped and fell in the parking lot on 1/23/19. She was walking out to her bus across an icy lot that she was required to traverse to access the bus. She was in the performance of her work duties.

With regard to the "arising out of aspect" of the issue of accident, the decisive issue is whether the employee was, at the time of the accident, violating a rule while still in the scope of his employment, or whether the alleged rule violation took him outside its sphere. *Heyman Distribution Co. v. Industrial Comm'n*, 32 N.E.2d 894 (1941).

In *J. S. Masonry, Inc. v. Industrial Comm'n*, 861 N.E.2d 202 (2006), the appellate court considered the issue of whether an injury arose out of the employment relationship without regard to the facts in dispute as to whether the Petitioner had violated a company rule regarding safety. In upholding benefits, the court found that "though he may have been performing his duties in a negligent manner, the claimant was "doing exactly the thing he was employed to do." *Id.* In *Republic Iron & Steel Co. v. Industrial Comm'n*, 302 Ill. 401, 134 N.E. 754 (1922), the supreme court set forth the proposition which governs cases in which an employee violates a rule and is injured. The rule is, 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. * * * [I]t 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 the sphere of his employment and in the course of it the accident arose out of it." *Republic*, 302 Ill. at 406, 134 N.E. 754.

The Arbitrator initially notes that the safety rules of Respondent in this case were vague in terms of exactly what type of shoes were required. They do specify that gym shoes were not to be worn. In this case, Ms. Bailey-

Diggs testified that the Petitioner was wearing gym shoes when she found her on the ground. Petitioner testified that the Sketchers shoes she was wearing in winter had a thicker sole than what she wore in summer. As the shoes themselves or a photo of them were not submitted into evidence, it is unclear to the Arbitrator whether the shoes were or were not what a reasonable person would consider to be gym shoes. However, even if they were, the Arbitrator sees nothing egregious about the Petitioner wearing them such that it would result in her taking herself out of her employment. The Arbitrator also notes with significant interest that a significant preponderance of the evidence indicates the Petitioner had never previously been reprimanded for violating company policy by wearing the Sketchers shoes. This shows an acquiescence of the Respondent to the shoes the Petitioner normally wore to work. Furthermore, notwithstanding the above analysis, the Arbitrator finds the Respondent failed to affirmatively prove that Petitioner was in violation of company policy. Petitioner testified she was wearing Sketcher brand "winter style" shoes. Petitioner maintained the shoes were not gym shoe and were not in violation of company policy. Petitioner testified she wore those shoes routinely to work and was never reprimanded by Respondent. Respondent's witnesses confirmed that Petitioner was not reprimanded, and that "winter style shoes" were acceptable.

The Arbitrator finds that, regardless of this safety violation dispute, the act of wearing gym shoes is not a bar to compensability because Petitioner was still within the "sphere of employment" at the time of the accident. The Petitioner was a bus monitor walking through the parking lot to the bus. The parking lot where Petitioner fell was not open to the public. Only employees of Respondent had access to the parking lot. As part of her job duties, Petitioner had to walk through the parking lot to get to the bus multiple times daily. The accident occurred when it was dark outside (6:30 am in January). Petitioner was "doing exactly the thing she was employed to do" when she fell in the parking lot on her way to monitor the bus. *J. S. Masonry, Inc. v. Industrial Comm'n*, 861 N.E.2d 202 (2006). Therefore, even if Petitioner was wearing gym shoes in violation of the company policy, the violation is not a bar to compensability, because the act of walking through the parking lot to the bus to monitor the bus was within the sphere of employment and is thus compensable under *J.S. Masonry*.

While the Respondent has cited a number of Commission cases that have denied benefits based on the violation of company rules, the Arbitrator notes that these cases are not of true precedential value as our supreme and appellate courts have identified the bases for making the necessary determinations in this case. Additionally, without more it is impossible for the Arbitrator to determine the final outcome of those cited cases.

The Arbitrator did locate one fairly recent case where the appellate court determined that the violation of a safety rule resulted in the case being determined to be non-compensable, *Saunders v. Industrial Comm'n*, 301 Ill.App.3d 643, 235 Ill.Dec. 490, 705 N.E.2d 103 (1998). In that case a worker was riding double on a forklift, in violation of safety rules, to go and take his lunch, and stepped off the moving lift. The court distinguished cases where an employee did permitted work in a prohibited manner versus an employee engaging in prohibited duties that were personal to the employee, such as riding double on a forklift in order to go to lunch. This case is clearly distinguishable from the case at bar.

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 Petitioner testified that she struck her posterior head and back when she slipped and fell on 1/23/19. The initial reports from Ingalls and South Holland Medical Center are consistent with her report. While her initial head injury appears to have been minor, the remainder of the medical records indicate mainly ongoing low back complaints. Treating physicians Dr. Foreman and Dr. Najera have opined to a causal relationship, and while she may disagree on the specific diagnoses, Respondent's Section 12 Examiner Dr. Wehner also opined that her diagnoses were causally related to the 1/23/19 accident.

The Arbitrator finds that the Petitioner's cervical and lumbar strains, head injury and coccyx contusion were causally related to the 1/23/19 accident. While the Arbitrator notes that the Petitioner did strike her head and may have sustained a cervical strain, all complaints and treatment after the initial 1/23/19 visit to the Ingalls ER have been related only to the lumbar spine.

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 adopts the conclusions in part (F) above. Therefore, Respondent shall pay Petitioner the following medical bills per the Illinois fee schedule:

Provider	Balance
AMCI 1	$4,418.00
AMCI 2	$1,429.00
G & U	$4,025.20
EQMD	$1,695.73
MRAD MRI	$1,600.00
TOTAL:	$13,167.73

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on a review of the complete medical records, the Arbitrator finds that the Petitioner reached maximum medical improvement as of 3/18/19 visit of Dr. Najera. Dr. Wehner had already previously opined that Petitioner had reached MMI on 2/25/19. While Dr. Najera recommended an orthopedic evaluation and that he disagreed with Dr. Wehner's conclusions, the Arbitrator notes that the Petitioner's FCE appears to have some type of invalidity issues with regard to the Petitioner's performance. She was released to full work duties by Dr. Wehner. Her MRI appears to show age-appropriate degenerative changes for a 69 year old woman. While Dr. Najera continued her off work pending orthopedic evaluation, the Arbitrator accepts the orthopedic evaluation of Dr. Wehner. The Arbitrator notes that the Petitioner's job appears to be relatively sedentary, despite what is indicated in the FCE report, as her only description of her job is walking to and from her assigned buses and monitoring the school bus. Neither Dr. Foreman nor Dr. Najera indicated their basis for continuing to hold Petitioner off work. The preponderance of the evidence supports that the Petitioner reached MMI as of 3/18/19.

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

The Arbitrator finds that the Petitioner was temporarily totally disabled from 1/24/19 through 3/18/19, based on the findings noted above with regard to accident, causation and MMI.

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

DONNA SMITH,

Petitioner,

vs. NO: 18 WC 17246

20 I W C C 0 4 9 5

ZF CHASSIS SYSTEMS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), and prospective medcial, 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 22, 2019 is hereby affirmed and adopted.

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

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 $15,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 - 2020

D. Douglas McCarthy

DDM/tdm
O: 7/8/20
052

Stephen Mathis

DISSENT

I view the medical evidence in a different light than the majority as I would afford greater weight to the opinions of Dr. Fetter over those of Dr. Colman. As such, I respectfully dissent.

On February 25, 2019, Dr. Fetter evaluated Petitioner pursuant to Section 12 of the Act at Respondent's request. During the evaluation, Dr. Fetter noted three out of five Waddell's sign which "may indicate non-organic or psychological component to chronic back pain." RX1. The Majority, in affirming and adopting the Arbitrator's decision, acknowledges Petitioner's questionable ongoing back complaints finding "there does appear to be a level of embellishment in her testimony, both in terms of the weight of the manipulator as well as her current condition. It is difficult to believe that she has worsened significantly since her therapy ended, as she was essentially discharged at that time with, as noted, self-reported 90% improvement and no ongoing radicular symptoms in her right leg." *Infra*, p. 6, ¶ 6.

Dr. Fetter found Petitioner sustained a lumbar strain which resolved following a course of physical therapy. This opinion is consistent with Petitioner's treatment regime. On December 20,

2018, Petitioner reported "she has been feeling much better, no longer has much LBP or radicular pain in her L LE." Thereafter physical therapy continued, and on April 3, 2019, Petitioner was discharged from physical therapy with a good outcome and a complete resolution of her radicular pain. PX2. As such, I would deny Petitioner's request for further medical treatment.

For the above-stated reasons, I, respectfully, dissent.

L. Elizabeth Coppoletti

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

SMITH, DONNA
Employee/Petitioner

Case# **18WC017246**

ZF CHASSIS SYSTEM
Employer/Respondent

20IWCC0495

On 9/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

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

20IWCC0495

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

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

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

DONNA SMITH
Employee/Petitioner

v.

ZF CHASSIS SYSTEM
Employer/Respondent

Case # **18** WC **17246**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **May 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **May 22, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,188.32**; the average weekly wage was $**715.16**.

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

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

Respondent shall be given a credit of $**9,180.00** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**9,180.00**.

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

ORDER

The Arbitrator finds that the Petitioner's lumbar condition is causally related to the May 22, 2018 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$476.77 per week** for weeks, commencing **6/4/18 through 5/15/19**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$9,180.00** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expense balances of **Midwest Orthopedics totaling $377.00 and Four Seasons Medical Center totaling $336.00**, as provided in Sections 8(a) and 8.2 of the Act, so long as this does not constitute balance billing in excess of what is allowable pursuant to Section 8.2 of the Act.

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

The Respondent shall authorize a **return visit to Dr. Coleman**.

Petitioner's Petition for penalties and fees pursuant to Sections 16, 19(k) and 19(l) 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

September 10,2019
Date

SEP 11 2019

STATEMENT OF FACTS

Petitioner testified she was employed by Respondent on 5/22/18 as an OP 490. Petitioner testified her normal job involved making brakes for Fords, and that lifting the manipulator was not part of her normal job. She would be on her feet at work for 10 to 12 hours per shift with twenty-minute breaks every 3 hours and a half hour lunch. She testified she would be lifting the whole time at work, including calipers (10-12 pounds) and rotors (30-40 pounds), and that she would make at least 1200 brakes per day in a 10-hour periods. Petitioner testified she had no back problems or pain, or pain going down her legs, prior to 5/22/18.

On 5/22/18, Petitioner testified she lifted what she estimated to be a 100 to 200 pound "manipulator" overhead and developed pain shooting down her back on the right. She sought treatment that night at occupational health. She went back to work at her regular job. No records were located in the presented evidence with regard to this visit.

Petitioner testified she was eventually taken off work by her doctor and received TTD benefits. A 6/4/18 report from Four Seasons Medical Center notes the Petitioner hurt her low back at work and had missed time from work for the first time in 3 to 4 years. Her pain was noted to be in the sacral area and it was painful to move or touch. She was prescribed Mobic and Flexeril, and an MRI was ordered. At a 7/6/18 follow up, Petitioner indicated the medication helped her and she was seeking a refill. (Px2).

The 7/24/18 lumbar MRI report's impression was intact ring grade 1 spondylolisthesis at L4/5 related to facet arthropathy, and multilevel degenerative changes with varying degrees of subarticular and foraminal stenosis. A review of the body of the report indicates degenerative changes throughout, worst at the L3/4, L4/5 and L5/S1 levels, and a disc osteophyte complex at L2/3. The report indicates severe facet degeneration with marked narrowing of the facet joint spaces, articular osteophytes, and thickening of the ligamentum flava, with mild to moderate narrowing of the right foramen and mild narrowing of the left foramen at L4/5. At L5/S1, it also reflects that she had moderate to marked facet degenerative changes, articular osteophytes and thickening of the ligmentum flava, with mild right and moderate left subarticular stenosis and moderate narrowing of the left foramen. (Px2).

Petitioner next sought treatment with orthopedic surgeon Dr. Colman at Midwest Orthopaedics at Rush on 9/26/18. It was unclear to the Arbitrator from her testimony whether this was on referral from her primary doctor or her attorney. Petitioner reported low back pain with radiation into her right leg to the shin and right ankle inflammation. She indicated that her job with Respondent involved twisting, turning, bending, and lifting,

and that she was injured on 5/24/18 after she lifted a manipulator that weighed more than 50 pounds. She indicated she developed low back pain which then worsened throughout the week, noting she had not experienced back pain or radiating symptoms prior to this incident. X rays showed a mobile spondylolisthesis at L4/5 and spinal stenosis. Dr. Colman opined that the work injury exacerbated her diagnosis of L4/5 mobile spondylolisthesis and spinal stenosis, and he recommended conservative care before considering any surgical options, including physical therapy, epidural injection at L4/5 and anti-inflammatory medication. He also restricted her from working. (Px3).

Petitioner underwent therapy at Midwest Orthopaedics before returning to Dr. Colman on 11/20/18. His 11/20/18 report notes her pain was significantly improved with therapy but ongoing problems with prolonged sitting or standing, and pain radiating down the right leg to her heel. Dr. Colman continued physical therapy, ordered an L4/5 epidural and continued to keep Petitioner off work. The epidural was performed on 1/2/19 and Petitioner followed up with Dr. Colman's office on 1/28/19, seeing physician's assistant (PA) Samuels and reporting the epidural injection had helped with the sharp shooting pain she was having into the right leg. However, she reported she continued to feel what she described as "internal pain" in both legs, which was mainly in the right thigh and also sometimes in her left thigh when resting at night. Petitioner reported that she did not have pain in her left leg until after the epidural. She also reported that she had made progress with physical therapy though it did not completely relieve her pain. PA Samuels indicated Petitioner should remain off work during therapy, continue medications and was to follow up in two months for evaluation. (Px3).

Petitioner testified that the epidural only helped temporarily, less than a week, after which she indicated it actually gave her pain and aches in both of her legs, noting she wasn't sure why as her left leg wasn't hurting her prior to the epidural.

Respondent had Petitioner examined by orthopedic surgeon Dr. Fetter on 2/25/19 pursuant to Section 12 of the Act. He indicated that Petitioner reported injuring her back at work while lifting a manipulator on 5/22/18, and she denied any prior similar injuries. She indicated she initially noted pain in her right leg, later noting pain in her left leg during physical therapy. As to her occupational history, the report notes she had worked for Respondent for 14 years in a job which involved lifting up to 50 pounds. It appears that Dr. Fetter found evidence of three out of five Waddell signs. Following examination and review of medical records, Dr. Fetter concluded that the Petitioner had sustained a lumbar sprain at most at the time of the accident, which was temporary and had resolved. He opined that the MRI showed a pre-existing degenerative condition of her lumbar spine which was not caused by the accident nor aggravated beyond any normal progression. He further opined that the treatment rendered by Dr. Colman was causally related to the accident and that she had reached maximum medical improvement (MMI) by 7/22/18, with any ongoing treatment after that date not being reasonable and necessary. He did not specify the significance of the 7/22/18 date other than it being two months after the accident. He indicated that she could perform her full duty work without restrictions.

Petitioner testified she felt Dr. Fetter's examination was "rushed", that he touched her up and down on each side of her body, asked her to bend and touch her toes. From her perspective, he did not really examine her well.

Petitioner continued to participate in physical therapy through 4/3/19. At this last visit, she rated her improvement at 90% since she had started physical therapy with no ongoing radicular pain or symptoms in her leg, just achiness in her thighs in the evenings. She was able to do all her activities of daily living and her household chores with no pain but reported she fatigues easily and must stop to rest. The therapist indicated it was now muscle weakness and deconditioning that was limiting the Petitioner, not pain. She reported she could be on her feet for 30 minutes and could only walk 20 minutes at a time before she is tired, but again had no pain. She could lift lighter items that weighed under 20 pounds at home, noting this made laundry difficult. Her

employer had closed its doors and she was concerned about performing any heavy lifting in a new job. Petitioner was advised to participate in a home exercise program and of the importance of cardiovascular activity. She was discharged and was to return to Dr. Colman's office on 4/26/19. (Px3).

Petitioner testified she was in "a little" pain at the hearing but was mainly nervous. She testified that she completed her physical therapy but was unable to follow up with Dr. Colman without authorization from Respondent, as she has no private insurance. She testified that physical therapy also helped, reducing her pain by at least 50%, and that she has worsened since it ended. Currently, the Petitioner testified that she has mild pain from her low back down her posterior right leg to her foot. She testified she has had pain down her leg since the accident and that it hadn't really improved much. Petitioner testified that she was talking prescribed Diclofenac until she ran out last month, and now takes Aleve at least 3-4 times per day since, which also provides temporary relief. Without medication, she testified her pain is severe, most days at 9 out Of 10, shooting from the low back to the right foot. She feels her best when she wakes up in the morning. When she goes to bed she has a numbness as opposed to achy feeling. Once she gets up and starts moving around she starts feeling achiness and pressure from her back going down her leg. Prolonged driving, standing and walking (15 to 25 minutes or more) increase her pain. She testified that she is unable to lift, noting she tried to lift a case of water the day before the hearing and was unable to do so as the pain shot into her foot when she tried. She does not feel she could perform her regular job with Respondent at this time.

On cross examination, Petitioner testified she told Dr. Fetter how she was injured and provided an accurate history. She did provide him with a CD copy of her MRI, which he gave back to her. She didn't see him review it so couldn't say if he did or did not do so. Petitioner continued to work for approximately a week after the accident date before going off work, and she agreed she received TTD until the report of Dr. Fetter was received. She was unable to say which of her medical bills were or were not paid, though her attorney believed the expenses of Midwest Orthopaedics likely had been paid, and the parties have agreed that the Respondent is entitled to credit for any awarded medical expenses that were paid by Respondent prior to the hearing date. Petitioner agreed she saw a physician's assistant at her last visit to Dr. Coleman's office, not the doctor himself.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner's current condition of ill-being is causally connected to her accident. While it appears clear that the Petitioner had a pre-existing condition of spondylolisthesis and degenerative disease in her lumbar spine, there is no evidence indicating this condition was symptomatic prior to the hearing date. Instead, it appears that the 5/22/18 accident triggered symptoms of low back pain into the right leg. The incident itself involved lifting a heavy manipulator, the history of which does not appear to be in dispute. While the Petitioner seems to have exaggerated the weight of this item somewhat in her testimony, 50 pounds is nevertheless quite heavy and a reasonably competent cause of a low back injury. The histories contained in Petitioner's medical records are consistent with her developing symptoms after lifting a heavy manipulator. This evidence supports the finding that the 5/22/18 work accident aggravated the preexisting low back condition and led to the development of symptoms. Even though an employee has a pre-existing condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 797 N.E.2d 665 (2003).

Dr. Colman's records reflect his opinion that Petitioner's condition was aggravated by her work injury. Under Illinois law, an accidental injury need not be the sole or primary causative factor in a condition of ill-being, it need only be a causative factor. Dr. Fetter's conclusion that Ms. Smith sustained only a temporary lumbar strain which resolved in on 7/22/18 is not sufficiently explained by the doctor. While the Arbitrator understands his position that the accident didn't cause the degenerative changes viewed in the MRI films, he seems to have chosen an arbitrary date in terms of when he determined the aggravation of the condition ended, despite the fact he did not actually examine the Petitioner until 2/25/19. The medical records in evidence support the determination that the Petitioner remained symptomatic after 7/22/18. Her condition did significantly improve with physical therapy that continued through 4/3/19, but she has indicated her symptoms have not fully resolved, and at a minimum right now her physical therapist believed she was deconditioned and had some ongoing weakness.

Based on the above noted evidence, he Arbitrator finds that Petitioner's current condition of ill-being relative to her low back is causally connected to the 5/22/18 work accident.

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

Petitioner's treatment to date has been reasonable and necessary to treat her lumbar condition of ill-being. Petitioner submitted bills from Midwest Orthopedics at Rush (Px3) and from Four Seasons Medical Center (Px2). The bill from Midwest Orthopedics shows an unpaid balance of $377.00 for physical therapy, while the bill from Four Seasons Medical Center shows an unpaid balance of $336.00. The Arbitrator finds these bills reasonable and necessary and awards same pursuant to Sections 8(a) and 8.2 of the Act.

The Respondent is entitled to credit for any payments previously made towards these awarded bills, and with regard to any such credits shall hold the Petitioner harmless.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

This is a difficult issue in this case. The Arbitrator acknowledges that the Petitioner's work aggravation of her low back condition continued after 7/22/18. At the same time, the records from physical therapy and the Petitioner's testimony indicate that she improved 90% with therapy. They, as well as the 1/28/19 report of Dr. Colman's office, indicate that the Petitioner's radicular symptoms resolved following the epidural injection. While she did note some type of "ache" in her thighs, this was a significantly nonspecific complaint and quite different than the leg complaints she had previously.

The Arbitrator also notes that while he is not finding that the Petitioner was not credible, there does appear to be a level of embellishment in her testimony, both in terms of the weight of the manipulator as well as her current condition. It is difficult to believe that she has worsened significantly since her therapy ended, as she was essentially discharged at that time with, as noted, self-reported 90% improvement and no ongoing radicular symptoms in the right leg. The Arbitrator also notes that her problems at that point, according to the physical therapist, was weakness and deconditioning as opposed to pain. Petitioner was also advised of the importance of performing ongoing home exercise and cardiovascular conditioning, but she did not testify as to whether she has continued such activities since 4/3/19. However, the evidence indicates the Petitioner was unable to follow up with Dr. Colman following her discharge from physical therapy.

The Respondent shall authorize an additional visit with Dr. Colman. However, it would be more than reasonable for the Respondent to obtain an updated Section 12 examination should Dr. Colman recommend any treatment beyond reconditioning the Petitioner in preparation for a return to the work force.

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

The parties agree that Petitioner was temporarily totally disabled from 6/4/18 through 2/25/19. The dispute is with regard to TTD benefits from 2/26/19 through the 5/15/19 hearing date. Respondent terminated the benefits based on the report of Dr. Fetter.

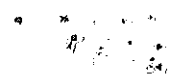
Dr. Colman restricted the Petitioner from work starting on 9/26/18 and continued those restrictions through 1/28/19, at which time his PA Samuels indicated the Petitioner was to remain off work pending follow up in two months.

On this issue, the Arbitrator finds in favor of the Petitioner. While there is a question in the Arbitrator's mind whether the Petitioner was able to return to work by the time of her last physical therapy visit on 4/3/19, the greater weight of the evidence indicates the Petitioner was not authorized to return to Dr. Colman to make such determination. Dr. Fetter examined the Petitioner in February 2019 and opined that she would have able to return to work in September 2018, despite not having seen her during that time, and therefore Dr. Colman's opinion is more persuasive on this issue. The Arbitrator also notes with interest that the Respondent's facility was closed at some point which the Petitioner testified left her without any group health insurance either via which she may have been able to return for a follow up visit.

The Arbitrator finds that the Petitioner is entitled to TTD benefits from 6/4/18 through 5/15/19. Respondent shall receive a credit for TTD totaling $9,180.00 that was previously paid to the Petitioner.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the findings with regard to causal connection, there is not sufficient evidence to support a finding that Respondent acted unreasonably or vexatiously in their denial of benefits. The Respondent reasonably relied upon the opinions of Dr. Fetter. While the Arbitrator has noted that Dr. Fetter's indication that the Petitioner was capable of returning to work two months after the accident date seems somewhat arbitrary, his opinion was certainly reasonable by the time he issued his report. Any delay alleged pursuant to Section 19(l) was explained by the opinions of Dr. Fetter and was not unreasonable.



STATE OF ILLINOIS	)		
	) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF KANE	)	☐ 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

Semeli Tanya Yousif,

Petitioner,

20IWCC0496

vs. Nos. 15 WC 10947
16 WC 08127

State of Illinois/Illinois Youth Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner's application for adjustment of claim in case No. 15 WC 10947 alleges that on August 16, 2014, Petitioner "[w]hile opening door, struck head and fell backward into desk." Petitioner's application for adjustment of claim in case No. 16 WC 08127 alleges that on December 8, 2015, Petitioner "struck control console of van." Both claims allege injuries to the neck, back and person as a whole. Claim No. 15 WC 10947 further alleges head injuries.

Petitioner testified that she began working for Respondent as a juvenile justice specialist in September of 2013. Before starting the job, Petitioner completed self-defense training and passed a physical examination. Petitioner denied any ongoing medical treatment or complaints relative to her head, neck or back before August 16, 2014.

Petitioner described the accident on August 16, 2014, as follows: "I was assigned to the hospital post that day. It was a Saturday. And I was closing the hospital post which is a really tight corridor. There is a desk right next to the door and the chair and it's like all almost within the same space. ¶ So

20IWCC0496

the door was open and then there was a chair that was like right by my leg. I just wanted to push it out of the way and fell right into the [steel] door." The left frontal lobe of Petitioner's head struck the door; Petitioner then "flew back and the lower back part hit the desk directly behind [her]." Petitioner's "immediate symptom *** was intense fog." The following day, Petitioner worked her regular shift. Her symptoms worsened. She developed dizziness and blurred vision.

Petitioner testified that she sought medical care on August 19, 2014, at Immediate Care Park Ridge. After the immediate care visit, Petitioner followed up with her primary care physician, Dr. Boris Sheynin. Petitioner then saw Dr. Suzanne Greider, an internist. Dr. Greider oversaw much of Petitioner's post-accident medical care. Dr. Greider prescribed physical therapy, which Petitioner underwent at St. Francis Hospital. Dr. Greider also referred Petitioner to Dr. John Panopoulos "for some conservative manipulations" and to Dr. Caroline Agha for neurological treatment. Dr. Agha diagnosed post-concussive syndrome and recommended vestibular therapy and consulting an ophthalmologist and an ENT. Petitioner saw an ophthalmologist, Dr. Gila Buckman, who diagnosed convergence insufficiency. Dr. Greider then referred Petitioner to another ophthalmologist, Dr. Henry Meisels, who agreed with the recommendation for convergence therapy. Petitioner saw an ENT, Dr. Matthew Pogodzinski, who also diagnosed post-concussive syndrome. Dr. Panopoulos, the chiropractor, referred Petitioner to Dr. George Michalopoulos, a chiropractic neurologist. Dr. Michalopoulos ultimately referred Petitioner to Carrick Brain Center (Carrick) in Marietta, Georgia. In January of 2015, Petitioner underwent "an intense brain and vestibular rehabilitation program" for one week, followed by a supervised home exercise program. Carrick then recommended a local rehabilitation program at Wholistic Therapeutics, which Petitioner started on March 30, 2015. Petitioner explained: "With the accident, my scalp was tender to the touch. It was difficult shampooing so the tissue was knotted, and they had to do therapy on the tissue on my scalp." Petitioner agreed that she also had tightness and tenderness in her neck.

Post-accident, Petitioner worked on light duty until Respondent stopped accommodating her restrictions as of November 25, 2014.

Petitioner further testified that in September and October of 2015, she saw Dr. Edward Sclamberg, an orthopedic surgeon, giving a history of striking her left arm while walking out of an elevator. Petitioner attributed the incident to fogginess and vision problems. Dr. Sclamberg stated Petitioner could work on light duty. However, Respondent did not offer Petitioner light duty work. In November of 2015, Dr. Greider recommended a return visit to Carrick. Petitioner did not go because she never received an authorization.

On December 7, 2015, Petitioner returned to work on restricted duty. The following day, Petitioner sustained another work accident. Petitioner described the accident as follows: "I came in. Reported for shift. And there was a van that was taking us to all of our posts and you get inside of the back of the van where security drives you to your post. But when I got in, that space issue I was having again with the eyesight I guess I didn't determine how high the ceiling was and the console. ¶ You take out *** the buttons, *** off the console, like the heat and air conditioning. You take them off and the metal pins are in there. I struck the metal pin on the top of the console." On December 16, 2015, Petitioner went to the emergency room of St. Francis Hospital because of worsening neck and low back pain after the accident. Petitioner followed up with Dr. Greider, who referred her to Chicago Body Works for physical therapy. The second accident did not change Petitioner's work restrictions. She

continued to work on light duty through March 6, 2016, when Respondent again stopped accommodating the restrictions.

Petitioner further testified that in December of 2016, she came under the care of Dr. Susan Keeshin at the Rehabilitation Institute of Chicago/Shirley Ryan Ability Lab. Petitioner underwent physical, occupational and speech/language therapy under Dr. Keeshin's supervision through May of 2017. Dr. Keeshin also referred Petitioner to Dr. Michael Zost, a vision rehabilitation specialist. Dr. Zost diagnosed difficulty with tracking and convergence related to the accident on August 16, 2014, and prescribed vision rehabilitation/convergence therapy. Petitioner did not undergo the therapy prescribed by Dr. Zost because of lack of authorization. Dr. Zost also referred Petitioner to Dr. Marshall Dickholtz, who prescribed hyperbaric oxygen therapy with Dr. Daphne Denham. Dr. Dickholtz additionally referred Petitioner to Dr. Lenny Cohen, a neurologist. Petitioner underwent some hyperbaric oxygen therapy, and Dr. Cohen prescribed continued hyperbaric oxygen therapy. Petitioner stated she "[v]ery much" made progress with the hyperbaric oxygen therapy. However, Respondent refused to pay for further hyperbaric oxygen therapy.

Petitioner wishes to continue treatment under the direction of Dr. Cohen, Dr. Dickholtz and Dr. Zost. Petitioner described her current condition as follows: "My energy level is one. The eye convergence with the exercises he had given me, I was making a lot of progress, but I'm still seeing issues on a day-to-day [basis] like with doors or spacing and things of that sort. ¶ As to the brain stem, I'm limited on my neck movement so if I—I'm restricted from doing any rapid movements *** that will aggravate. ¶ These are symptoms from the concussion to the speech. It will aggravate like the brain stem part until it's fully healed. It's in the healing process." Petitioner does not believe she can return to work full duty until she completes the treatment with Dr. Cohen, Dr. Denham, Dr. Dickholtz and Dr. Zost.

At Respondent's request, Petitioner was examined by: Dr. Jeffrey Kramer in November of 2014; Dr. Howard An in September of 2017; and Dr. Randy Epstein in November of 2017.

On cross-examination, Petitioner testified she did not undergo the vestibular therapy recommended by Dr. Kramer because it was not authorized. Petitioner affirmed that she underwent physical therapy at St. Francis Hospital, which was originally prescribed by Dr. Sheynin. Petitioner also attended the physical therapy prescribed by Dr. Greider. Additionally, Petitioner underwent the chiropractic treatment prescribed by Dr. Panopoulos. Petitioner denied that Dr. Keeshin placed her at maximum medical improvement on May 2, 2017. On redirect examination, Petitioner clarified that on May 2, 2017, Dr. Keeshin declared her at maximum medical improvement from the physical medicine perspective, but wanted her to follow up with Dr. Zost.

Regarding her current restrictions, Petitioner testified that Dr. Dickholtz restricted her from rapid movement of the neck or any strenuous activity, and Dr. Cohen "did not want [her] in anything where it would be like a violent environment where it would cause any physical strenuous activity." Petitioner feels she is now healing a lot slower compared to when she was undergoing oxygen therapy. Petitioner denied any preexisting conditions that would cause her current complaints.

Turning to the exhibits, an employee accident report dated August 22, 2014, states that Petitioner reported she "was securing office and opened door to leave when door hit side of head."

The medical records in evidence show that on August 19, 2014, Petitioner sought treatment at Immediate Care Park Ridge for dizzy spells, headache and fatigue for three days, after hitting her head on a door. The attending physician recommended over-the-counter medication and instructed Petitioner to follow up with her primary care provider.

On August 21, 2014, Petitioner followed up with Dr. Sheynin, who noted: "Patient hit a steel door at work very hard on Saturday. She developed headache, dizziness on Saturday afternoon. On Sunday and Monday, she started to feel lethargic and sleepy, with the headache over her left temporal area, but also everywhere in her head. On Tuesday, she went to see a doctor at the Emergency center, did not have any imaging and was diagnosed with brain contusion." Petitioner complained of persistent dizziness and lethargy. Physical examination was notable for neck tenderness to palpation, nystagmus to the right, and a positive Rhomberg test. Dr. Sheynin diagnosed a head contusion, whiplash and vertigo, and ordered a CT scan of the head. On August 22, 2014, Petitioner followed up after undergoing the CT scan, which was normal, and asked Dr. Sheynin to complete short-term disability paperwork. On August 25, 2014, Petitioner reported her headache was better. Her main complaint was fatigue. Physical examination was unchanged. On August 28, 2014, Petitioner complained of "severe throbbing neck pain upon awakening today, with throbbing and numbness in both arms." She also complained of heaviness and numbness in her feet, as well as allergy-type symptoms. Dr. Sheynin diagnosed cervical radiculopathy and ordered x-rays of the cervical spine. The x-rays were unremarkable.

On September 4, 2014, Petitioner presented to Dr. Greider "with c/o 3 week history of being hit in head with steel door at work. She states no LOC. The next day she developed symptoms of dizziness and cervical pain. * * * Today she c/o room spinning for several seconds with change of position in bed and cervical neck pain." Physical examination was unremarkable. Dr. Greider prescribed physical therapy and restricted Petitioner to light duty work. On September 11, 2014, Petitioner followed up, reporting improved vertigo and headaches, and continued cervical and trapezial pain. Dr. Greider instructed Petitioner to continue physical therapy. On September 18, 2014, Petitioner reported continued improvement with physical therapy.

The next note from Dr. Greider is dated April 20, 2015. Petitioner sought treatment for acute bronchitis and sinusitis. On July 9, 2015, Petitioner sought treatment for acute abdominal symptoms. Dr. Greider further noted: "She continues to be off work from accident at work as she states her perception is still 'off' and is being treated [Carrick] Brain Center for her concussion." On October 21, 2015, Petitioner again sought treatment for abdominal symptoms. On November 25, 2015, Petitioner presented "with papers for Disability. She is going to Cerebrum Brain Center in Atlanta Georgia in January 2016 for re-evaluation." Dr. Greider filled out the disability forms.

On December 22, 2015, Petitioner followed up with Dr. Greider "after being seen in the ERD for neck and low back pain and given Flexeril. She states feeling tightness in right cervical and low back pain and as 'Workmans Comp is SO slow' she is going for PT at The Chicago Body Work's or Pro-Health Medical Group and self-pay. She also has Disability papers to be filed." Dr. Greider diagnosed "[p]ostconcussional syndrome," "[s]prain of ligaments of lumbar spine" and cervicalgia, and completed the disability paperwork. On January 20, 2016, Dr. Greider again completed disability paperwork for Petitioner. On March 8, 2016, Petitioner presented "for disability papers to be filed out. She states no

acute medical problems at time of this visit." Physical examination was normal. Dr. Greider noted: "Disability papers filed out. No Objective findings."

Thereafter, Dr. Greider continued to periodically complete disability paperwork for Petitioner. On September 7, 2016, Petitioner stated "she has pain and swelling of her left knee after hitting it with a laundry basket and swelling of her left ankle after hitting it with a cutting board." She requested an orthopedic referral. Physical examination from the accident *sequelae* was normal. There are no further office notes; only two additional completed disability forms.

The medical records from Presence St. Francis Hospital show that on September 5, 2014, Petitioner underwent a vestibular and physical therapy evaluation at the referral of Dr. Greider. The physical therapist assessed: "Impaired Joint Mobility, Motor Function, Muscle Performance, and Range of Motion Associated with Connective Tissue Dysfunction" and "Primary Prevention/Risk Reduction for Loss of Balance and Falling." Petitioner attended seven physical therapy sessions for vertigo and neck pain. She canceled the remaining two appointments. A physical therapy discharge note dated November 14, 2014, states: "[The patient] reported her dizziness and neck pain has resolved however reported increasing fatigue, memory loss and headaches. Pt was recommended to see neurologist for further evaluation."

In the meantime, Petitioner underwent a number of diagnostic tests at St. Francis Hospital. Electrodiagnostic studies performed by Dr. Agha on October 7, 2014, showed: "Nerve conduction study of the left arm was normal. Needle EMG of the sampled left C5-C7 muscles was normal. Pt unable to tolerate the rest of the EMG and therefore not all the muscles were obtained." A cervical spine MRI performed October 8, 2014, showed "C5-6 and C6-7 with circumferential disc bulge with superimposed posterior central disc protrusion causing moderate spinal stenosis and mild effacement of the thecal sac. No neuroforaminal narrowing bilaterally." An MRI of the brain performed October 31, 2014, was normal. A contemporaneous MRA of the neck was also normal. A contemporaneous MRA of the head/brain was also normal. A lumbar spine MRI performed November 24, 2014, was normal.

Voluminous chiropractic records from Dr. Panopoulos span the time period from September 29, 2014 through July of 2015 and note complaints of pain all over. Contained within the records from Dr. Panopoulos are cervical, thoracic and lumbar spine MRI reports from Swedish Covenant Hospital dated July 5, 2013 (pre-accident). The reason for the cervical MRI was "[n]eck pain down to bodies [*sic*]. Previous injury." The MRI showed: "1. Cervical spondylosis with disc degeneration, and a reversal of cervical lordosis. 2. Disc protrusion impinging the ventral spinal cord at C5-C6 and C6-C7. Resultant mild central canal stenosis." The thoracic MRI report states a history of "[b]ack pain into the rib cage. Previous injury." The MRI showed minor degenerative changes. The lumbar MRI report states a complaint of "[b]ack pain into the lower extremities." The MRI showed mild degenerative changes.

The medical records from Dr. Agha, a neurologist, show that on October 2, 2014, Petitioner presented with complaints of headaches and dizziness since the work accident. Dr. Agha further noted: "Pt is very frustrated because she is concerned about her memory and concentration being suboptimal, blurred vision and itching of the eyes almost constant, and she is having occasional headaches, noticed decreased hearing in the left ear when using earphones. *** She has been having difficulty reading." Petitioner reported her neck pain had resolved. Neurological examination was normal. There was no nystagmus. Rhomberg test was negative. Dr. Agha opined: "This is most likely post concussive

syndrome with a component of increased anxiety ***. Pt believes anxiety stems from fear of permanent disability due to the head trauma." Petitioner refused a referral to a mental health clinic. Dr. Agha ordered diagnostic studies and referred Petitioner to an ophthalmologist "for dry eyes and redness (not seen on exam today)" and an ENT "for sensation of hearing loss in the left ear." On October 31, 2014, Petitioner reported decreased headaches, but increased fatigue. She also complained of memory problems. "She saw ophthalmology but she told me that she did not get her eyes dilated. She denied numbness, tingling, weakness, no new vision changes." Neurological examination was normal. Dr. Agha reviewed a CT of the cervical spine and ordered repeat electrodiagnostic studies. Dr. Agha thought the post-concussive syndrome was improving.

The medical records from Dr. Pogodzinski and Dr. Liza Cohen show that on October 14, 2014, Dr. Pogodzinski ordered an audiogram to assess Petitioner's hearing. On December 4, 2014, Dr. Pogodzinski noted normal audiogram results. On September 18, 2015, Petitioner saw Dr. Cohen for a red-orange discharge from the left ear. Dr. Cohen opined it was likely due to cleaning with Q-tips. On November 25, 2015, Petitioner saw Dr. Pogodzinski for recent nose bleeds. Dr. Pogodzinski cauterized the area.

The medical records from Dr. Buckman show that on October 28, 2014, Dr. Buckman diagnosed "Convergence Insufficiency, possibly due to head injury."

The medical records from Dr. Meisels show that on November 25, 2014, Dr. Meisels assessed: "No ophthalmic sequelae of injury. Mild hyperopic astigmatism."

Chiropractic records from Dr. Michalopoulos span the time period from December 1, 2014 through December 31, 2014. On December 31, 2014, Dr. Michalopoulos referred Petitioner to Carrick at Petitioner's request.

The medical records from Carrick show a consultation visit from January 20 through January 26, 2015. "She presented with the complaints of chronic fatigue, physical and mental exhaustion, fogginess, dizziness, unsteadiness, difficulty with concentration, short term memory loss, eye pain with movement, blurred vision, global pain and headaches." Petitioner was assessed by Chiropractic Neurologists Diana Albertin and Nathan Keiser, who diagnosed "[p]ost concussive syndrome with a centrally maintained vestibulopathy" and prescribed "neuromuscular re-education and vestibular rehabilitation" exercises. After the visit, Petitioner was to continue the exercises at home and follow up biweekly with Dr. Albertin by email. On May 26, 2015, Dr. Albertin recommended that Petitioner return for a follow-up evaluation.

The medical records from Wholistic Therapeutics span the time period from March 30 through May 20, 2015. Petitioner underwent therapy for "myofascial restriction within head and neck, shoulders area." She reported a 70 to 80 percent improvement after 10 sessions.

The medical records from Dr. Sclamberg, an orthopedic surgeon, show that on September 29, 2015, Petitioner presented with a five-month history of pain in the left arm. "Approximately 5 months ago she was walking out of an elevator and hit her left arm on a door. Since that time she has had pain in the left upper arm. She has been seeing the chiropractor for it. She stated that at the time she hit the door it was because she has lost some of her coordination." Petitioner also reported some numbness

and tingling in the left arm "from her head injury." Physical examination and x-rays of the left arm were normal. Dr. Sclamberg diagnosed a soft tissue contusion and prescribed physical therapy. The medical bills show a subsequent visit. However, there are no accompanying medical records.

An employer accident report dated December 17, 2015, describes the accident on December 8, 2015, as follows: "EE was stepping into van, when temp control overhead grazed head, EE ducked to lower head/body, later on EEs lower back began aching, EE felt cold and lightheaded."

Emergency room records from St. Francis Hospital dated December 16, 2015, state that Petitioner presented with a history "significant for post concussive syndrome, presents w/ low back pain and neck pain x 1 wk." Petitioner gave a history of the accident in August of 2014, further reporting "on Dec 7, she was climbing into a van at work when she grazed her head on the top of the van stepping inside, but did not actually hit her head directly, and no bruising. Denies LOC. She states in order to not hit her head she had to suddenly crouch down and bend in order to avoid direct trauma. The following day, she developed worsening neck pain R lateral and worsening low back pain on the R side which is similar to a back strain she suffered a couple years ago. She has no weakness, numbness, ui/bi. Gait is stable. Denies nausea, vomiting, blurry vision, ams. *** She reports headaches that have actually improved since her injury 1 year ago." Physical examination was normal. The attending physician diagnosed cervical and lumbar strain, and prescribed medication.

The next set of medical records and accompanying bill is from Chicago Body Works (Chiropractor Christopher Halliday). Although the bill is for services from April 11 through August 16, 2016, the (handwritten, poorly legible) medical records only span the time period from July 20 through August 16, 2016.[1]

The medical records from Dr. Keeshin span the time period from December 6, 2016 through May 2, 2017. Petitioner treated with Dr. Keeshin for "persistent visual issues, fatigue, impaired cognition, sleep after concussion." Dr. Keeshin diagnosed post-concussive syndrome and prescribed a day rehab program, three full days a week, for vestibular and balance retraining, increased endurance, as well as cognition, attention and memory strategies. Dr. Keeshin also diagnosed anxiety and depression, and referred Petitioner for neuropsychologic testing, psychotherapy and counseling. Further, Dr. Keeshin referred Petitioner to Dr. Zost, a neurooptometrist. On January 30, 2017, Dr. Keeshin noted that Dr. Zost diagnosed issues with convergence and divergence and recommended visual rehabilitation, which was added to Petitioner's physical therapy. On May 2, 2017, Dr. Keeshin declared Petitioner at maximum medical improvement and recommended a functional capacity evaluation. Dr. Keeshin noted: "In therapy at RIC day rehab she was able to perform all higher level balance tasks and visual tasks without issue. She was able to multitask without issue. Neuropscy testing was canceled because she did so well on cognitive testing and she feels any cognitive issues are more related to visual issues/fatigue. She continues to state that she can not work however, now due to her 'neck' issues."

In the meantime, Petitioner began treating with Dr. Zost on January 23, 2017. Dr. Zost diagnosed: "Scotoma involving central area, bilateral" and "Psychophysical visual disturbances." He recommended vision rehabilitation therapy. On April 14, 2017, Dr. Zost transitioned Petitioner to a

[1]The Arbitrator denied the charges unsupported by the medical records.

20 IWCC0496
home maintenance program for 12 weeks. On May 30, 2017, Petitioner reported no improvement and possible worsening. Dr. Zost recommended to "[c]ontinue with vision rehab." On May 31, 2017, Petitioner returned with complaints regarding the right eye. Dr. Zost changed the diagnosis to psychophysical visual disturbances only. On June 22, 2017, Dr. Zost noted: "When had blurry vision from last visit, due to getting castor oil in eyes from hair treatment." Dr. Zost again recommended a home maintenance program for 12 weeks. On September 21, 2017, Petitioner reported improvement with the treatment she received from Dr. Dickholtz and oxygen therapy. Dr. Zost recommended a home maintenance program once a week. On January 3, 2018, Petitioner reported continued improvement with hyperbaric oxygen treatment. Dr. Zost recommended a home maintenance program for another 12 weeks. "Finish up oxygen treatment and then PR." On January 4, 2018, Dr. Zost issued a "to whom it may concern" letter stating: "At no time since I first began providing care for [the patient] have I concluded that she has reached maximum medical improvement with her vision. Due to her lingering visual issues in the area of fatigue, tracking and depth perception, I have instructed her to continue with her vision rehabilitation therapy and follow-up with me for a progress evaluation once she has completed her program of hyperbaric oxygen therapy."

The records from Chiropractor Dickholtz span the time period from February 9, 2017 through February 8, 2018. At the outset of treatment, Petitioner reported severe symptoms and disability due to problems with her neck, headaches/migraines, sinus issues, posture, weight gain, numbness and tingling in the extremities, dizziness, fatigue, sleeping problems, tension, ringing/buzzing in ears, upset stomach, hot flashes, light sensitivity, irritability and back pain. The symptoms interfered with "[e]verything. On days it is severe I don't and can not go anywhere. I can't speak, focus, eat, see light or anything." Petitioner attributed her conditions of ill-being to the accident on August 16, 2014. Dr. Dickholtz recommended "adjustment *** to the C1 vertebra to relieve the effects of an atlas subluxation complex." Petitioner underwent chiropractic manipulation, reporting gradual improvement. She also reported benefit from oxygen therapy. Dr. Dickholtz completed disability forms initially indicating Petitioner could work on light duty. As treatment went on, Dr. Dickholtz modified the restrictions to sedentary or off work.

The medical records from Dr. Denham at Healing with Hyperbarics span the time period from August 29 through December 12, 2017. Petitioner received 24 hyperbaric oxygen treatments, reporting benefit. During the course of treatment, Petitioner's complaints were mild, mostly relating to the left ear and some head and neck pain or stiffness.

The medical records from Dr. Lenny Cohen at Chicago Neurological Services appear incomplete. The only clinical note, missing the first page, is for the visit on April 30, 2018. Dr. Cohen noted a history of post-concussive syndrome. "She still has some residual problems and problems with response time." Petitioner reported benefit from her 24 hyperbaric oxygen treatments, and Dr. Cohen recommended 20 more. He restricted Petitioner to light/desk duty.

The last set of medical records is handwritten records from Dr. Prieto for a visit on February 1, 2018. Petitioner gave a history of striking her left knee two years earlier on a laundry basket and a table, and complained of a "bubble" over the knee.

As noted, Respondent had Petitioner examined by Dr. Kramer in November of 2014, Dr. An in September of 2017, and Dr. Epstein in November of 2017.

Dr. Kramer, chief of neurology at Mercy Hospital and clinical assistant professor at the University of Illinois, testified by evidence deposition on March 22, 2016. Dr. Kramer examined Petitioner on November 11, 2014. Petitioner gave a history consistent with her testimony. Physical examination was significant for "some brief nystagmus, which is a jerky eye movement, when she was looking to the right. She had some increased sensitivity to pin sensation to the left thumb and index finger. And she had a cautious gait." Dr. Kramer diagnosed post-concussive syndrome with chronic subjective dizziness and recommended an additional six weeks of active vestibular physical therapy, as well as physical therapy for the neck and light duty restrictions. He also recommended Valium and Lexapro. Dr. Kramer understood that Petitioner never underwent the recommended vestibular therapy. Dr. Kramer stated that chiropractic treatment was outside his recommendation. In an addendum dated July 20, 2015, having reviewed additional medical and chiropractic records, Dr. Kramer opined Petitioner's care was excessive. "So my opinion was that since [my recommendations] weren't followed, there was no medical reason to continue treatment." Dr. Kramer did not think Petitioner received appropriate treatment for her dizziness. Because his treatment recommendations were not followed, Dr. Kramer declared Petitioner at maximum medical improvement.

Dr. An, an orthopedic surgeon, issued a report after examining Petitioner on September 29, 2017. Petitioner reported a neck injury from the accident on August 16, 2014. "Her main issue is the stiffness and neck pain, headache in the upper cervical spine and her condition is improving with recurrent treatment." Dr. An was forwarded very few medical records. He reviewed a cervical MRI, which showed "some disc herniation or protruding disc at C5-C6 with some localized kyphosis with some foraminal stenosis. There is no evidence of any spinal cord compression." Dr. An opined the accident "probably aggravated her preexisting condition of cervical spondylosis causing mostly neck pain. Her radicular symptom down the left arm has basically resolved at the present time. Her current subjective complaints of upper cervical neck pain is consistent with the neck pain due to cervical spondylosis and possibly neck pain due to C1 to motion segment." Dr. An further noted: "The patient seems to be focused on her upper cervical condition as well as her chiropractic treatment, she has been getting that is helping and there may be some behavioral component to her condition as well." Dr. An thought the treatment Petitioner had received was reasonable, although the chiropractic treatment may be somewhat excessive. Nevertheless, Dr. An approved of continuing chiropractic treatments for a month. Dr. An concluded: "Because she is making progress, I believe that her prognosis is good and I do believe that she will reach plateau with MMI in 1 month and she should go back to her regular job without restrictions in 1 month."

Dr. Epstein, an ophthalmologist, testified by evidence deposition on May 2, 2018. Dr. Epstein examined Petitioner on November 17, 2017. Petitioner complained of "difficulty with near vision, eye strain." Dr. Epstein found: "[The claimant] had an uncorrected acuity of 20/20 in both eyes, and no specific abnormalities of any kind whatsoever were noted on her examination." Dr. Epstein opined the treatment to date had been reasonable and necessary, deferring any need for further treatment to Dr. Zost. Dr. Epstein thought Petitioner was at maximum medical improvement, and did not anticipate any permanent eye problems. On cross-examination, Dr. Epstein deferred to Dr. Zost regarding maximum medical improvement and the need for further convergence exercises. Dr. Epstein qualified that he thought Petitioner was at maximum medical improvement, but might need ongoing convergence exercises to maintain it. Dr. Epstein added that convergence was not his area of specialization. On redirect examination, Dr. Epstein clarified that he found no evidence of convergence insufficiency.

The Arbitrator filed two decisions sharing the same findings of fact and conclusions of law. In case No. 15 WC 10947, the Arbitrator awarded: temporary total disability benefits of $75.39 [*sic*][2] per week from November 25, 2014 to December 6, 2015, and from March 7, 2016 to October 29, 2017; and medical bills in the sum of $63,539.00 pursuant to sections 8(a) and 8.2 of the Act and subject to appropriate credit. In case No. 16 WC 08127, the Arbitrator ruled: "The award for any benefits is made in 15 WC 10947."

On review, Petitioner focuses her arguments on her vision, head and neck conditions. The Commission agrees with Petitioner that her vision, head and neck conditions are causally connected to the work accidents. However, except for the vision condition, the Commission agrees with the Arbitrator's determination that Petitioner has reached maximum medical improvement. Regarding the neck condition, the Commission adopts the opinion of Dr. An. Regarding the head/neurological condition, the Commission relies on the opinions of Dr. Kramer and Dr. Keeshin.

Accordingly, the Commission corrects the clerical error in the temporary total disability rate and affirms the award of temporary total disability benefits. Further, the Commission affirms the award of past medical expenses. Turning to prospective medical care, the Commission awards reasonable and related vision treatment recommended by Dr. Zost, pursuant to sections 8(a) and 8.2 of the Act. The Commission denies any other prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed June 19, 2019, are 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 $675.39 per week for a period of 139 6/7 weeks, from November 25, 2014 through December 6, 2015, and from March 7, 2016 through October 29, 2017, those being the periods of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills enumerated by the Arbitrator in the sum of $63,539.00 pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given §8(j) credit for the amounts paid by its group health insurance, provided that Respondent holds Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving this credit. Respondent shall also be given credit for the medical payments made by its workers' compensation carrier.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for reasonable and related vision treatment recommended by Dr. Zost, pursuant to §§8(a) and 8.2 of the Act.

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

---

[2]The findings of fact and conclusions of law state the correct temporary total disability rate of $675.39.

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

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

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

SEP 2 - 2020

DATED:
o-08/05/2020
SM/sk
44

Stephen J. Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

20IWCC0496

YOUSIF, SEMELI TANYA
Employee/Petitioner

Case# **15WC010947**

16WC008127

ST OF IL/IYC OF ST CHARLES
Employer/Respondent

On 6/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5019 SEIDMAN MARGULIS & FAIRMAN LLP
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

JUN 19 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

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

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

Semeli Tanya Yousif
Employee/Petitioner

Case # 15 WC 10947

v.

Consolidated cases: **16 WC 08127**

State of Illinois/IYC of St. Charles
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 Geneva on **September 11, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

F. **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

20IWCC0496

On the date of accident **August 16, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,680.16;** the average weekly wage was **$1,013.08**

On the date of accident, Petitioner was **31** years of age, **single** with **0** dependent children.

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

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

Respondent shall be given a credit of **$86,218.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$86,218.20**

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

ORDER

Medical benefits

Respondent shall pay the bills totaling **$63,539.00**, subject to the fee schedule and pursuant to §8 and §8.2 and subject to credit for any payments made by respondent for the claimed bills.

Temporary Total Benefits

Respondent shall pay **Temporary Total Disability from November 25, 2014 to December 6, 2015** and from **March 7, 2016 to October 29, 2017,** which is a total of **139-6/7 weeks** at the rate of **$75.39 per week.**

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

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

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

Christine M. Ory

Signature of Arbitrator

IC ArbDec19(b) p. 2

June 18, 2019

Date

JUN 19 2019

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

YOUSIF, SEMELI TANYA
Employee/Petitioner

Case# **16WC008127**
15WC010947

ST OF IL/IYC OF ST CHARLES
Employer/Respondent

20IWCC0496

On 6/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5019 SEIDMAN MARGULIS & FAIRMAN LLC
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

5204 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

JUN 19 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

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

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

Semeli Tanya Yousif
Employee/Petitioner

v.

State of Illinois/IYC of St. Charles
Employer/Respondent

Case # 16 WC 8127

Consolidated cases: 15 WC 10947

An *Application for Adjustment 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 Geneva on **September 11, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

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

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

F. **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 **December 8, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,680.16;** the average weekly wage was **$1,013.08**

On the date of accident, Petitioner was **31** years of age, **single** with **0** dependent children.

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

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

Respondent shall be given a credit of **$86,218.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$86,218.20 (for both cases)**

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

ORDER

The award for any benefits is made in 15 WC 10947.

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

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

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

Christine M Ory
Signature of Arbitrator

June 18, 2019
Date

IC ArbDec19(b) p. 2

JUN 19 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Semeli "Tanya" Yousif	)
Petitioner,	)
vs.	) **No. 15 WC 10947 and 16 WC 2494**
State of IL. IYC of St. Charles	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Geneva on September 11, 2018. The parties agree that on August 16, 2014 and December 8, 2015. Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act that their relationship was one of employee and employer, that petitioner suffered accidental injuries that arose out of and in the course of her employment with respondent. They further agree that in the year preceding the August 16, 2014 injuries, the petitioner earned $52,680.16, and that her average weekly wage, calculated pursuant to §10, was $1,1013.08; and in the year preceding the December 8, 2015 injuries petitioner earned $58,296.00 and her average weekly wage, calculated pursuant to §10 was $1,121.88.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills
3. Whether petitioner is entitled to payment for prospective medical treatment.
4. Whether petitioner is due TTD.

STATEMENT OF FACTS

Petitioner began her employment with respondent on September 19, 2013 as Juvenile Justice Specialist. She underwent regular and self-defense training before she was assigned to her position. She was assigned to various posts.

On August 16, 2014, she was assigned to the hospital post. Petitioner testified she was opening a metal door with one hand while moving a chair with the other; she fell into the door with her front left lobe. She then fell backwards; landing on her back on the desk behind her.

She waited to seek medical treatment until her symptoms worsened, which was on August 19, 2014. She felt intense fog immediately; the next day her vision was blurry. She sought treatment from the Immediate Care in Park Ridge. She was instructed to follow up with her primary care doctor; which she did.

She was seen by Dr. Greider, who prescribed physical therapy and medication, and released petitioner to return to work light duty. Petitioner continued on light duty until November 24, 2014, when respondent no longer could accommodate light duty.

Petitioner was seen by chiropractor Dr. Panopoulos, who referred her to Dr. Michaelopoulos. Petitioner was then seen on Dr. Agha for post concussive syndrome.

Petitioner was seen by ophthalmologist, Dr. Gale Buckman for convergence insufficiency. She was then seen by Dr. Henry Meisels.

Dr. Panopoulos referred petitioner to Carrick Brain Center in Georgia, where she was seen on January 20, 2015. She was given exercises and a program to track her symptoms. On March 30, 2015, Carrick recommended holistic therapy.

She received treatment from Dr. Pogodzinski.

She was seen by Dr. Sclamberg on September 29, 2015 after striking her arm on an elevator.

In November, 2015, a recommendation was made for petitioner to return to the Carrick Brain Center in Georgia.

Petitioner returned to work on December 7, 2015. On December 8, 2015, petitioner struck a metal pin on the console roof of respondent's van.

She was seen at St. Francis Hospital on December 16, 2015.

She received treatment from Dr. Keeshin until May, 2017.

Dr. Zost provided eye therapy beginning in January, 2017 and then from Dr. Dickholtz.

She received hyperbaric treatment from Dr. Daphne Denham. She was seen by Dr. Lenny Cohen who recommended additional hyperbaric treatment. The treatment was cancelled by respondent.

Petitioner remains off work under restrictions due to energy level, eye convergence and restricted to rapid eye movement.

Petitioner confirmed she was seen by Dr. Jeffry Kramer in November, 2014, by ophthalmologist, Dr. Randy Epstein and Dr. Howard An; all at respondent's request.

She would like to undergo treatment recommended by Dr. Cohen for hyperbaric pressure, ophthalmologist, Dr. Dickholtz and Dr. Zost for the brain stem.

On cross-examination, she confirmed that Dr. Dickholtz restricted her from doing any rapid movement or strenuous activity. Dr. Cohen and Dr. Zost restricted her from any violent area.

Petitioner would like to continue with the oxygen therapy as it helped her brain stem.

On November 18, 2014, Dr. Kramer recommended regular physical therapy that was not authorized. As of July 20, 2015, petitioner had yet to receive the regular physical therapy.

She did not receive any treatment from November 14, 2014 to July 20, 2015.

She received physical therapy for her neck at St. Francis Hospital at the direction of Dr. Boris Shayin. Her care was then switched to Dr. Greider.

Immediate Care of Park Ridge Records (PX.1)

Petitioner was seen on August 19, 2014 with complaints of dizziness and headache. She reported she struck her head on a door three days before. Diagnosis was dizziness and headache.

(Also included in this exhibit is a bill from Presence Health for various services rendered.)

Dr. Suzanne Greider M.D. Records (PX.2)

Petitioner was first seen by Dr. Suzanne Greider On September 4, 2014 for dizziness and cervical pain. She was referred for physical therapy.

The October 7, 2014 EMG was incomplete as petitioner claimed she could not tolerate the procedure.

Dr. Greider reported petitioner was released to return to work with restrictions on September 7, 2014. Petitioner was seen in follow up on September 11, 2014; physical therapy was continued. She was seen again on September 18, 2014; physical therapy was continued.

She was seen on April 20, 2015 for a cold. She was seen July 9, 2015 and October 21, 2015 for diarrhea.

On November 25, 2015, Dr. Greider reported petitioner's condition was unremarkable except for her chief complaint (which was listed as papers for disability and advising she was going to Cerebrum Brain Center in Atlanta Georgia in January, 2016 for re-evaluation.) Petitioner was released to return to her usual employment.

Petitioner was seen by Dr. Greider on December 22, 2015 as follow up to December 16, 2015 emergency room visit. She had complaints of low back and right trapezius shoulder pain. She was capable of working her regular position. Petitioner reported she was receiving physical therapy from Chicago Body Works as self-pay as workers' compensation was slow in paying.

Petitioner was released to return to regular employment by Dr. Greider on March 8, 2016 and April 5, 2016.

On April 7, 2016 petitioner's release to return to work was changed to restrictions. On May 9, 2016, June 9, 2016, August 9, 2016, September 7, 2016 petitioner was placed on restricted work by Dr. Greider.

On November 7, 2016, petitioner was seen with light headed, headaches, nausea and "feeling in a fog". It was noted petitioner was scheduled to receive treatment at RIC.

Petitioner was seen on September 7, 2016 for pain and swelling of her left knee after hitting it with a laundry basket and swelling of her left ankle after hitting it with a cutting board. A referral to orthopedist was requested. Petitioner was referred by Presence Health Partners to orthopedist, Dr. Perieta, on September 27, 2016.

Dr. Boris Shayin Records (PX.3)

Petitioner was first seen by Dr. Shayin on August 21, 2014 after feeling lethargic and headaches. She also had dizziness when bending and getting gup or turning. Diagnosis was head contusion, whiplash and vertigo. A CT scan was ordered.

On August 22, 2014, Dr. Shayin reported the CT scan was negative. She was seen again on August 25, 2014. On August 28, 2014, she reported severe throbbing neck pain and numbness in her arms. Diagnosis was cervical radiculopathy. X-rays were ordered.

Bill for services rendered on August 21, 2014 for $250.00.

Presence St. Francis Hospital Records (PX.4)

The records are for the CT scan, X-rays and physical therapy.

Dr. Caroline Agha Records (PX.5)

Petitioner was first seen by Dr. Agha for dizziness and headaches on October 2, 2014. MRIs were ordered. The October 31, 2014 brain and cervical MRI were essentially normal.

Dr. Gail Buckman October 28, 2014 Report (PX.6 & PX.26)

Dr. Buckman performed an eye exam of petitioner on October 28, 2014. The diagnosis was convergence insufficiency. Dr. Buckman recommended referral to an eye muscle specialist if the MRIs were normal. Charges for services rendered is $300.00.

Dr. Henry I. Meisels Record (PX.7)

Petitioner was examined by ophthalmologist, Dr. Meisels on November 25, 2014. Dr. Meisels concluded there was no ophthalmic sequallae of injury.

Dr. Matthew Pogodzinski Records (PX.8)

Petitioner was seen by ENT, Dr. Pogodzinski on October 14, 2014 because of hearing loss that began two weeks after the work accident. Petitioner also noted some memory loss.

On December 4, 2014, Dr. Pogodzinski reported the audiogram was normal.

Petitioner was seen on September 18, 2015 by Dr. Liza Michelle Cohen because of reddish orange fluid from left ear. Use of Q-tips were indicated as the cause of the condition.

She was seen again by Dr. Pogodzinski on November 25, 2015 due to nose bleeds.

Active Health Ltd/John Panopoulos, D.C. Records (PX.9)

Petitioner was first seen by Dr. Panopoulos on September 29, 2014 for brachial neuritis, cervical and thoracic strain. Her complaints were of her head, neck and upper back. Dr. Panopoulos provided treatment to November 26, 2014, when it was suspended until petitioner received cognitive rehabilitation.

Petitioner returned on March 23, 2015 and reported an exacerbation of neck and upper back pain that occurred ten days before. She was released at MMI as of July 10, 2015.

There records include a July 5, 2013 cervical MRI which showed a left central C5-C6 central disc protrusion, as well as a lumbosacral MRI which showed lumbosacral degenerative disc disease and tiny right foraminal disc protrusion at L4-L5

Illinois Neuro & Physical Rehab/Dr. George Michaelopoulos, D.C. Records (PX.10)

Petitioner was first seen by Dr. Michaelopoulos on December 1, 2014 as a referral by Dr. Panopoulos for therapy. On December 29, 2014, Dr. Michaelopoulos released petitioner from care to the Carrick Institute at her insistence, even though petitioner had not given the therapeutic gaze stability exercise enough time to work.

Carrick Brain Centers Records (PX.11 & PX.24)

Petitioner was evaluated at Carrick Brain Centers of Marietta Georgia from January 20, 2015 to January 25, 2015 for post concussive syndrome with a centrally maintained vestibulopathy as a referral by Dr. Michaelopoulos. A home exercise program was prescribed.

On May 26, 2015, chiropractor, Dr. Albertin, recommended petitioner returned to Carrick for a follow-up evaluation. On November 20, 2015, Dr. Meera Chauhan recommended petitioner return to Cerebrum Health Centers for additional treatment.

Wholistic Therapeutics Records (PX.12)

Petitioner received physical therapy from March 30, 2015 to May 20, 2015 at the direction of Dr. Albertin. Total bill for services rendered is $3,550.00.

Orthopaedics and Rheumatology of North Shore/Dr. Edward Sclamberg Records (PX.13)

Petitioner presented to Dr. Sclamberg on September 29, 2015 after striking her left arm when exiting an elevator approximately five months before. Petitioner attributed the incident to loss of coordination from the work accident of August 16, 2014. Physical therapy was ordered.

Shirley Ryan Ability Lab/Dr. Susan Keeshin Records (PX.14)

Petitioner was evaluated by Dr. Keeshin on December 6, 2016. Petitioner was admitted to day program on January 9, 2017. On January 30, 2017, continued vestibular therapy was recommended. Although petitioner had almost completed visual rehab as of May 2, 2017, her

visual disturbance persisted. Dr. Keeshin believe petitioner was at MMI and recommended an FCE. The neuropsychology testing was cancelled as petitioner did so well on cognitive issues. Petitioner believed the cognitive issues were more related to visual issues/fatigue. Petitioner believed she could not work due to "neck" issues.

Dr. Michael Zost Records (PX.15)

Petitioner received treatment to her eyes by Dr. Michael Zost from January 23, 2017, through January 3, 2018. Dr. Zost reported on January 3, 2018 that petitioner had lingering issues in the area of fatigue, tracking and depth perception. Dr. Zost recommended she was to continue with her vision rehabilitation therapy and follow up with Dr. Zost after completing the program of hyperbaric oxygen therapy.

Health Smart/Marshall Dickholtz Jr., D.C. Records (PX.17)

Petitioner was seen by Dr. Dickholtz on February 9, 2017 as a referral by Dr. Zost. She received treatment by Dr. Dickholtz through February 15, 2018. On February 15, 2018, Dr. Dickholtz reported petitioner had not reached MMI and was not released to return to work.

Dr. Daphne Denham Records (PX. 18)

Dr. Denham provided HBO (hyperbaric oxygen) treatment from August 29, 2017 to December 12, 2017.

Chicago Body Works Records and Bills (PX.19)

Petitioner received therapy from July 20, 2016 to August 16, 2016. Total bills for services rendered is $2,260.00

Chicago Neurological Services/Dr. Lenny Cohen (PX.20)

Petitioner was seen by Dr. Cohen on April 30, 2018. He recommended petitioner be allowed to continue with 20 more hyperbaric oxygen treatments.

Presence Saint Francis Hospital Records (PX.21)

On December 16, 2015, petitioner was seen in the emergency room of Presence St. Francis Hospital with low back and neck pain of one week. Petitioner reported the original work injury and also that she grazed the top of her head, not hitting it directly, on December 7, 2015. She worsening neck pain and low back pain on the right. She was diagnosed with cervical and low back strain.

Presence Medical Group Bills (PX.22 & 23)

The following medical bills are the only ones for treatment of the work injuries.
1,123 .00 to Dr. Caroline Agha - 10/02/2015, 10/07/2014, 10/31/2014
$788.00 Dr. Pogodzinski - 10/14/ 2014; 04/2014
$280.00 Dr. Khan on 08/19/2014

Dr. Suzanne Greider

$400.00 – 09/04/2014
$151.00 – 09/11/2014
$151.00 – 09/18/2014

$151.00 - 04/20/2015
$151.00 – 07/09/2015
$151.00 - 10/21/2015
$50.00 – 11/25/2015
$230.00 – 12/22/2015
$151.00 – 03/06/2016
$240.00 – 09/07/2016

Dr. Michael Zost/Vision Rehabilitation Associates Bills (PX.27)
Total bills are $1,943.00 for services rendered from January 23, 2017 to January 3, 2018

Dr. Edward Sclamberg/Ortho & Rheumatology of the North Shore Bill (PX.28)
Dr. Sclamberg's $119.00 bill for services rendered on September 29, 2015 was paid by respondent on May 9, 2016.

Dr. Susan Keeshin/Shirley Ryan Ability Lab Bills (PX.29)
$25,190.00 for services rendered from December 6, 2016 to May 2, 2017.

Health Smart/Dr. Marshall Dickholtz, Jr. Bills (PX.30)
$5,194.00 for services rendered from February 9, 2017 to June 14, 2018. ($520.00)

Dr. Daphne Denham Bills (PX.31)
Total bills claimed are $16,290.00 for hyperbaric oxygen treatment from August 29, 2017 December 12, 2017.

Dr. George Michaelopoulos/Illinois Neuro & Physical Rehabilitation Bills (PX.32)
Bills for services rendered from December 1, 2014 to December 29, 2014 totals $5,758.00.

Dr. Jorge Prieto M.D. Records (PX.33)
Petitioner was seen by Dr. Prieto for left knee problems on February 1, 2018. Total bill for services rendered is $115.00.

Active Health Bills (PX.34)
Total bills from November 28, 2014 to January 16, 2015 are $375.00

Workers' Compensation Notice of Injury (RX.1)
Petitioner reported she struck her head with door and didn't think much of it at time. Reported the incident to Sis Mitchell the next day.

Employer's First Report of Injury (RX.2)
Petitioner reportedly grazed her head on overhead temperature control while getting into a van on December 8, 2015. She reported low back pain.

Respondent's Payment Listing (RX.5)
The list shows petitioner was paid temporary total disability from November 24, 2014 to December 20, 2017 for a total of $86,218.20 and $29,326.50 for medical bills.

Dr. Howard An September 29. 2017 Report (RX.6)

Dr. An examined petitioner on September 29, 2017 at respondent's request. Dr. An diagnosed cervical spondylosis that had been aggravated by the work accident. Dr. An believe petitioner had received appropriate treatment to date; noting the chiropractic treatment may have been excessive, but as she was making progress Dr. An agreed with another month of treatment at which time petitioner should be able to return to unrestricted work and would be at maximum medical improvement.

Dr. Jeffrey Kramer March 22, 2016 Deposition (RX.7)

Dr. Kramer, board certified neurologist and Chairman at the Department of Medicine at Mercy Hospital, testified in behalf of respondent via deposition. Dr. Kramer examined petitioner on November 11, 2014 and authored a report (Kramer Dep. No. 2).

Dr. Kramer reported his exam showed petitioner had brief nystagmus, or jerky eye movement, when looking to the right. She had some increased sensitivity to pin sensation to the left thumb and index finger, as well as a cautious gait. Dr. Kramer found petitioner suffered post-concussion syndrome with residual chronic subjective dizziness and left C5-6 radiculopathy as a result of the work accident. Dr. Kramer recommended certain medications and therapy. He also believed petitioner was capable of working light duty. Dr. Kramer recommended physical therapy rather than chiropractic treatment. He believed the treatment to date was appropriate.

Dr. Kramer authored and addendum report date July 20, 2015 after reviewing records of Dr. Greider, Holistic Therapeutics and vestibular testing from Nathan Kelser a chiropractic neurologist and a report from Dr. Agha. Based upon the fact that petitioner did not follow his recommended treatment and went with chiropractic treatment, Dr. Kramer concluded petitioner had reached maximum medical improvement and believed the treatment after his exam was not appropriate. He also believed petitioner could return to work.

Dr. Randy Epstein May 2, 2018 Deposition (RX.8)

Dr. Randy Epstein, board certified ophthalmologist, testified in behalf of respondent. Dr. Epstein examined petitioner on November 17, 2017 and reviewed medical records. His diagnosis was history of concussion, current eye problems limited to convergence insufficiency by history. Dr. Epstein reported petitioner was unable to work due to orthopedic problems related to her cervical spine and not her eyes.

He deferred to Dr. Zost for a determination as to whether petitioner had reached maximum medical improvement as it related to her eyes. Dr. Epstein clarified this position that he felt it was appropriate for petitioner to continue with exercises with Dr. Zost to maintain her condition.

In his report, Dr. Epstein indicated petitioner had no objective findings of convergence insufficiency (Dr. Epstein Dep. Ex. 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

Petitioner denied she had any problems relative to her head, neck or back. The diagnosis was head contusion, whiplash and vertigo. However, petitioner had a prior neck and back injury

in June, 2013 and the July 5, 2013 cervical MRI showed a left central C5-C6 disc protrusion and the lumbar MRI showed degenerative disc disease and a tiny foraminal disc protrusion.

Petitioner had undertaken treatment with twenty medical providers; including a treatment program at Carrick Cerebrum Brain Centers in Georgia in January, 2015 and at the Rehabilitation Institute of Chicago/Shirley Ryan Ability Lab in January, 2017. Petitioner's CT brain scan and MRI were negative. Although Dr. Buckman, who performed an eye exam on October 28, 2014, diagnosed convergence insufficiency, Dr. Meisels, who saw petitioner as a referral from Dr. Buckman, concluded petitioner had no ophthalmic sequallae of injury. On May 2, 2017, Dr. Keeshin, with the Rehabilitation Institute of Chicago, reported she cancelled petitioner's neuropsychological testing as petitioner was doing so good relative to the cognitive issues. Dr. Keeshin believed petitioner's cognitive issues related to her visual issues/fatigue. Ophthalmologist, Dr. Epstein reported on November 17, 2017, petitioner had no objective findings of convergence insufficiency. ENT, Dr. Pogodzinski, reported petitioner's audiogram was normal.

The foregoing medical shows petitioner lacks any objective evidence of ongoing problems for her claimed head injury.

Dr. An, who examined petitioner at respondent's request on September 29, 2017, agreed petitioner had aggravated her spondylosis of the upper cervical spine. Dr. An reviewed an MRI that showed petitioner had a disc protrusion at C5-6. This is the same findings that were on the MRI from July 5, 2013, which was taken before the work accident. Dr. An believed petitioner would require an additional month of treatment and then be released to return to work without restrictions. There was no objective evidence of petitioner's ongoing cervical condition.

Early on, petitioner's complaints were centered on her head, neck and upper back. The first discussion of any low back problems was at the time of petitioner's visit to the emergency room at Presence Saint Francis Hospital on December 16, 2015. Petitioner related the onset to the August 16, 2014 accident. She also mentioned grazing the top of her head on December 8, 2015. Based upon the lack of low back complaints until December 16, 2015 and the lack of any physician related petitioner's low back complaints to either work accident, the Arbitrator finds petitioner failed to prove her low back condition is related to either work accident.

In addition, based upon the foregoing, the Arbitrator finds petitioner failed to prove by any objective evidence, that she has any ongoing head or neck or low back problems resulting from the work accidents of August 16, 2014 or December 8, 2015.

J. With respect to the issue regarding medical bills, the Arbitrator makes the following conclusions of law:

Respondent's examining doctor, Dr. An, agreed that the treatment petitioner had received to the date of his exam on September 29, 2017 was appropriate and also that petitioner should be allowed another month of treatment at which time she would be at maximum medical improvement.

Respondent's ophthalmologist, Dr. Epstein, agreed it was appropriate for petitioner to continue with exercises with Dr. Zost and deferred to Dr. Zost as to whether petitioner had reached maximum medical improvement as to her eyes.

However, respondent's neurologist, Dr. Kramer, determined petitioner had reached maximum medical improvement as of July 20, 2015 mainly because she did not follow the treatment her recommended at the time of his exam on November 11, 2014.

Based upon the foregoing, the Arbitrator finds the following medical bills were for treatment that was reasonable and necessary to treat petitioner of her work injuries, and supported

by medical evidence, and awards same to be paid in accordance with the fee schedule, §8 and §8.2 of the Act with credit to be given for any payments already made by respondent:

$1,123.00 Dr. Caroline Agha - 10/02/2015, 10/07/2014, 10/31/2014
$788.00 Dr. Pogodzinski - 10/14/ 2014; 04/2014
$280.00 Dr. Khan on 08/19/2014
$400.00 –Dr. Susan Greider 09/04/2014
$151.00 – Dr. Susan Greider 09/11/2014
$151.00 – Dr. Susan Greider 09/18/2014
$300.00 - Dr. Gail Buckman 10/28/2014
$50.00 – Dr. Susan Greider 11/25/2015
$230.00 – Dr. Susan Greider 12/22/2015
$151.00 – Dr. Susan Greider 03/06/2016
$250.00 Dr. Boris Shayin 08/21/2014.
$3,550.00 Wholistic Therapeutics 03/30/2015 to 05/20/2015
$2,260.00 Chicago Body Works 07/20/2016 to 08/16/2016.
$1,943.00-Dr. Michael Zost/Vision Rehabilitation Associates 01/23/2017 to 01/03/2018
$25,190.00 Dr. Susan Keeshin/Shirley Ryan Ability Lab 12/06/2016 to 05/20/2017.
$4,674.00 Health Smart/Dr. Marshall Dickholtz, Jr. 02/09/2017 to 08/24/2017 only.
(There were no medical records to support treatment after February 15, 2018.)
$16,290.00 Dr. Daphne Denham (hyperbaric oxygen treatment) 08/29/2017 to 12/12/2017.
$5,758.00 Dr. George Michaelopoulos 12/01/2014 to 12/29/2014

The $115.00 bill from Dr. Prieto is denied as it was treatment to petitioner's left knee that was not related to the work accidents.

The $375.00 bill for nutritional supplements from Active Health bills are not supported by any evidence.

K. With respect to the issue regarding prospective medical care, the Arbitrator makes the following conclusions of law:

Petitioner has received treatment from a plethora of medical providers. The treatment included vestibular therapy at Carrick Brain Center in Georgia in January, 2015 and Shirley Ryan Ability Lab in January, 2017, as well as hyperbaric oxygen treatment from Dr. Denham from August to December, 2017. In addition, she received chiropractic treatment by Dr. Panopoulos, Wholistic Therapeutics, Dr. Dickholtz, and Chicago Body Works.

Although ophthalmologist, Dr. Henry Meisels, concluded on November 25, 2014 that petitioner had no ophthalmologist sequallae from her injury, petitioner also received vision rehabilitation therapy from Dr. Zost and Dr. Michaelopoulos. Dr. Epstein, who examined petitioner at respondent's request on November 17, 2017, concluded petitioner had no objective findings of convergence insufficiency.

According to the records of Dr. Keeshin with Shirley Ryan Ability Lab, from May 2, 2017, petitioner believed she could not work due to neck issues. However, Dr. An concluded on September 29, 2017, petitioner should only receive another month of chiropractic treatment at which time she would be at maximum medical improvement and should return to work without restrictions.

Despite all of this treatment and lack of objective evidence of ongoing problems, petitioner claims she needs additional medical treatment; specifically, hyperbaric treatment by Dr. Cohen, and eye treatment by Dr. Dickholtz and Dr. Zost. However, the Arbitrator finds, based upon the foregoing evidence, petitioner failed to prove she requires any further medical treatment for any of her claimed injuries from the August 16, 2014 or the December 8, 2015 accident, and denies her claim for prospective medical treatment.

L. With respect to the issue regarding TTD, the Arbitrator makes the following conclusions of law:

Petitioner claimed that she was disabled from November 25, 2014 to December 6, 2015 and from March 7, 2016 to the date of hearing. Petitioner reported to Dr. Keeshin that as of May 2, 2017, she was disabled because of neck issues. Dr. An determined, as it related to petitioner's neck condition, she should be able to return to unrestricted work as of October 29, 2017.

The evidence therefore supports a finding that petitioner was temporarily totally disabled from November 25, 2014 to December 6, 2015 and from March 7, 2016 to October 29, 2017 and awards temporary total disability for said period, which is 139-6/8 weeks at the rate of $675.39.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nancy Try,

Petitioner,

vs. NO. 09WC042260

State of Illinois Department of Human Services, **20 IWCC0497**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, prospective medical care, 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 4, 2019 is hereby affirmed and adopted.

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

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

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

DATED: SEP 2 - 2020
SJM/sj
7/8/2020
44

Stephen J. Mathis

Douglas D. McCarthy

SPECIAL CONCURRENCE/DISSENT

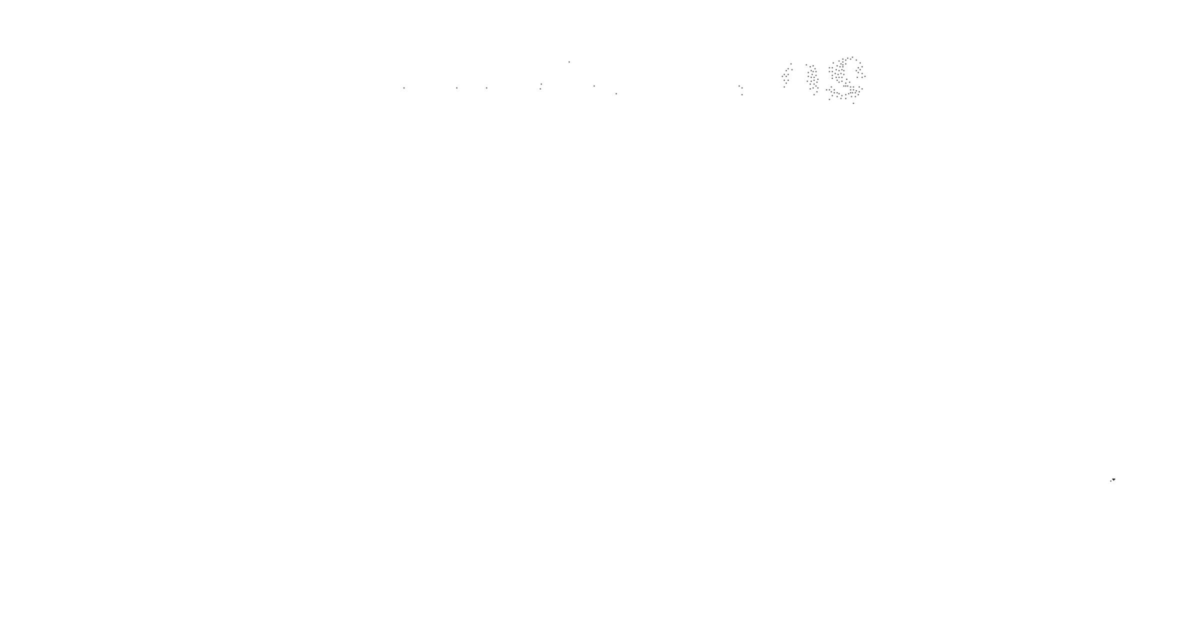
I concur with the Majority's decision save its causation finding and its award of medical expenses relating to the total knee replacement surgeries. I would vacate the award of benefits both medical and temporary total disability awarded after July 18, 2011. I would modify the award of permanent partial disability benefits to 25% loss use of the left leg pursuant to Section 8(e)12 of the Act.

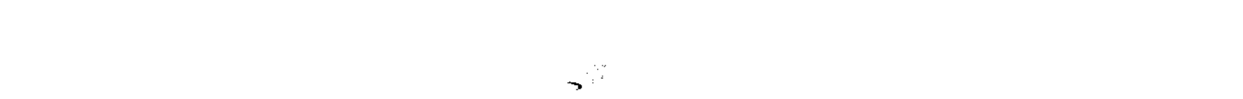
On August 28, 2009, Petitioner sustained an undisputed accident when she slipped and fell injuring her left knee. On September 17, 2009, Dr. Carlson evaluated Petitioner who provided a consistent history of injury and ongoing knee complaints. An MRI was prescribed which was performed on September 22, 2009 evidencing a medical meniscus tear and a fracture of the patella. On September 28, 2009, Dr. Carlson recommended surgery which was scheduled and subsequently cancelled due to Petitioner's unrelated health conditions. On March 11, 2011, Petitioner underwent the previously recommended surgery.

Thereafter, Dr. Carlson continued to provide the necessary follow-up care. On April 13, 2011, Petitioner advised Dr. Carlson she had recently fallen from a chair causing increased pain to her knee and new symptoms regarding her leg and back. Petitioner continued to follow-up with Dr. Carlson throughout 2011 for knee, hip, and back complaints. On July 18, 2011, Dr. Carlson re-evaluated Petitioner who "reports it is her back and hip, not the knee, which are causing pain…Overall, back pain is rated a[n] 8 out of 10, and extremity pain is also 8 out of 10. She reports the extremity pain is in her left buttocks and left hip, and into her left groin." PX2. Thereafter, Petitioner's treatment focused on her lower back and corresponding left extremity complaints. On January 19, 2012, Dr. Carlson discharged Petitioner from care and released her to return to work.

For the next nine months, Petitioner sought no care for her left knee. On October 22, 2012, Petitioner again sought treatment from Dr. Carlson complaining as follows: "She has had worsening pain recently and also popping. She also reports instability and feelings like the knee will give out. This has been ongoing for 4 weeks…" PX2. On August 19, 2014, Dr. Carlson performed a total knee replacement with a revision total knee replacement performed on February 4, 2015. On April 20, 2015, Dr. Carlson released Petitioner from care.

I agree with the Majority's finding that Petitioner's fall in April of 2011 did not constitute and intervening accident which broke the chain of causation regarding her left knee injury. Petitioner was still under active medical treatment for her left knee as surgery had only been undertaken a month prior. As evidenced by the medical records, this fall, though, did lead to new symptoms regarding Petitioner's lower back with associated radicular symptoms in her left leg which are unrelated to the accident of August 28, 2009. As evidenced by the medical records, Petitioner ceased treatment for her left knee in and around July 18, 2011 after which time Dr. Carlson released Petitioner from care as of January 19, 2012 once the back and lower extremity symptoms had also resolved. Thereafter, Petitioner sought no treatment for nine months when she presented to Dr. Carlson with a significant increase of pain over a four-week duration.





20IWCC0497

As such, I find her current condition of ill-being, in part, specifically her need for surgeries for a total knee replacement and associated revision unrelated to her accident of August 28, 2009. As such, I would award temporary total disability benefits and medical expenses through July 18, 2011. I would modify the award for permanent partial disability benefits to 25% loss of use of the left leg pursuant to Section 8(e)12 of the Act.

For the above-stated reasons, I, respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRY, NANCY
Employee/Petitioner

Case# **09WC042260**

STATE OF ILLINOIS DEPT OF HUMAN SERVICES **20IWCC0497**
Employer/Respondent

On 6/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0529 TUITE LAW
GREG SZUL
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61105

0000 ASSISTANT ATTORNEY GENERAL
DANIEL KALLIO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUN - 4 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)

20 IWCC0497

COUNTY OF **Winnebago**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nancy Try
Employee/Petitioner

Case # **09** WC **42260**

v.

Consolidated cases: **n/a**

State of Illinois, Department of Human Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Rockford**, on **5/9/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 **8/28/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,076.80**; the average weekly wage was $**578.40**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Medical benefits

Respondent shall pay/reimburse reasonable and necessary medical services of $24,117.34, pursuant to Sections 8 and 8.2 of the Act. PX 6. Respondent shall pay Petitioner reasonable and necessary medical services of $1,875.30, and reimburse Petitioner $21.25 in out of pocket expenses pursuant to Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $385.60/week for a total of 79 weeks, commencing 2/18/11 through 12/22/11 and 8/19/14 through 4/20/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/18/11 through 12/22/11 and 8/19/14 through 4/20/15, and shall pay the remainder of the award, if any, in weekly payments.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $347.04/week for **86** weeks, because the injuries sustained caused the 40% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Carolyn M. Doherty
Signature of Arbitrator

6/1/19
Date

JUN 4 - 2019

FINDINGS OF FACT

On August 28, 2009, Petitioner was employed by the State of Illinois, Department of Human Services as a personal assistant. Her duties included taking care of a woman named Mae on a daily basis and performing errands on her behalf. On the date of the undisputed accident, Petitioner went to the bank on behalf of Mae. Petitioner was in the ATM area of the bank when she slipped and fell on water striking her left knee on the marble floor. Petitioner testified that she landed on her left leg and knee and that she immediately noticed pain in her left knee.

Petitioner continued to care for Mae that day and then later the same day, Petitioner went to the St. Anthony Medical Center Emergency Room. (PX1). The records indicate a history of the injury, exam findings of joint effusion in the left knee, a diagnosis of a knee contusion, and a referral to Carlson Orthopedic for further follow up care. On September 17, 2009, Petitioner first saw Dr. Mark Carlson at Carlson Orthopedic. (PX2). The history again noted a slip and fall directly on the left knee. A diagnosis of internal derangement was made and an MRI ordered. On September 29, 2009, a left knee MRI was performed at Carlson Orthopedic which showed a tear of the medial meniscus and a fractured patella. (PX2). On September 28, 2009, Dr. Carlson recommended arthroscopic surgery.

Petitioner testified that while undergoing a pre-op for the proposed knee surgery, she was diagnosed with lung cancer. She then underwent a course of medical care for the cancer over the next 18 months. Petitioner testified that her knee pain did not subside or improve over her 18 months of chemotherapy.

On February 14, 2011, Petitioner returned to Dr. Carlson. An updated MRI was performed on February 15, 2011 which confirmed ongoing pathology in the left knee including the medial meniscal tear. On February 18, 2011, Dr. Carlson again recommended surgery and ordered Petitioner off work. On March 11, 2011, Petitioner underwent a first left knee surgery which included a partial medial and lateral meniscectomy and patellofemoral debridement. Petitioner then began a course of therapy at Carlson Orthopedic. On a visit with Dr. Carlson on April 13, 2011, Petitioner indicated she had a fall from a chair 5 days earlier. Dr. Carlson noted that when she fell Petitioner's knee was flexed and she fell on her left side. She reported severe muscle spasms in the leg, pain in the buttock, and radicular pain down the leg. Petitioner's left knee exam revealed no evidence of post surgical infection and x-rays revealed no fractures or abnormalities. Petitioner was to continue full weight bearing and ambulation as tolerated and to return to physical therapy after a one week break. Petitioner continued to follow up for her left knee with Dr. Carlson and for multiple complaints including lumbar and hip pain thereafter. No new treatment was ordered for her left knee during this time. On December 22, 2011, Dr. Carlson saw Petitioner for a 9 month follow up post left knee arthroscopy. He recommended that Petitioner undergo additional therapy to improve range of motion and strength. Petitioner's last visit with Dr. Carlson was on January 19, 2012. Physical therapy was noted as no longer effective so it was discontinued and Petitioner was told to follow up as needed. Petitioner reported doing well and ambulating and full weight bearing as tolerated. Petitioner was returned to work activities. PX 2.

Petitioner returned on October 22, 2012, and complained of "worsening pain recently and also popping. She also reports instability and feelings like the knee will give out. This has been ongoing for 4 weeks, recently getting much worse over the last week; however, prior to that, she did have weight bearing pain on the left and usually unweights the left to stand on the right when she does have to stand for prolonged periods of time." PX 2. A repeat MRI was ordered to rule out meniscus tear and evaluate cartilage loss under a diagnosis of "recurrent left knee pain-instability s/p left knee scope in 2011." PX 2. The MRI revealed a complex tear of the medial meniscus with associated degenerative joint disease grade 3 and 4 and

small radial tear of the lateral meniscus. PX 2.

On October 29, 2012, Dr. Carlson recommended a total knee replacement. PX 2. Petitioner had to postpone the knee replacement in 2012 due to a gall bladder surgery. On June 10, 2013, Dr. Carlson's record indicated Petitioner again had to postpone surgery due to a hernia repair. Petitioner testified that her knee pain did not subside during the period of time she treated for unrelated health conditions. She testified that her pain was always present at some level subsequent to the accident in 2009.

On August 19, 2014, Petitioner underwent a unicompartmental knee replacement performed by Dr. Carlson. She commenced therapy at OSF Rehab. (PX3). After attempting therapy and knee injections, on February 4, 2015, Petitioner underwent revision total knee arthroplasty. On April 20, 2015, Dr. Carlson released Petitioner from care, to continue her home exercises.

On May 3, 2018, Petitioner saw Dr. Carlson. PX 5. Dr. Carlson noted Petitioner was post total knee replacement which was the "ultimate result from a direct fall with injury back in 2009." He noted her knee replacement was in good position and alignment. Any additional treatment discussed was related to her left hip. PX 5.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

(F)
CAUSAL RELATIONSHIP

In support of the Arbitrator's decision relating to (F) CAUSAL RELATIONSHIP, the Arbitrator concludes as follows:

It is undisputed that Petitioner had no left knee problems prior to her August 28, 2009 accident. The contemporaneous medical records from the emergency room and all subsequent records of Dr. Carlson give a consistent history of the injury. Dr. Coe, who saw Petitioner on October 24, 2012 for a Section 12 exam, opined that Petitioner's medial meniscal tear and fractured patella were caused by the work injury. (PX 4, p. 23). Petitioner returned to Dr. Carlson in October of 2012 noting ongoing pain in the knee even after the first surgery. On October 29, 2012, Dr. Carlson recommended a knee replacement. Petitioner then postponed the knee replacement surgery until 2014 due to unrelated medical conditions. The Arbitrator finds that based on the record in its entirety, there is no break in the "causal chain" of Petitioner left knee injury due to these unrelated medical conditions. On the last visit in May of 2018, Dr. Carlson opined that Petitioner's knee replacement was the ultimate result from the work injury. Respondent did not offer any medical opinions contradicting the opinions of either Dr. Coe or Dr. Carlson.

Lastly, the Arbitrator finds that although Petitioner sustained a fall off a chair at home in April 2011 while undergoing physical therapy after her first knee surgery, the fall was not sufficient to constitute an intervening accident which severed the causal connection between the undisputed accident and her related and continued left knee complaints. In so finding the Arbitrator notes that the overwhelming majority of complaints following the chair incident were unrelated to her left knee and had no effect on her left knee condition for

which she underwent her initial surgery and for which she continued to follow up thereafter. When Petitioner returned to Dr. Carlson in October 2012, Dr. Carlson specifically noted that Petitioner complained of "worsening pain recently and also popping. She also reports instability and feelings like the knee will give out. This has been ongoing for 4 weeks, recently getting much worse over the last week; however, prior to that, she did have weight bearing pain on the left and usually unweights the left to stand on the right when she does have to stand for prolonged periods of time." PX 2. A repeat MRI was ordered to rule out meniscus tear and evaluate cartilage loss under a diagnosis of "recurrent left knee pain-instability s/p left knee scope in 2011." PX 2. Based on the foregoing, the Arbitrator accordingly finds that Petitioner's current condition of ill-being in her left knee is causally related to the work accident of August 28, 2009 and that causal connection was not severed by an intervening accident.

(J)
MEDICAL EXPENSES

In support of the Arbitrator's decision relating to (J) MEDICAL EXPENSES, the Arbitrator concludes as follows:

Petitioner's medical bills were admitted into evidence as PX6, with the exception of the $66.00 charge from Rockford Radiology. PX6 demonstrates the following outstanding medical bills:

- $1,145.30 to St. Anthony Hospital for a date of service of 8/28/09, and
- $730.00 to Carlson Orthopedic for a date of service of 5/3/18.
-

Respondent is to pay these outstanding bills directly to Petitioner pursuant to Sections 8 and 8.2 of the Act. Respondent is not ordered to pay the Rockford Radiology bill of $66.00 which was not admitted into evidence.

PX6 contains two claims of reimbursement for amounts paid with itemizations, one from the Illinois Department of Health and Human Services for $5,013.22, and one from Medicare for $19,104.12. PX6 also demonstrates that Petitioner paid $21.25 in out of pocket medical expenses to Carlson Orthopedic. Having found for Petitioner on the issue of causal connection, the Arbitrator concludes that Respondent shall pay these claims for reimbursement totaling $24,117.34 and out of pocket expenses totaling $21.25 pursuant to Sections 8 and 8.2 of the Act.

(K)
TEMPORARY TOTAL DISABILITY

In support of the Arbitrator's decision relating to (K) TEMPORARY TOTAL DISABILITY, the Arbitrator concludes as follows:

Dr. Carlson took Petitioner off work on February 18, 2011 just prior to her first surgery. Petitioner was then off work till at least December 22, 2011 when Dr. Carlson initially released her from care. Thus, Petitioner is owed TTD benefits from 2/18/11 through 12/22/11, a period of 44 weeks.

Though Petitioner was recommended to have a knee replacement in 2012, she did not undergo the first knee replacement until August 19, 2014. After a revision replacement on February 4, 2015, Dr. Carlson

released Petitioner at maximum medical improvement on April 20, 2015. As she did not work during this period, and was recovering from her multiple knee replacements, Petitioner is also owed TTD benefits for a period of 8/19/14 (the date of first knee replacement) through 4/20/15 (the release from care date) a period of 35 weeks.

(L)
NATURE AND EXTENT OF INJURY

In support of the Arbitrator's decision relating to (L) NATURE AND EXTENT OF INJURY, the Arbitrator concludes as follows:

The Arbitrator notes that Petitioner's injury occurred prior to the 2011 Amendments to the Act pertaining to permanent partial disability. Notwithstanding that, Petitioner suffered a severe left knee injury which included a medial meniscus tear with fractured patella. She then underwent a unicompartmental knee arthroplasty which failed to offer significant relief such that Petitioner eventually underwent a total knee replacement with subsequent revision surgery.

Petitioner testified that she has had pain in her knee since the injury. She has ongoing issues with pain, locking of the knee, swelling, and uses a cane. She has to elevate and ice the knee frequently and takes over the counter medicine. She has trouble with sitting as it causes stiffness in the knee. She has difficulty bending and straightening the knee from a seated to standing position.

Based on the above and having found for Petitioner on the issue of causal relationship, the Arbitrator finds that Petitioner is entitled to 40% loss of use of the left leg pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOS MIRELES, JR,

Petitioner,

20IWCC0498

vs.

NO: 13 WC 23948

CITY OF CHICAGO,

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 issue of the imposition of penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

CONCLUSIONS OF LAW:

Petitioner's request for penalties and fees is predicated solely on Respondent's late payment of §8(d)1 wage differential benefits. The Arbitrator awarded Section 19(l) penalties of $10,000.00; Section 19(k) penalties of $19,675.19; and Section 16 attorney's fees of $3,935.04. For the reasons detailed below, the Commission vacates the award of §19(l) penalties and modifies the awards of §19(k) penalties and §16 fees.

I. Section 19(l)

The Commission observes §19(l) does not apply to late payment of permanency benefits. Section 19(l) provides as follows:

> In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the

> benefits *** have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)* (West 2012) (Emphasis added).

See, *Theis v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 161237WC, ¶20, 74 N.E.3d 468 ("…section 19(l) penalties are not applicable to PPD awards. Rather, section 19(l) penalties apply to the delayed payment of medical expenses (section 8(a)) and TTD benefits (section 8(b))."). Therefore, while there is no question Respondent repeatedly delayed payment of Petitioner's wage differential benefits, §19(l) is inapplicable. The award of §19(l) penalties is hereby vacated.

II. Sections 19(k) and 16

Section 19(k) of the Act provides, "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." *820 ILCS 305/19(k)* (West 2012). Section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory, and "is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms 'vexatious,' 'intentional' and 'merely frivolous.'" *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E.2d 545 (1998). Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under 19(k) is appropriate. *820 ILCS 305/16* (West 2012). In challenging the imposition of penalties and fees, Respondent raises two points: 1) Petitioner worked multiple positions with various rates of pay which complicated the accounting process and gave rise to a legitimate dispute as to what Petitioner was capable of earning, and 2) Respondent had no obligation to pay any wage differential benefits at all until a final order was issued. The Commission finds Respondent's arguments are without merit.

The Commission first notes Respondent's assertion that no wage differential benefits are owed unless and until there is a final order is contrary to established caselaw. In *City of Chicago v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3d 258, 267, 947 N.E.2d 863 (2011), the Court addressed, *inter alia*, the propriety of the Commission's imposition of penalties and fees based on the City's delay in paying wage differential benefits. The claimant therein was a laborer earning $29.00 per hour. Pertinent to the issues here, the claimant sustained a low back injury which resulted in permanent Medium Physical Demand Level restrictions. He returned to work with the City as a night watchman earning $17.00 per hour on May 2, 2005, yet the City did not pay wage differential benefits until March 31, 2006. The Commission imposed penalties and fees, finding the City should have instituted wage differential benefits as of May 2, 2005, the date the claimant returned to work as a night watchman. On appeal, the Court affirmed the award of penalties and fees based on the City's failure to initiate wage differential benefits when the claimant began the watchman job:

> A claimant's entitlement to a wage differential is determined by when the claimant is employed with a reduced earning capacity. *See Payetta v. Industrial Comm'n*, 339 Ill. App. 3d 718, 721, 791 N.E.2d 682, 274 Ill. Dec. 590 (2003). The employer paid the claimant a wage differential benefit. However, it waited over 10 months to

20IWCC0498

> commence payment. At the hearing, the employer gave no reason for the delay. On appeal, the employer maintains that the delay was the result of mere bureaucratic inertia. The employer does not maintain that it had a reasonable basis to believe that the claimant was not entitled to begin receiving a wage differential benefit when he returned to work as a night watchman, nor did it assert a reasonable belief that it was not required to pay a wage differential. In fact, it gave no explanation for the delay. *City of Chicago*, 409 Ill. App. 3d at 268 (Emphasis added).

As *City of Chicago* makes clear, Respondent's argument is untenable.

Turning to Respondent's argument that the varying weekly earnings caused accounting difficulties, the Commission finds Respondent has confused the temporary partial disability benefit calculation for the wage differential calculation. Pursuant to §8(a), temporary partial disability benefits are equal to two-thirds of the difference between the average amount the claimant would be making in the full performance of the pre-accident job and "the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working" (*820 ILCS 305/8(a)*); as such, the "gross amount" for each pay period generates a distinct temporary partial disability benefit calculation. In contrast, §8(d)1 speaks of a benefit predicated on averages and the calculation is rather simple. Calculating the wage differential rate requires two earnings determinations: (1) "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 (2) "the average amount which he…is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1* (Emphasis added).

As to the first calculation, the letter from the union treasurer reflects a current hourly rate of $36.21 (PX4); therefore, the average amount Petitioner would be able to earn in the full performance of his pre-accident job is $1,448.40 ($36.21 x 40 = $1,448.40). Regarding the second earning determination, "Suitable employment is employment which the claimant is both able and qualified to perform." *Crittenden v. Illinois Workers' Compensation Commission*, 2017 IL App (1st) 160002WC, ¶24, 73 N.E.3d 654. The evidence shows Petitioner was under the job placement tutelage of Triune until September 2016, when he was hired at Beckers Incorporated earning $12.50 per hour. Petitioner testified the job leads both of Respondent's chosen vocational counselors provided to him over his three-plus years of job search paid $10.00 to $15.00 per hour; therefore, the Beckers position was the mean of the earning capacity range. T. 33. Given Petitioner's restrictions did not prohibit him from full-time work (T. 59), as of September 2016, Petitioner's post-accident suitable employment average weekly earnings were $500.00 ($12.50 x 40 = $500.00), which yields a wage differential of $632.27 ($1,448.40 - $500.00 = $948.40 / 3 x 2 = $632.27). Pursuant to the holding in *City of Chicago*, Respondent should have initiated weekly wage differential payments of $632.27 in early October 2016.

While Respondent argues there was a "legitimate dispute" that the $12.50 per hour position at Beckers Incorporated accurately reflected Petitioner's earning capacity, the Commission emphasizes that argument was negated as of November 16, 2016, when Petitioner started his job at Noble Charter Schools; this job paid $15.30 per hour. Given this hourly rate exceeded the highest pay rate of the job leads Respondent's vocational counselors provided to Petitioner, the Commission finds there could be no reasonable dispute that it accurately reflected

Petitioner's earning capacity. This job yields a wage differential rate of $557.60 ($1,448.40 - $612.00 = $836.40 / 3 x 2 = $557.60). We note the Arbitrator calculated Petitioner's wage differential rate at $557.60, and neither party has challenged this rate on Review.

"When an employer chooses to delay payment of compensation, it has the burden of showing that it had a reasonable belief that the delay was justified." *City of Chicago*, 409 Ill. App. 3d at 267. There is no question the wage differential benefits were issued in a sporadic manner, and Respondent submitted no evidence to explain the repeated delays. While Respondent's brief claims there were accounting difficulties, it provided no testimonial or documentary support for that argument. Moreover, as explained above, it was Respondent's misapplication of the statute which unnecessarily complicated the calculation.

The Commission has thoroughly reviewed the wage differential payments made by Respondent as detailed in the payment log. RX2. For each check, we have analyzed the date of issuance, the benefit period it covers, the number of weeks in that period, the §8(d)1 amount owed based on the $557.60 rate, the amount paid, any resulting underpayment, and the number of weeks between first day of benefit accrual and payment. Respondent's payment log establishes the §8(d)1 payments were consistently late and repeatedly underpaid the benefits owed. The Commission finds the egregious nature of the payment delays from December 2016 through May 2017; the cumulative underpayment of $9,747.26 for the period of September 15, 2016 through March 8, 2018; and Respondent's refusal to pay the benefits accrued from March 9, 2018 through the June 26, 2018 hearing, qualify as unreasonable and vexatious as contemplated by §19(k).

On December 12, 2016 Respondent issued two checks covering October 27, 2016 through November 9, 2016 and November 16, 2016 through November 23, 2016. Respondent did not issue another payment until one month later, on January 11, 2017. Rather than cover the four weeks of accrued benefits, though, this check purported to cover only 2 1/7 weeks of benefits but was underpaid by $417.64.

Respondent did not issue another payment until six weeks later, on February 24, 2017. This purported to cover December 9, 2016 through February 16, 2017, but the Commission observes there is an underpayment of $1,689.85.

Respondent did not issue another payment until five weeks later, on March 29, 2017. The payment log does not specify the benefit period but it appears to cover February 17, 2017 through March 17, 2017, however we note this is underpaid by $686.89.

Respondent did not issue another payment until seven weeks later, on May 15, 2017. This purported to cover March 18, 2017 through May 16, 2017, but is again underpaid, this time by $1,447.63.

To be clear, for the five-month period after December 12, 2016, Petitioner received only four wage differential benefit checks. Aside from its arbitrary payment schedule with weeks-long and months-long gaps between payments, Respondent underpaid benefits by over $4,000.00 for that period. Petitioner testified credibly and in great detail as to the severe financial hardships this caused. The delayed benefits date to November 24, 2016 and Respondent did not bring

20IWCC0498

Petitioner current until May 15, 2017, totaling $13,780.69 in delayed benefits.

The evidence further shows Respondent terminated Petitioner's wage differential benefits as of March 8, 2018. This corresponds to when Petitioner was laid off by Noble Charter Schools. The Commission emphasizes, however, this fact does not represent an excuse to unilaterally terminate benefits. Rather, in that circumstance there are two options: 1) continue paying wage differential benefits at $557.60 based on Petitioner's demonstrated earning capacity of $15.30 per hour; or 2) reinstitute job search efforts while paying maintenance benefits. To be clear, terminating all benefits was not a viable option under the Act. Petitioner testified, and the payment log demonstrates, wage differential benefits from March 9, 2018 through June 26, 2018, totaling $8,762.29, remain unpaid.

The Commission finds Respondent vexatiously delayed payment of $22,542.98 in benefits as detailed above, and further, from October 2016 through March 8, 2018, Respondent underpaid benefits by $9,747.26. Therefore, the Commission finds Petitioner entitled to §19(k) penalties of $16,145.12 ($22.542.98 + $9,747.26 = $32,290.24 x 50% = $16,145.12) and §16 fees of $3,229.02 ($16,145.12 x 20% = $3,229.02).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 11, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $881.07 per week for a period of 53 weeks, representing June 8, 2013 through June 13, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $45,508.69 for Temporary Total Disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits in the amount of $881.07 per week for a period of 117 5/7 weeks, representing June 14, 2014 through September 14, 2016, as provided in §8(a) of the Act. Respondent shall have a credit of $103,875.79 for maintenance benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $557.60 per week commencing on September 15, 2016 and continuing until Petititioner reaches the age of 67 or five (5) years from the date the award becomes final, whichever is later, as provided in §8(d)1 of the Act. Respondent shall have a credit of $31,913.43 for §8(d)1 benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of §19(l) penalties is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §19(k) penalties in the amount of $16,145.12.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner §16 attorney's fees in the amount of $3,229.02.

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

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

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

Stephen Mathis

D. Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the Majority's decision to vacate the penalties awarded pursuant to Section 19(l) of the Act. I, respectfully, dissent as to the Majority's decision to award penalties pursuant to Section 19(k) and fees pursuant to Section 16 of the Act.

The Supreme Court of Illinois articulated the standards for the imposition of penalties and fees over two decades ago in *McMahan v. Industrial Commission*:

> Viewing the statue as a whole, we believe that section 19(k) and section 19(l) were actually intended to address different situations. The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." If the payment is late for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.
> In contrast to section 19(l), section 19(k) provides for substantial penalties, imposition of which are discretionary rather than mandatory. See *Smith v. Industrial Comm'n 170 Ill. App. 3d 626, 632, 121 Ill. Dec. 275, 525 N.E.2d 81 (1988)*. The statute is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. This is apparent in the statute's use of the terms "vexatious," "intentional" and "merely frivolous." Section 16, which uses identical language, was intended to apply in the same circumstances. *McMahan v. Industrial Commission*, 183 Ill. 2d 499, 515, 702 N.E. 2d 545 (1998).

Regarding penalties pursuant to Section 19(l) of the Act, Respondent has failed to provide an adequate explanation for the delay in payment. "The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified." *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶ 19. Respondent's contention that the complexity in calculating Petitioner's wage due to various jobs and corresponding wages is not reasonable and does not justify the delay. With that said, as the Majority found, Section 19(l) penalties are simply not applicable.

Regarding penalties pursuant to Section 19(k) and attorneys' fees pursuant to Section 16 of the Act, as noted above, a different standard applies, and such delay in payment must be "deliberate or the result of bad faith or improper purpose." *McMahan* at 515. I find to award such penalties and fees is not appropriate and decline to award the same. Respondent's failure to pay the appropriate wage differential benefits pursuant to Section 8(d)1 of the Act was neglectful and without good and just cause; it was not intentional nor done in bad faith nor with improper purpose. The Majority finds Respondent's repeated delay in payments and miscalculation of paid benefits, evidences conduct by Respondent amounting to vexatiousness or intentionality. I, though, find the opposite. As the Majority found "Respondent has confused the temporary partial disability calculation for the wage differential calculation." *Infra*, p. 3, ¶ 1(full). Such conduct on Respondent's behalf evidences negligence and a lack of competence but not a deliberate and intentional refusal. Penalties pursuant to Section 19(k) and attorneys' fees pursuant to Section 16 of the Act are not warranted. I, therefore, respectfully dissent.

DATED: SEP 3 - 2020

L. Elizabeth Coppoletti

LEC/mck

O: 7/8/2020

43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIRELES, CARLOS
Employee/Petitioner

Case# **13WC023948**

CITY OF CHICAGO
Employer/Respondent

20IWCC0498

On 10/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5327 MICHAL A HIGGINS
ATTORNEY AT LAW
6204 W 63RD ST
CHICAGO, IL 60638

0010 CITY OF CHICAGO CORP COUNSEL
L DONALD CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20 IWCC0498

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

Carlos Mireles
Employee/Petitioner

Case # **13** WC **23948**

v.

City of Chicago
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **June 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were 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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **6/17/2013**, 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 $**68,827.54**; the average weekly wage was $**1,321.61**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**45,508.69** for TTD, $**0.00** for TPD, $**103,875.79** for maintenance, and $**31,913.43** for 8(d)1 (wage differential) benefits, for a total credit of $**181,297.91**.

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

ORDER

Respondent shall pay Petitioner TTD benefits of $**881.07**/week from **6/8/2013** through **6/13/2014**, which represents a period of **53** weeks, because Petitioner was temporarily totally disabled during this time, in accordance with Section 8(b) of the Act.

Respondent shall pay Petitioner Maintenance benefits of $**881.07**/week from **6/14/2014** through **9/14/2016**, which represents a period of **117-5/7** weeks, because Petitioner had reached MMI and was participating in a vocational rehabilitation program during this time, in accordance with Section 8(a) of the Act.

Respondent shall pay Petitioner $**557.60**/ week from **9/15/2016** through **the duration of his disability**, but only until he reaches the age of **67**, which will occur on **3/18/2042**, as he has sustained an impairment of his earning capacity, pursuant to Section 8(d)1 of the Act.

Respondent shall pay Petitioner penalties in the amount of $**19,675.19**, pursuant to Section 19(k) of the Act.

Respondent shall pay Petitioner penalties in the amount of $**10,000.00**, pursuant to Section 19(l) of the Act.

Respondent shall pay Petitioner attorney's fees in the amount of $**3,935.04**, pursuant to Section 16 of the Act.

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

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

20IWCC0498

Signature of Arbitrator

10/10/18
Date

OCT 1 1 2018

State of Illinois)
) SS.
County of Cook)

20IWCC0498

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos Mireles Employee/Petitioner	)	
v.	)	Case No. **13** WC **23948**
City of Chicago Employer/Respondent	)	

ATTACHMENT TO ARBITRATION DECISION

Findings of Fact:

Carlos Mireles (hereinafter "Petitioner") performed job duties as a Sanitation Laborer for the City of Chicago (hereinafter "Respondent"). Petitioner testified that he is better known as "your friendly, neighborhood garbage man." His job duties required transporting refuse from the cans in the alley to his garbage truck.

Petitioner dumped trash cans and hand-loaded debris into the garbage truck. Debris could be found on the ground or on top of trash cans. The weight of the debris ranged from 5 to 100 pounds. Petitioner would lift debris daily to throw it into the garbage truck. Petitioner would also be required to dig out trash cans on snowy days.

On June 17, 2013, Petitioner performed his normal job duties. Among the pick-ups that day was junk in the alley that included a stove, a washing machine, a television, a refrigerator and a dresser. Petitioner and a co-worker lifted the junk from the alley to garbage truck. While they squatted to pick up a television, Petitioner's co-worker let go and the television fell onto

Petitioner. Petitioner twisted his body while lifting the television. Petitioner immediately felt a "pop" in his lower back and fell to the ground.

Petitioner notified his supervisor. His supervisor instructed him to seek immediate medical treatment. Petitioner sought medical treatment at Mercy Medical Center. He was told to follow up with an orthopedic specialist. Petitioner sought treatment with Patrick J. Sweeney, M.D. (Px 1)

Dr. Sweeney's August 8, 2013 office notes indicate that he reviewed the July 2, 2013 MRI and diagnosed Petitioner with herniated nucleus pulposus at L3-4, L4-5, and L5-S1. (Px 1) Dr. Sweeney referred Petitioner to Jalaja V. Piska, M.D., for the surgical insertion of an electronic spinal cord stimulator. (Px 3)

Dr. Piska performed this procedure on November 4, 2013. Petitioner testified that the electronic stimulator reduced his pain levels from 10/10 to 6/10. (Px 3)

Dr. Sweeney prescribed a functional capacity examination ("FCE"). Petitioner underwent the FCE on April 1, 2014 at ATI physical therapy. Matt Holton, M.S., a Certified Key Assessment Specialist, found that the FCE results indicate Petitioner is not capable of performing VERY HEAVY work, which is the physical demand level of the position of Sanitation Laborer. (Px 2)

Respondent hired a Vocational Rehabilitation Specialist, Mary Schmidt, from Triune Health, to aid Petitioner in finding gainful employment. Petitioner worked with Mary for 2½ years. Ms. Schmidt gave him 20 leads per week and Petitioner searched for 5 jobs on his own. He testified that he completed and filed job applications and went to job fairs near O'Hare and

outside the City. Petitioner testified that every day he looked for a job. Petitioner's attempt to find gainful employment while working with Ms. Schmidt was unsuccessful.

Respondent replaced Mary Schmidt with a second Vocational Rehabilitation Specialist, whose name Petitioner could not recall. Petitioner performed the same activities with the second specialist. Petitioner worked with this vocational specialist for about 1 year. She would provide him with 20 job leads a week and he searched for 5 to 10 jobs on his own. So, Petitioner testified, he was performing 25-30 job searches per week. Petitioner's job search included positions that paid in the range of $10.00-$15.00/hour.

Through the help of a friend, Petitioner finally landed a position at Becker's, Incorporated, as a Pan Washer. Petitioner testified that this job paid $11.25/hour, although Px 6 indicates it paid $12.50/hour. After performing as a pan washer for 2 months, Petitioner found a better paying job at Noble Charter Schools as an Assistant Engineer. In this position, Petitioner earned $15.30/hour. He worked 40 hours/week.

Due to a layoff at Noble Charter Schools, Petitioner was forced to find a position as a Security Officer at Securitas. Petitioner began this occupation in May of 2018. Petitioner earns $13.00/hour and works 24-32 hours/week for Securitas.

Petitioner testified that after he first received a pay stub from a new employer, he would take it and deliver it to Respondent. Respondent would photocopy the pay stub and time stamp it. Sometimes, Petitioner testified, he would bring the pay stub to Respondent on the same day he received it. Other times, he continued, it would take 3 days to present a pay stub to Respondent. Then the procedure changed: he would have to email a copy of the pay stub to Respondent, to his lawyer, and to Ken Smith, the Adjuster.

Petitioner testified that he has never tendered a pay stub from a new employer to Respondent later than 1 week after he received it.

Petitioner testified on cross-examination that no time passed between his employment with Becker and his employment with Noble Charter Schools. However, between his employment with Noble Charter Schools and Securitas, 1 month passed. Petitioner did not submit pay stubs to Respondent during that month.

Since September of 2016, when Petitioner found gainful employment, Respondent has been repeatedly late in paying him his wage differential benefits. Payment by Respondent has been late 10 weeks on one occasion, 9 weeks on one occasion, 6 weeks on one occasion, 5 weeks on five different occasions, 4 weeks on four different occasions, 3 weeks on five different occasions, and 2 weeks on four different occasions. (Px 5)

Petitioner testified that he has endured many a hardship due to the delay in receiving checks from Respondent. Petitioner testified his car was repossessed; his landlord filed several eviction notices; Commonwealth Edison shut off his power; his children were informed they were not allowed to attend their Catholic school due to non-payment of tuition; Petitioner struggles to provide food for his family; Petitioner could not buy birthday or Christmas gifts for his children; bill collectors call Petitioner constantly.

Conclusions of Law:

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

The Arbitrator finds Petitioner's lumbar condition of ill-being to be causally related to the June 17, 2013 accident. Petitioner suffered an undisputed accident while working for Respondent on June 17, 2013. Petitioner immediately sought medical treatment for his low back condition of ill-being. Petitioner sought treatment with Dr. Patrick Sweeney on June 20,2013. Dr. Sweeney's office note reflects a low back injury and need for treatment. His August 8, 2013 office note indicates that Dr. Sweeney reviewed the July 2, 2013 MRI and diagnosed Petitioner with multiple disc herniations at L3-4, L4-5, and L5-S1.

To provide relief from low back pain and radicular symptoms after the June 17, 2013 accident, Dr. Sweeney prescribed and Dr. Piska performed, surgery on Petitioner on November 4, 2013. Such surgery consisted of the installation of an electronic spinal cord stimulator.

"A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982)

Respondent has not offered any evidence to dispute the issue of causal connection. Therefore, the Arbitrator finds that Petitioner's November 4, 2013 surgery and his current condition of ill-being of his low back are causally related to the June 17, 2013 accident.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD and Maintenance", the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is entitled to TTD benefits from June 8, 2013 through June 13, 2014 for a total of 53 weeks. The records of Dr. Sweeney and Dr. Piska show that Petitioner was unable to perform his job duties and was temporarily totally disabled from work during this time. Respondent offered no evidence to rebut Petitioner's period of temporary total disability.

The Arbitrator further finds that Petitioner is entitled to Maintenance benefits from June 14, 2014 through September 14, 2016 for a total of 117-5/7 weeks. Petitioner performed the requested vocational rehabilitation tasks and co-operated with the two Triune Vocational Rehabilitation Specialists hired by Respondent during this time period. Petitioner testified that he performed a job search of over 20 contacts/week, attended job fairs and carried out all that was asked of him by these two vocational rehabilitation specialists. Respondent offered no evidence of non-compliance by Petitioner with the vocational rehabilitation program.

Respondent is entitled to a credit in the amount of $45,508.69 for TTD benefits paid, and $103,875.79 for Maintenance benefits paid to Petitioner. (Rx 2)

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

Section 8(d)1 of the Illinois Worker's Compensation Act states the following:

§8(d)1: Wage Differential

(d)

1. 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.

Petitioner's Exhibit #2, the April 1, 2014 FCE results, demonstrates Petitioner is not physically capable of performing the VERY HEAVY physical demands of a Sanitation Laborer for Respondent. Instead, Petitioner demonstrated his functional capabilities at the MEDIUM to HEAVY physical demand level during the FCE. (Px 2)

In a letter dated March 24, 2017, Victor Roa, Secretary-Treasurer of Union Local 1001, wrote that effective January 1, 2017, the current rate of pay for a Sanitation Laborer (Title Code 6824) is $36.21/week. (Px 4)

While employed at Noble Charter Schools, Petitioner established that he is capable of earning $15.30 per hour for 40 hours/week. The wage difference is $20.91/ hour. Then, 66⅔% of that difference is $13.94/hour. When calculated for 40 hours/week, that differential is $557.60/week.

Therefore, the Arbitrator finds Respondent shall pay Petitioner $557.60/ week from September 15, 2016 through the duration of his disability, but only until he reaches the age of 67, which will occur on March 18, 2042.

Respondent is entitled to a credit of $31,913.43 in wage differential benefits paid. (Rx 2)

In support of his decision with regard to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds as follows:

§19(k): Penalty for Delay

(k) In the case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay.

§19(l): Penalty for Delay

(l) If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). 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.

In *City of Chicago v. Illinois Workers' Comp. Comm'n*, 947 N.E.2d 863 (1st Dist. 2011), the Court held as follows: "Given the employer's failure to justify the delay in payment of the wage differential benefit, it cannot be said that the Commission's award of penalties and attorney

fees was against the manifest weight of the evidence." In that case, the employer waited over 10 months to commence payment of a wage differential benefit. Specifically, after claimant recovered from the accidental injury, he started working as a night watchman on May 2, 2005 where he earned $17.00/hour. However, the employer did not begin paying the wage differential until March 31, 2006. On appeal, the employer maintained that the delay was the result of mere bureaucratic inertia.

In the case at bar, the Arbitrator concludes that since September of 2016, Respondent has not paid Petitioner in a timely manner. Petitioner's Exhibit 5 shows the length of time that each wage differential voucher was delayed by Respondent. Respondent did not present any evidence to refute Petitioner's handwritten figures under the heading "On time or Weeks Late." (Px 5)

Petitioner testified that after he first received a pay stub from a new employer, he would take it and deliver it to Respondent. Respondent would photocopy the pay stub and time stamp it. Sometimes, Petitioner testified, he would bring the pay stub to Respondent on the same day he received it. Other times, he continued, it would take 3 days to present a pay stub to Respondent. Then the procedure changed: he would have to email a copy of the pay stub to Respondent, to his lawyer, and to Ken Smith, the Adjuster.

Petitioner testified that he has never tendered a pay stub from a new employer to Respondent later than 1 week after he received it.

Petitioner testified on cross-examination that no time passed between his employment with Becker, Inc., and his employment with Noble Charter Schools. However, between his

employment with Noble Charter Schools and Securitas, 1 month passed. Petitioner did not submit pay stubs to Respondent during that month.

Respondent argues that it is Petitioner's burden to prove entitlement to an Section 8(d)1 award. Yet, Section 8(d)1 clearly directs Respondent to pay Petitioner wage differential benefits after he finds gainful employment. Petitioner provided unrebutted testimony as to how and when he submitted pay stubs to Respondent. Such pay stubs indicated the hourly rate of pay and number of hours worked per week. Respondent presented no evidence that the pay stubs were not what they purported to be.

Respondent offered no evidence to prove Petitioner was not cooperative while working with Triune Vocational Rehabilitation Specialists.

Petitioner was able to find gainful employment through his own job search and leads.

Respondent offered no evidence that they were unaware of Petitioner's gainful employment.

Respondent argued that they paid 53 weeks of TTD benefits and 117-5/7 weeks of Maintenance benefits and that all the TTD benefits were paid on time, and all but 2 of the Maintenance benefits were paid on time.

Respondent points out that Petitioner worked in 3 different positions. He was first a Pan Washer, then an Assistant Engineer, and then a Security Officer. Each position had a different rate of pay. Respondent argues that the various rates of pay complicated the accounting process and, more importantly, gave rise to a legitimate dispute as to what Petitioner was capable of earning in his post-accident employment.

In *City of Chicago v. Illinois Workers' Comp. Comm'n* (supra), payment the wage differential check was delayed 10 months and not 10 weeks, and claimant only had one job as a night watchman with a single rate of pay.

However, Petitioner's Exhibit #5 shows that Respondent was repeatedly late in paying the wage differential benefits, sometimes very late. Respondent was late 10 weeks on one occasion, 9 weeks on one occasion, 6 weeks on one occasion, 5 weeks on five different occasions, 4 weeks on four different occasions, 3 weeks on five different occasions, and 2 weeks on four different occasions. Petitioner testified that for one 19-week period, he only received a wage differential check once. Petitioner also testified at the June 26, 2018 trial that he last received a wage differential check in April of 2018.

Petitioner's Exhibit #6 is composed of various pay stubs and emails that show Respondent was made aware of Petitioner's jobs and his hourly rates. The emails indicate, among other things, that Petitioner was not receiving several of his wage differential checks on time, that the Adjuster on this file lost his job, and that a new lawyer for Respondent took over the file.

Due to Respondent's lengthy delay in making payments, Petitioner testified, he and his family suffered many hardships. Petitioner testified that his car was repossessed; his landlord filed several eviction notices; Commonwealth Edison shut off his power; his children were told that they were not allowed to attend their Catholic school due to non-payment of tuition; Petitioner struggles to provide food for his family; Petitioner could not buy birthday or Christmas gifts for his children; bill collectors call Petitioner constantly.

The Arbitrator finds Respondent's delay in their payment of wage differential benefits to be unreasonable and vexatious. Since Petitioner testified that the latest he submitted a pay stub to Respondent was 1 week after he received it, the Arbitrator does not include in his calculation of 19(k) penalties the wage differential vouchers that were delayed by 2 weeks. Therefore, the Arbitrator calculates 19(k) penalties based on a sum of the following periods: 9/15/16 - 5/16/17, 6/9/17 - 9/23/17, 10/9/17 – 11/7/17, 11/30/17 – 1/23/18, and 4/30/18 – 6/26/18. The first 5 period here are based on Px 5 and Petitioner's testimony; the last period here is based on Petitioner's testimony only. The number of weeks here add up to 70-4/7.

Therefore, the Arbitrator finds that Respondent shall pay 19(k) penalties in the amount of (70.571 x $557.60) x .50 = $19,675.19.

For the reasons stated above, the Arbitrator also awards Petitioner $10,000.00 in Section 19(l) penalties.

§16: Attorneys' Fees To Be Paid as Penalty

Whenever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier. (Source: P.A. 94-277, eff. 7-20-05.)

As stated above, the Arbitrator finds Respondent's delay in paying wage differential benefits to be unreasonable and vexatious. In addition to 19(k) and 19(l) penalties, the

Arbitrator, pursuant to Section 16, compels Respondent to pay Petitioner's attorney's fees in the amount of $19,675.19 x .20 = $3,935.04.

Brian T. Cronin 10-10-2018

Brian T. Cronin
Arbitrator

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheila Howliet,

Petitioner,

vs. No. 14 WC 15185

Lincoln's Challenge Academy/State of Illinois,

Respondent. **20IWCC0500**

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

Sheila Howliet, a 40-year-old civilian drill sergeant employed by Respondent, testified that prior to her accident, she never experienced any problems or pain to her wrist, hand or knees, and she had never received any treatment or restrictions for them. On January 30, 2014, Petitioner had been riding in a school bus with her students. The roads were icy, and when Petitioner exited the bus, she slipped and fell. She landed directly on her knees and right hand near her 5th metacarpal. Petitioner immediately felt pain in her hand and noticed it began to swell. However, she did not notice the pain in her knees until a few days later.

Petitioner received emergency room treatment on the day of her accident for pain in her back and right hand. An x-ray of her right hand showed no acute abnormalities and she was diagnosed with a hand contusion. Approximately three days later, Petitioner noticed pain in her knees. She reported to her HR rep that her knees were bothering her from the fall, and that she

was having difficulty walking up three flights of stairs – an activity she performed four times a day. Petitioner was referred to a nurse practitioner, Virginia Brown, at Carle. Brown ordered physical therapy for Petitioner's neck, low back and knees; and occupational therapy for her right hand.

Carle Clinic records dated February 10, 2014 document Petitioner's complaints of right hand pain, specifically noting she had tenderness along her 5th metacarpal. On February 24, 2014, Petitioner's therapist, Brandi Hughes, reported Petitioner's history of having landed with her right wrist hyperextended and feeling initial pain in her right hand along the ulnar aspect. Petitioner also reported difficulty writing. Therapy records during the subsequent months noted some improvement in Petitioner's right hand symptoms. However, on May 6, 2014, Petitioner was still complaining of persistent hand numbness, and therapist Hughes recommended placing Petitioner's hand therapy on hold, but keeping that plan of care open.

On July 9, 2014, Petitioner saw Dr. Chen for her ongoing hand and knee complaints. Dr. Chen ordered an EMG for Petitioner's right hand tingling and another course of aqua therapy for her knees. On August 29, 2014, Dr. Chen referred Petitioner to Dr. Kolb for a second opinion due to her ongoing knee complaints. Dr. Kolb examined Petitioner's knees on November 11, 2014 and diagnosed Petitioner with chondromalacia in her patella. He found her able to work without restrictions, and recommended she see a rheumatologist.

Petitioner returned to Dr. Chen on March 3, 2015, still complaining of knee pain. Following his exam, he ordered MRI scans of Petitioner's knees. Those MRI's, taken on March 31, 2015, revealed tricompartmental degenerative changes, effusion and evidence of chondromalacia associated with patellar fissuring, suggestive of recently ruptured Baker's cysts. On April 2, 2015, Dr. Chen recommended further physical therapy for Petitioner's knees.

On December 7, 2015, Petitioner saw pain management physician, Dr. Jung, for ongoing pain in her knees and right wrist. Dr. Jung referred Petitioner to a knee specialist and to a specialist in the Hand Department. Petitioner saw Dr. Gurtler for her knee symptoms on January 5, 2016 and April 7, 2016. He initially recommended no treatment for Petitioner's knees, but subsequently agreed that a judicious use of knee injections would be beneficial to Petitioner. Petitioner's pain physician, Dr. Jung, administered steroid injections to Petitioner's knees in May 2016. Since then, he has given Petitioner multiple steroid and Hyalgan injections; most recently, on May 16, 2018.

On January 12, 2016, Petitioner was examined by physician's assistant, Anne Marshall, at the Carle Hand Surgery Clinic. Petitioner reported right hand pain which began two years earlier when she slipped and fell on ice. Marshall recommended an MRI of Petitioner's right hand. Following that March 22, 2016 MRI, Marshall diagnosed a triangular fibrocartilage complex ("TFCC") injury of the right wrist. Petitioner was given an intraarticular wrist injection; that provided temporary relief. Petitioner received another wrist injection on July 26, 2016. When it became apparent that the injections did not provide lasting relief, PA Marshall recommended

surgery. On May 30, 2017, Petitioner's hand surgeon, Dr. Sobeski, performed a right wrist arthroscopy with triangular fibrocartilage complex debridement.

At Dr. Sobeski's deposition, he testified that Petitioner's TFCC tear was causally related to her January 30, 2014 work accident. He testified that ulnar wrist pain would be suspicious for a TFCC tear, and that such an injury would not show up on an EMG. An MRI is required to confirm that condition. He testified that TFCC tears could be missed if the treater did not know to look for it. Dr. Sobeski opined that the surgery he performed helped Petitioner's hand condition, and she has done well since. She now has less pain, and full unrestricted wrist and forearm motion. While Dr. Sobeski testified that other hand intensive activities performed after Petitioner's accident could have caused her TFCC tear, he believed her work accident caused the tear because her hand was asymptomatic prior to that fall, but has been painful, since.

Dr. Jung testified at his deposition that, while Petitioner had preexisting degenerative changes to her knees prior to January 30, 2014, her accident of that date aggravated her knee condition and the treatment she received was causally related. Dr. Jung testified that while the injections he administered provided temporary pain relief, Petitioner's ongoing knee condition was causally related to her work accident because her pain returned after the injections wore off. He disagreed that Petitioner's current symptoms were simply a progression of her prior degenerative condition and unrelated to her fall.

Respondent presented the deposition testimony of orthopedic surgeon, Dr. Nemickas, who reviewed Petitioner's medical records and examined her on August 21, 2014 and August 8, 2016. At his first exam, Dr. Nemickas believed Petitioner suffered a right knee contusion with residual patellofemoral chondromalacia, diffuse musculoskeletal myofascial pain and right cubital tunnel syndrome. He agreed that Petitioner was not at MMI for her right knee; she required restrictions and aqua therapy. Following Dr. Nemickas' August 8, 2016 exam, he diagnosed Petitioner's causally related work injuries to be: bilateral knee contusions; temporary aggravations of patellofemoral chondromalacia; cervical and lumbar spondylosis; degenerative disc disease without myelopathy; right wrist contusion/sprain; bilateral shoulder sprains, and right upper extremity cubital tunnel syndrome. He opined that Petitioner's knee and right wrist injuries had reached MMI or returned to their baseline state by March 3, 2015, and that the treatment she received after that date was not related to her fall, but rather, to her underlying conditions. In reaching his opinions, Dr. Nemickas noted no symptom magnification or submaximal effort by Petitioner.

II. CONCLUSIONS OF LAW

A. Causal Connection

The Arbitrator found Petitioner's right hand and knee injuries were causally related to her January 20, 2014 work accident, but only through March 3, 2015. The Arbitrator did not find Petitioner's right hand TFCC tear was causally related to her accident because it had not been

diagnosed until almost two years after her accident. The Arbitrator noted that a TFCC tear would have caused more immediate ulnar-sided complaints which, the Arbitrator found, "Petitioner did not have until she was examined on April 25, 2016."

The Arbitrator, in finding that Petitioner had reached MMI for her knee condition by March 3, 2015, relied upon Dr. Kolb's findings that Petitioner's knees were normal at his November 10, 2014 exam. The Arbitrator also relied upon Dr. Chen's similar, March 3, 2015 exam findings, and the opinion of Respondent's Section 12 examiner, Dr. Nemickas.

The Commission views the evidence differently than the Arbitrator. The record reflects that Petitioner did have ulnar-sided symptoms in her right hand shortly after her accident. Petitioner gave undisputed testimony that she fell on her right hand in the vicinity of her 5th metacarpal. On February 10, 2014, just 11 days after her accident, nurse practitioner Brown reported that Petitioner's right hand was tender, "along the 5th metacarpal." Two weeks after that, physical therapist Brandi Hughes also reported the location of Petitioner's initial right hand complaint as being, "along the ulnar aspect."

Dr. Sobeski, Petitioner's hand surgeon, provided a causation opinion that Petitioner's TFCC tear was related to her January 30, 2014 accident. He testified that ulnar-sided wrist pain is a symptom of a TFCC tear. He testified that the reason Petitioner's TFCC tear might not have been diagnosed sooner, was because her treater may not have known to look for the symptoms of that injury. None of Petitioner's prior treaters ordered an MRI – which confirmed the injury to Petitioner's TFCC – until two years after her accident.

Moreover, the Commission does not find Dr. Nemickas' opinions relative to Petitioner's right hand injury to be persuasive. He is not a hand surgeon. Nor did he offer any contrary opinion regarding the TFCC tear or its relationship to Petitioner's accident. The Commission finds Dr. Sobeski more qualified than Dr. Nemickas to give causation opinions regarding Petitioner's TFCC tear, and finds Petitioner did prove a causal connection of her right wrist TFCC tear to her work injury.

With regard to Petitioner's knees, the Commission finds Petitioner proved her knee condition after March 3, 2015 was related to her work injury. Records document that Petitioner's knee complaints did not end on that date. To the contrary, Petitioner told Dr. Chen on March 3, 2015 that her knee symptoms were no better than they had been a year before. Petitioner continued to undergo physical therapy for her knees which Dr. Chen had ordered after March 3, 3015. Petitioner received numerous steroid and Hyalgan injections beginning in 2016 and continuing into 2018, and testified that she still sees Dr. Jung from time to time for treatment for her knees.

In reaching his opinion relating Petitioner's condition to her accident, Dr. Jung acknowledged that Petitioner had preexisting degenerative changes in her knees prior to January 30, 2014, but explained that her accident of that date aggravated that condition. He opined that Petitioner's ongoing knee condition, and the treatment she received for it, were causally related to

her work accident because her pain returned after the injections wore off. He disagreed that Petitioner's current symptoms were simply a progression of her prior degenerative condition and unrelated to her fall.

Considering the opinion of Respondent's Section 12 examiner, the Commission finds the opinions of Dr. Nemickas regarding Petitioner's knees to be less persuasive. He testified that an injection given to Petitioner's knee had restored her knee to her preinjury state, but then admitted that the relief she received from her injection did not last. Dr. Nemickas acknowledged that Petitioner's pain returned six weeks after her injection. He also had not seen Petitioner since his 2016 examination, prior to her TFCC diagnosis, and was unfamiliar with her condition and treatment after that date. In addition, Dr. Nemickas noted no issues with Petitioner's credibility.

It is well established that a claimant with a preexisting condition may recover where employment aggravates, accelerates or exacerbates that condition. *Caterpillar Tractor Co. v. Industrial Comm,* 92 IL 2d 30 (1982). Examining the facts, and considering the opinions given by both physicians, the Commission finds the opinions of Dr. Jung to be more persuasive given Petitioner's asymptomatic pre-accident condition. Thus, the Commission finds Petitioner's current knee condition was the result of an aggravation of her asymptomatic, preexisting condition.

B. Medical Expenses

Having found that Petitioner's conditions of ill-being are causally related to the accident at work, the Commission awards Petitioner all reasonably necessary and related expenses to be paid pursuant to §§8(a) and 8.2 of the Act. In so doing, the Commission reiterates the finding that the opinions of Petitioner's treating physicians, Dr. Jung and Dr. Sobeski, are persuasive given the totality of the record. Thus, the Commission affirms the award of Petitioner's reasonable and necessary medical expenses between January 30, 2014 and March 3, 2015. In addition, the Commission finds Petitioner entitled to her reasonable and necessary medical expenses incurred in treating her right wrist and hand, and bilateral knee conditions, after March 3, 2015.

C. Temporary Total Disability Benefits

Having found that Petitioner's conditions of ill-being are causally related to the accident at work, the Commission turns to Petitioner's claim for temporary total disability benefits. The dispositive test for awarding TTD benefits is "whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). The medical evidence and persuasive opinion of Dr. Sobeski established that Petitioner had not reached maximum medical improvement as it relates to her TFCC tear during the period requested. Thus, the Commission finds Petitioner also entitled to 1-4/7 weeks of TTD for the period she was unable to work following her TFCC surgery: from May 30, 2017 through June 9, 2017.

D. Permanent Partial Disability Benefits

Finally, the Commission vacates the Arbitrator's finding that Petitioner sustained no permanent partial disability as a result of her January 30, 2014 accident. In reaching this conclusion, the Commission has considered the five factors enumerated in §8.1b(b) of the Act, and assigns the following weights to them:

(i) **Disability impairment rating:** *little weight,* because although Dr. Nemickas provided a 6th Edition AMA impairment rating of whole body impairment for Petitioner's seven diagnoses, his rating did not take into consideration Petitioner's TFCC tear injury.

(ii) **Employee's occupation:** *some weight,* because Petitioner was able to resume her prior job duties following her treatment.

(iii) **Employee's age:** *some weight,* because at her age of 40, she will have decades to continue working with diminished strength and chronic knee pain.

(iv) **Future earning capacity:** *no weight,* because neither party presented evidence that Petitioner's future earning capacity would be impaired or diminished.

(v) **Evidence of disability corroborated by the treating records:** *significant weight,* because Petitioner continues to experience diminished strength in her right hand and inability to hold a pen longer than 30 minutes. She testified her hand occasionally goes numb. She has chronic pain in both knees, which sometimes swell. Petitioner has difficulty utilizing stairs and exercising, and can no longer run.

Accordingly, the Commission finds Petitioner entitled to 63 weeks of permanent partial disability benefits at a rate of $381.21, representing 7.5% loss of each leg (16.125 x 2), plus 15% loss of use of the right hand (30.75 weeks).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 21, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being in her right hand and wrist, and in her bilateral knees, is determined to be causally related to her January 30, 2014 accident.

IT IS FURTHER ORDERED BY THE COMMISSION that the denial of temporary total disability benefits is vacated. Respondent shall pay Petitioner the sum of $423.57 per week for a period of 1-4/7 weeks for the period of May 30, 2017 through July 9, 2017, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses is modified. The Commission affirms the Arbitrator's award of Petitioner's reasonable and

necessary medical expenses from January 30, 2014 through March 3, 2015; but also finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in treating her right hand and wrist and her bilateral knee conditions after March 3, 2015, which are contained in Petitioner's Exhibits 5 and 6, as provided in §8(a) and §8.2 of the Act, subject to the fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's denial of permanent partial disability benefits is vacated. Respondent shall pay Petitioner, for permanent partial disability, the sum of $381.21 per week for a total period of 63 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right hand (30.75 weeks), the 7.5% loss of use of the right leg (16.125 weeks), and the 7.5% loss of use of the left leg (16.125 weeks).

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.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: SEP 4 - 2020
o-07/09/2020
MP/mcp
68

Marc Parker

Barbara N. Flores

DISSENT IN PART & CONCUR IN PART

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Arbitrator found that Petitioner's stipulated accident did not cause any current condition of ill-being. He awarded medical expenses incurred between January 30, 2014 and March 3, 2015 but denied PPD benefits. The Majority basically reversed the Decision of the Arbitrator and found that Petitioner sustained permanent injuries to her right hand and both knees bilaterally. The Majority awarded all medical incurred and 63 weeks of PPD representing loss of the use of 15% of the right hand and 7.5% of each leg.

I concur with the Decision of the Majority on the issue of causation to a current condition of ill-being of Petitioner's right hand, the award of medical incurred for treatment of the right hand incurred after March 3, 2015, and the award of PPD for the right hand. However, I dissent from the Decision of the Majority in its decision to reverse the Decision of the Arbitrator and find Petitioner sustained her burden of proving that she sustained permanent disability of her legs, its award of medical treatment for her knees incurred after March 3, 2015, and the its award of PPD for her legs.

Petitioner testified she slipped on ice while exiting a bus while on duty and fell on her knees and outstretched right hand. Initially, she reported pain in her right hand and back. X-rays were taken on her right hand and no fracture was found. She was placed in physical therapy for her hand. She did not have any recorded symptoms regarding her knees until February 27, 2014, almost a full month after the accident. On that date in a physical therapy session for her hand, Petitioner stated that she fell on her knees on January 30, 2014 and complained of pain in her knees.

Petitioner was first examined by Dr. Chen on July 9, 2014. His examination of her knees was benign, but he recommended an EMG for her hand complaints. She returned to Dr. Chen on August 29, 2014, after the EMG. At the time Petitioner complained of aching in her knees. His examination of her knees was normal and he referred her to Dr. Kolb, an orthopedist. Petitioner was examined for her bilateral knee complaints by Dr. Kolb on November 10, 2014. Dr. Kolb's clinical examination was normal and he had no explanation for her continued complaints. After an MRI, Petitioner was examined by Dr. Gurtler, an orthopedic surgeon. He noted that the MRI showed some bilateral degenerative joint disease on her knees, but her bilateral knee condition did not need treatment.

Petitioner was seen by Dr. Nemickas for a Section 12 examination at the direction of Respondent. He opined that Petitioner sustain bilateral knee contusions as a result on the accident on January 30, 2014 which resulted in a temporary exacerbation of her pre-existing patellofemoral chondromalacia. He also opined that Petitioner was at MMI for her knee condition as of the date of Dr. Chen's examination on March 3, 2015, at which time her bilateral knee condition returned to baseline. In contrast, Petitioner's treating doctor, Dr. Jung, opined that the trauma aggravated her pre-existing condition. However, he testified a condition cannot be only a temporary exacerbation if a patient continues to have complaints and declined to opine on the underlying diagnosis of patellofemoral chondromalacia because he was not an orthopedist. I find the opinions of Dr. Nemickas, which are fully supported by the clinical findings of Dr. Chen, Dr. Kolb, and Dr. Gurtler more persuasive than those of Dr. Jung.

For the reasons stated above, I concur with the Decision of the Majority on the issue of causation to a current condition of ill-being of Petitioner's right hand, the award of medical incurred for treatment of the right hand incurred after March 3, 2015, and the award of PPD for the right hand. However, I dissent from the Decision of the Majority in its decision to reverse the

Decision of the Arbitrator and find Petitioner sustained her burden of proving that she sustained permanent disability of her legs, its award of medical treatment for her knees incurred after March 3, 2015, and its award of PPD for her legs.

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWLIET, SHEILA M Case# **14WC015185**
Employee/Petitioner

LINCOLN'S CHALLENGE ACADEMY/ST OF IL
Employer/Respondent

20 IWCC0500

On 11/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0258 HELLER HOLMES & ASSOC
FRED JOHNSON
1101 BROADWAY AVE
MATTOON, IL 61938

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

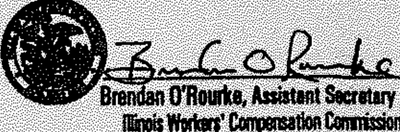
1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA M SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

NOV 21 2019



Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sheila M. Howliet
Employee/Petitioner

v.

Lincoln's Challenge Academy/State of Illinois
Employer/Respondent

Case # 14 WC 15185

Consolidated cases: n/a

20IWCC0500

An *Application for Adjustment 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 Urbana, on September 25, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 30, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $33,038.20; the average weekly wage was $635.35.

On the date of accident, Petitioner was 40 years of age, married with 2 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner from January 30, 2014, through March 3, 2015, as identified in Petitioner's Exhibits 5 and 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Based upon the Arbitrator's Conclusions of Law attached hereto, no temporary total disability benefits or permanent partial disability 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.

William R. Gallagher, Arbitrator

November 16, 2019
Date

NOV 2 1 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on January 30, 2014. According to the Application, Petitioner was "Getting out of bus, slipped on ice" and sustained an injury to her "Right hand and arm, both shoulders, back and both knees" (Petitioner's Exhibit 1). Petitioner and Respondent stipulated Petitioner sustained a work-related accident on January 30, 2014, but Respondent disputed liability on the basis of causal relationship. Further, Respondent disputed liability for any medical expenses or temporary total disability benefits subsequent to March 5, 2015, on the basis Petitioner was at MMI at that time (Arbitrator's Exhibit 1).

Petitioner worked for Respondent, a military school for 16 to 18 year olds, as a civilian drill sergeant, Petitioner's job duties included coaching, counseling and mentoring the teens. Petitioner was also required to participate in military type training of the teens which included marching, running, doing push-ups, sit ups, etc.

At trial, Petitioner testified that on January 30, 2014, she was in the process of exiting a bus at Respondent's facility when she slipped and fell because of ice on the pavement. When Petitioner fell, she stated she fell on both of her knees and her outstretched right hand.

Petitioner initially sought medical treatment on January 30, 2014, at the ER of Carle Foundation Hospital. At that time, Petitioner complained of right hand and low back pain, but did not complain of any knee symptoms. X-rays of Petitioner's right hand were obtained which were negative for fracture. Petitioner was given medication and advised to follow up with occupational health (Respondent's Exhibit 6).

Petitioner began physical therapy at Carle Therapy Services on February 24, 2014, and received treatment there intermittently through May 19, 2015. When seen there on February 27, 2014, Petitioner complained of bilateral knee pain and advised she fell on both of her knees on January 30, 2014. She was diagnosed with bilateral knee contusions and it was recommended she limit going up/down stairs (Respondent's Exhibit 6).

On July 1, 2014, Petitioner was seen by Virginia Brown, a Registered Nurse, at Carle Therapy Services. At that time, Petitioner complained of right knee pain, bilateral shoulder pain and numbness in the fingers of her right hand. RN Brown continued Petitioner's work restrictions and referred her to Dr. Philbert Chen, an orthopedic surgeon (Respondent's Exhibit 6).

Dr. Chen evaluated Petitioner on July 9, 2014. Dr. Chen's findings on examination of Petitioner's knees and shoulders were benign. However, because of her complaints of numbness in the fingers of her right hand, he recommended Petitioner undergo EMG/nerve conduction studies (Respondent's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Tomas Nemickas, an orthopedic surgeon, on August 21, 2014. In connection with his examination of Petitioner, Dr. Nemickas reviewed medical records provided to him by Respondent. At the time of his examination,

Petitioner complained of pain in the neck, both shoulders, both knees, and low back as well as numbness/tingling in the right fourth and fifth fingers. Dr. Nemickas opined Petitioner had sustained a right knee contusion with residual patellofemoral chondromalacia, right arm cubital tunnel syndrome and diffuse musculoskeletal myofascial pain. He opined the right knee condition was related to the accident and Petitioner should undergo EMG/nerve conduction studies in regard to the right arm cubital tunnel syndrome. In regard to the musculoskeletal myofascial pain, he opined there were no positive objective findings on examination to explain her continued complaints, but recommended she have some aquatic therapy (Respondent's Exhibit 2; Deposition Exhibit 3).

Petitioner was seen by Dr. Chen on August 29, 2014. At that time, he reviewed EMG/nerve conduction studies of the right arm and noted there were no significant findings, but Petitioner continued to complain of right hand symptoms. Petitioner complained of aching in both knees, more on the right, but Dr. Chen's findings on examination in regard to her knees were normal. He referred Petitioner to Dr. Edward Kolb, an orthopedic surgeon (Respondent's Exhibit 6).

Dr. Kolb evaluated Petitioner on November 10, 2014. Petitioner continued to complain of pain referable to both knees, right worse than left, both shoulders, low back and right hand with diminished sensation. Dr. Kolb's findings on examination were normal and he had no explanation as to why Petitioner continued to have symptoms. He opined Petitioner's symptoms were possibly related to a rheumatological condition and recommended evaluation by a rheumatologist. He did not impose any work/activity restrictions (Respondent's Exhibit 6).

Petitioner continued to receive therapy and was seen by Dr. Chen on March 3, 2015. Petitioner's complaints remained essentially the same as they were previously. Dr. Chen noted Petitioner had not been seen by a rheumatologist as recommended by Dr. Kolb. Dr. Chen's findings on examination were normal. Dr. Chen opined Petitioner could attempt to perform any activities she wanted to, and noted "In her mind I think she thinks she is disabled." He did recommend MRI scans of the neck and both knees, but did not think they would reveal anything significant (Respondent's Exhibit 6).

On December 7, 2015, Petitioner was evaluated by Dr. Hyunchul Jung, an interventional pain doctor, for pain in the low back, both knees and right wrist. Dr. Jung confirmed the EMG/nerve conduction studies were unremarkable in regard to Petitioner's right wrist. He diagnosed Petitioner with bilateral knee pain and right sided wrist pain. He recommended referral to a knee specialist and the clinic's hand department (Respondent's Exhibit 6).

On January 5, 2016, Petitioner was evaluated by Dr. Robert Gutler, an orthopedic surgeon, in regard to her bilateral knee complaints. He reviewed an MRI of the right knee which revealed some degenerative joint disease in the patellofemoral compartment. He also reviewed an MRI of Petitioner's left knee which revealed similar findings. He opined Petitioner had very mild arthritis, but nothing warranted further treatment which included both surgery and injections. He discharged Petitioner from treatment at that time (Respondent's Exhibit 6).

On January 12, 2016, Petitioner was evaluated by Anne Marshall, a Physician Assistant associated with the Carle Hand Surgery Center. X-rays were taken which were negative for fracture, but revealed some arthritic changes of the radial carpal joint (Respondent's Exhibit 6).

Dr. Jung again saw Petitioner on March 10, 2016, and Petitioner continued to complain of bilateral knee pain. He noted Dr. Gutler had seen Petitioner and opined knee injections were not indicated. Petitioner thought Dr. Gutler had, in fact, recommended she undergo knee injections (Respondent's Exhibit 6).

Petitioner was seen by PA Marshall on April 25, 2016, and she continued to complain of right wrist pain, but on the ulnar side of the right wrist. It was noted Petitioner's prior wrist pain was on the radial side. PA Marshall opined Petitioner had sustained a triangular fibrocartilage complex injury. She administered an injection in Petitioner's right wrist (Respondent's Exhibit 6).

At the direction of Respondent, Petitioner was again examined by Dr. Nemickas on August 8, 2016. In connection with his examination of Petitioner, Dr. Nemickas reviewed medical records provided to him by Respondent. Dr. Nemickas opined that, as a result of the accident of January 30, 2014, Petitioner had sustained right and left knee contusions and temporary aggravations of patellofemoral chondromalacia as well as a right wrist contusion/sprain. Based upon his review of the medical records and the time intervals of when Petitioner had symptoms, he opined Petitioner was at MMI as of Dr. Chen's examination of March 3, 2015 (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Nemickas also provided AMA ratings of one percent (1%) of each lower extremity for Petitioner's knee conditions and zero percent (0%) of the right wrist. He also provided AMA ratings for other parts of Petitioner's anatomy for which Petitioner was not seeking workers' compensation benefits (Respondent's Exhibit 2; Deposition Exhibit 2).

Petitioner continued to be treated by Dr. Jung for her bilateral knee condition. He administered injections in both of her knees in March/April, 2017 (Respondent's Exhibit 6).

Petitioner was also treated by Dr. James Sobeski, an orthopedic surgeon, for her right hand condition. On May 30, 2017, Dr. Sobeski performed arthroscopic surgery which consisted of a TFCC debridement (Respondent's Exhibit 6).

Dr. Jung was deposed on March 7, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Jung's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. The primary treatment Dr. Jung provided were the series of injections in Petitioner's knees. He testified Petitioner had a pre-existing degenerative condition which was aggravated by the trauma (Petitioner's Exhibit 3; p 21).

On cross-examination, Dr. Jung was questioned whether the aggravation of the pre-existing knee conditions was temporary or permanent. He testified that if the symptoms resolved it would have been a temporary aggravation. However, when questioned about the specific diagnosis of patellofemoral chondromalacia, Dr. Jung stated he could not say whether he agreed with that

diagnosis or not because he is not a knee specialist or orthopedic surgeon (Petitioner's Exhibit 3; pp 24-25, 28-29).

Dr. Sobeski was deposed on July 26, 2018, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner's right hand condition, Dr. Sobeski's deposition testimony was consistent with his records and he reaffirmed the opinions contained therein. When questioned whether that TFCC tear was related to the accident of January 30, 2014, he opined that it was basing this opinion primarily on the fact that Petitioner was asymptomatic prior to the accident (Petitioner's Exhibit 2; p 10).

On cross-examination, Dr. Sobeski agreed that the TFCC tear was undiagnosed for approximately two years and he had not reviewed any of the prior medical records for that treatment. He also agreed that because of the TFCC tear, Petitioner's pain would have been on the ulnar side of the wrist at the time of the fall (Petitioner's Exhibit 2; pp 18-21).

Dr. Nemickas was deposed on August 23, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Nemickas's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Based upon his review of the medical records, Dr. Nemickas testified that as of March 3, 2015, Petitioner's condition had returned to their baseline state and Petitioner was at MMI at that time (Respondent's Exhibit 2; p 21).

On cross-examination, Dr. Nemickas noted that there were periods of time in which Petitioner had resolution of symptoms and other periods of time in which the symptoms were present. He opined this was the "natural course" of patellofemoral chondromalacia (Respondent's Exhibit 2; p 29).

Petitioner continued to work for Respondent following the accident and Respondent accommodated the restrictions imposed by her treating medical providers. Petitioner was subsequently promoted to the position of recruiter and given a pay increase. At trial, Petitioner agreed that the promotion had nothing to do with her inability to perform job duties. On January 16, 2019, Petitioner resigned her position with Respondent. Her letter of resignation of that date was received into evidence at trial. The reason Petitioner gave for resigning her position was so that she could complete her degree in psychology (Respondent's Exhibit 5).

At trial, Petitioner complained of weakness and numbness in her right wrist and pain/swelling in both knees. Because of her ongoing symptoms, Petitioner stated she was discharged from the Army Reserve in May, 2018. Petitioner presently works as a youth counselor.

Conclusions of Law

In regard to disputed issue (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner's current condition of ill-being is not causally related to the accident of January 30, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related accident on January 30, 2014.

In regard to Petitioner's bilateral knee symptoms, the first notation of any knee complaints in the medical records was dated February 27, 2014, almost one month post injury.

Petitioner received an extensive amount of treatment, primarily physical therapy for her knee symptoms, but when examined by Dr. Kolb on November 10, 2014, his findings on examination were normal.

When Dr. Chen saw Petitioner on March 3, 2015, he likewise noted the findings on examination were normal and could not explain Petitioner's continued symptoms.

Petitioner had complaints of numbness in the fourth and fifth fingers of her right hand and cubital tunnel syndrome was suspected; however, the EMG/nerve conduction studies were unremarkable.

Petitioner was diagnosed with a tear of the TFCC in the right hand, but this diagnosis was not made until two years post accident. Further, this condition would have caused ulnar sided complaints which Petitioner did not have until she was examined on April 25, 2016.

While Dr. Jung testified the accident aggravated Petitioner's pre-existing condition, he could not state whether the condition was the patellofemoral chondromalacia because he was not an orthopedic surgeon.

Respondent's Section 12 examiner, Dr. Nemickas, had the benefit of examining Petitioner on two separate occasions and reviewed all of the medical records. The Arbitrator is persuaded by his opinion that Petitioner had reached MMI as of the time of Dr. Chen's examination of March 3, 2015.

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 from January 30, 2014, through March 3, 2015, was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from January 30, 2014, through March 3, 2015, as identified in Petitioner's Exhibits 5 and 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issues (K) and (L) the Arbitrator makes the following conclusion of law:

Based upon the Arbitrator's conclusion of law in disputed issue (F) no temporary total disability or permanent partial disability benefits are awarded.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES BRANCH,

Petitioner,

vs. NO: 16 WC 007976

MARTEN TRANSPORT,

Respondent.

20 I W C C 0 4 9 9

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 15, 2018 is hereby affirmed and adopted.

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 a 15% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses of $3,005.00 as provided in Section 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.

20 I CC0499

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $59,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 3 - 2020

LEC/cak

D: 8/5/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRANCH, CHARLES
Employee/Petitioner

Case# **16WC007976**

MARTEN TRANSPORT
Employer/Respondent

20IWCC0499

On 10/15/2018, 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 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
MICHAEL A ROM
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHARLES BRANCH
Employee/Petitioner

Case # 16 WC 7976

v.

Consolidated cases: N/A

MARTEN TRANSPORT
Employer/Respondent

20IWCC0499

An *Application for Adjustment 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 8/09/2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/24/2016**, 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 $**68,062.80**; the average weekly wage was $**1,308.90**.

On the date of accident, Petitioner was **53** 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 $**6,606.45** for TTD, for a total credit of $**6,606.45**.

ORDER

Respondent shall pay gross reasonable and necessary medical services of **$3,005.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$755.22** per week for **75** weeks because the injuries sustained caused **15%** loss of the **person as a whole**, as provided **Section 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.

Signature of Arbitrator

10-15-2018
Date

OCT 1 5 2018

FINDINGS OF FACT

Background

Charles Branch ("Petitioner") alleged injuries arising out of and in the course of his employment with Marten Transport ("Respondent") occurring on February 24, 2016. Ax1. On August 9, 2018, the parties proceeded to arbitration on the disputed issues of causal connection, liability for unpaid medical bills and nature and extent of the injury. The following is a recitation of the facts adduced at trial.

Testimony and Other Evidence

The parties generally agreed that Petitioner suffered accidental injuries arising out of and in the course of his employment on February 24, 2016 while working as a truck driver for Respondent. Petitioner's unrebutted testimony was that on that day, he was assigned to a candy factory in Bellwood, Illinois where he backed his truck in and hooked up his air lines. He then proceeded to attempt to pull that handle up and as he was rolling the handle, it slipped in his hand, striking his mouth, face and nose. He was knocked to the ground and recalled he spit 3-4 teeth to the ground. He said he swallowed one. His girlfriend called an ambulance.

On February 24, 2016, Petitioner was admitted to Loyola on an emergency basis and eventually discharged on February 26, 2016. Px1. History noted that Petitioner presented with jaw pain after being hit in the jaw with work equipment. Other history noted that Petitioner was struck in the jaw by a mechanical object at work. There was an obvious jaw deformity and pain. He reported having difficulty swallowing due to pain.

Radiology CT findings showed comminuted fracture involving the right mandibular body extending to the symphysis with minimal displacement of fracture fragments. Px4. There was approximately 3 mm step off at the sepsis. The fracture plane extended through the central incisors, in between the second premolar and first molar on the right. Lucency surrounding the first molar on the right may represent sequela of tooth loosening from trauma or dental caries. There was adjacent subcutaneous gas and hematoma. There was mucosal thickening of bilateral maxillary sinuses. Final impression was comminuted right mandibular body fracture extending to the symphysis with minimal displacement of the fracture fragments as described. There may be traumatic loosening of the first molar tooth on the right. Petitioner underwent ORIF for the mandible fracture, oral approach with MMF, complex closure of the right chin laceration, 3 cm and complex closure of the right lip buccal mucosa laceration, Stellate3 cm. Px1:41-42.

On March 7, 2016, Petitioner followed up with Loyola. Px1:222-229. Teeth remained loose and were fixed with wiring. He was to follow up in six weeks. A letter from Dr. Amy Pittman indicated that Petitioner suffered a severe fracture of his mandible related to work injury. She noted that in order to fixate the mandible fracture, they typically intubate the patient through the nose while they are under general anesthesia. In this particular case, cocaine was used as a decongestant and anesthetic in the nose. This would cause systemic absorption that would show up positive on a blood test, up to several days after surgery. On March 14, Dr. Pitman issued a return to work letter indicating that Petitioner could return to work beginning April 4, 2016 with no restrictions. Px1.

On April 7, 2016, Petitioner returned to Loyola for follow-up. Px2. He was status post comminuted open fracture of the right mandible, avulsed number 9 and number 24, luxated numbers 3, 4, 6, 7, 11, 12 and 14. The previous treatment completed included splinting of the teeth at 4, 6, 7, 11, 12, 14, 19, 20 and 25-30 with double braided ortho wire and flowable composite.

On April 14, 2016, Petitioner followed up with Loyola. Px1:235-238, Px2. He complained of left sided numbness on his face. Petitioner had been seen for follow-up visits with his ENT for the right mandibular fracture. Pain was 0/10. On exam, there were no signs of infection, maxillary teeth had >75% alveolar bone loss and were class 2 mobile. Tooth 30 was class III mobile, remaining mandibular teeth were class 2 mobile. Mandibular anteriors had heavy calculus buildup and have >75% alveolar bone loss. Teeth 19 and 20 had >50% alveolar bone loss. Mandibular teeth were all class 2 mobile. The plan was for fabrication of FF after healing of soft tissue post extraction. Petitioner expressed interest in only definitive FF fabricated.

On April 18, 2016, Petitioner followed up with Loyola. Px1:239-246. Petitioner was excused from work through May 18, 2016. The doctor noted that the reason for the absence was prolonged need for procedures to address his mandible fracture and Dentoalveolar fractures related to a work accident. It was signed by Dr. Amy Pittman. Px1.

On April 21, 2016, Petitioner followed up with Dr. Peretti at Loyola. Px1:247-252. He presented on referral of GRP for extraction of remaining teeth for the FF. He was status post ORIF of fractures with LUHS ENT. On exam, there was severe periodontal disease of remaining teeth at 1-4, 6, 7, 11-15, 19, 20 and 25-30. The lower border fixation plate was in close approximation to the right inferior alveolar canal. The plan was to proceed with extraction 1-4, 6, 7, 11-15, 19, 20 and 25-30 with LA and N20. Dr. Peretti noted Petitioner was 8 weeks status post ORIF and it was okay to proceed with extractions.

On May 23, 2016, Petitioner followed up with Loyola. Px1:253-260. Petitioner complained of chin and face pain, 4/10. Pain was not relieved by taking pain medication. Interval history noted he continued to improve but had numbness and tingling with tooth brushing. He was having issues with workers' compensation and not getting documentation he needed from OMFS. On exam of the oral cavity, poor dentition, ok occlusion and no TMJ pain was noted. A letter was to be written to Worker's Compensation as to which teeth were covered. He was to follow up.

On that same date, Dr. Pittman wrote another letter and clarified that Petitioner's fracture was open, meaning that it communicated through the gums and dentition and the whole alveolar segment of the associated lower teeth were completely mobile. It was her opinion that there was no question that the mobility of his teeth was related to the blunt force injury that he sustained at work. He was seen by dental who attempted to splint the mobile teeth after his injury but are now recommending extraction. The teeth were not mobile before the injury and were consistent with this injury. Px1.

Dr. Mariusz Wrzosek similarly issued a letter that same date in regard to Petitioner's facial trauma and injuries. Px1. He noted that Petitioner had been referred to him by his dentist and surgeon after repair of complex mandible fractures for extraction of subsequent loose and non-restorable teeth to allow for prosthesis fabrication. Petitioner's trauma resulted in fractures treated with ORIF with Dr. Pittman. As a result of the accident, he also suffered multiple tooth avulsions, with loss of numerous teeth, as well as fractures of the dentoalveolar bone supporting the remaining teeth. It was not possible to re-implant the avulsed teeth and despite treatment by the dental team and splinting of the loose dentition for stabilization of the luxated teeth, the teeth did not regain stability and are deemed non-restorable. Petitioner was scheduled for extraction of all remaining teeth (1-4, 6, 7, 11-15, 19, 20 and 25-30) on June 2, 2016. The doctor requested authorization to proceed.

On July 18, 2016, Petitioner follow up with Loyola. Px1:261-268. Petitioner was approved for oral surgery and continued to work on getting treated. Pain was 2/10 located in the face and teeth described as

aching. On September 15, 2016, Petitioner followed up with Dr. Peretti at Loyola. Px1:269-279, Px4, Rx1. Petitioner underwent and Dr. Peretti performed extraction of 1-4, 6, 7, 11-15, 19, 20 and 25-30, along with alveloplasty x4 quadrants.

On October 6, 2016, Petitioner followed up with Dr. Peretti. Px1:280-284. Petitioner was healing well status post extraction of teeth. He was to follow up PRN with OMFS otherwise four weeks with GPR for denture fabrication. They would decide if small alvelo needs to be done on LL site of 21 and 22. On October 17, 2016, Petitioner followed up with Loyola. Px1:285-290. Petitioner related that he was recently seen by OMFS and had all of his teeth removed. He related that the pain he previously felt improved with tooth extraction. The plan was to get dentures.

On November 10, 2016, Petitioner followed up with Loyola. Px1:291-310, Px4. The plan was for initial impressions for CD/CD. Petitioner was status post extraction of remaining dentist in two months ago. Denture fabrication process was explained in detail. Custom trays were to be fabricated and Petitioner would follow up for border molding in final impressions. On November 17, 2016, Petitioner followed up with Loyola for border molding and final impressions for CD/CD. Px4.

On January 12, 2017, Petitioner followed up with clinic for set teeth try on. Px4. Both CDs were inserted and seated. Petitioner reported no pain at the moment. He agreed to wear them for one week in return for adjustments. On February 17, 2017, Petitioner followed up with Loyola clinic. Px4. The lower prosthesis was polished, and Petitioner reported improvement.

On January 26, 2018, the parties took the evidence deposition of Dr. Philip Fidel. Gx1. The doctor testified that he conducted a medical records review at the request of Respondent. To a reasonable degree of dental certainty, the doctor opined that the need for the extraction of teeth was in fact related to the work accident. Specifically, teeth numbers 9 and 24 were already completely involved due to the injury. Additionally, teeth 3, 4, 6, 7, 11 and 14 would luxated or loose by the injury and those were also related to the accident. However, the doctor that teeth 1, 2, 5, 12, 19, 20 and 25-30 were not related to work accident. In support thereof, the doctor relied on the report of Drs. Cho and Peretti, wherein Dr. Cho stated that Petitioner had preexisting periodontal and caries-compromised teeth referring to cavities and gum disease. There was an additional report that Petitioner had generalized, severe periodontal disease on all remaining teeth. Thus, the mandible fracture did not cause the need for the removal of these certain teeth. The doctor noted that the top teeth all had more than 75% bone loss, meaning there was only 25% left a bone supporting those teeth. Those were not related to or loosened by the accident.

Regarding the recommendation for complete upper and lower dentures, the doctor opined that partial dentures would not have given Petitioner service in the long term because a partial denture has hooks that hook onto other teeth and, in his opinion, hooking a partial onto the remaining teeth which were already weekend by the periodontal disease would not have given Petitioner service in the long term. Likewise, dental implants would not have worked due to the bone loss from the periodontal disease. On cross-examination, the doctor agreed he did not exam Petitioner, review prior dental records and has never treated or rendered treatment options without examining a patient first. The doctor stated that smoking as in Petitioner's case would contribute to periodontal disease. The doctor further testified that it would not have been the standard of care in dentistry to create a denture for work related teeth and not include what was labeled as non-work-related teeth. The doctor further acknowledged that Petitioner's luxated teeth was splinted, like a fence post, along with the alleged non-work-related teeth. The doctor said that would have been the appropriate standard of care for dentistry to include all teeth. The doctor testified that while it was not impossible to treat only work-related teeth, it would have breached the standard of care.

Petitioner testified that he has not treated since he last saw his doctors in 2017. He currently has dentures and said that the metal plate in his jaw area is permanent and still in place. He returned to work April 18, 2016 and drove a truck. He continues to drive a truck to date. He affirmed he had no prior injuries or treatment to his face, jaw or teeth. He recalled he received weekly benefits but did not recall receiving a check labeled as "statutory loss." As far as he could tell, bills were paid.

Petitioner testified that today, part of his face and lower lip are not "what it used to be," explaining that numbness is always there. When he eats, he has to watch hot and cold food. He is sensitive to shaving and pressure. Referring to the right side of his jaw, he stated it was hard to eat on that side. When he touches his right side, he said it lights up like a Christmas tree. As to his dentures, he said a couple are broken right now and he does not know how long they last. On cross, Petitioner said he lost 3 teeth immediately following the accident and that a 4th was pulled at the ER. He recalled he returned to work in April 2016. He said he received no treatment between April and September 2016 because his teeth were still wired together.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. Petitioner appeared credible and consistent in his recollection of his history of accident, treatment and credible as to his subjective complaints of ongoing issues.

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 considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being as it relates to his jaw, face and teeth are all causally related to his undisputed work injury. Here, there is no real dispute that Petitioner's work accident caused and resulted in a comminuted fracture involving the right mandibular body extending to the symphysis with minimal displacement of fracture fragments which was treated with ORIF. Petitioner's accident also resulted in luxated or missing teeth (avulsed number 9 and number 24, luxated numbers 3, 4, 6, 7, 11, 12 and 14, which was also not disputed.

Here, the dispute is whether Petitioner's loose teeth, many of which had pre-existing disease(s) and/or condition(s) and which were eventually extracted and dentured were causally related to his work accident. The record shows Petitioner's accident also resulted in many loose teeth (4, 6, 7, 11, 12, 14, 19, 20 and 25-30), which were initially treated with splinting and wiring.

Petitioner's treating physicians, found pre-existing significant bone loss, pre-existing calculus (tartar) and pre-existing severe periodontal disease of remaining teeth at 1-4, 6, 7, 11-15, 19, 20 and 25-30. Eventually, the plan was to proceed with extraction 1-4, 6, 7, 11-15, 19, 20 and 25-30 and that was done. Petitioner eventually received upper and lower dentures.

Dr. Fidel, who conducted utilization review only and did not perform a Section 12 exam, testified that while Petitioner in fact had these pre-existing conditions, it would have been below the standard of care to only create dentures for "work-related" teeth. Dr. Fidel further testified that Petitioner would have done poorly with only partial dentures and/or dental implants. The Arbitrator has considered all evidence, including competing medical opinions and finds that Petitioner's loose teeth, extractions and resultant upper and lower dentures are

all causally related to his work accident. But for the work accident, Petitioner's remaining teeth, which had pre-existing conditions, would not have been loosened or required wiring. The wiring failed to preserve the remaining loosened teeth and those teeth were eventually extracted. The need for the dentures, which included fitting for both the avulsed and extracted teeth at the upper and lower locations, are also causally related to the work accident. Based on the foregoing, the Arbitrator finds Petitioner's current condition of ill-being causally related to his work accident.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that the medical services provided to him were both reasonable and necessary and that Respondent has not yet paid for same. At trial, Respondent disputed liability, indicating that all bills were paid except for Px5, which alleged $3,005.00 in unpaid charges. Ax1, Px5. The Arbitrator has reviewed Px5 and finds that the charges from Loyola University Medical Center Loyola total $3,005.00 for dates of service September 15, 2016 through November 10, 2016. Px5. The dates of service correspond to medical records found in evidence and relate to Petitioner's causally related injuries. Therefore, Respondent shall pay gross reasonable and necessary medical services of **$3,005.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (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 considered all evidence, the Arbitrator concludes that Petitioner reached maximum medical improvement for his causally related injuries on February 17, 2017, at which time the lower prosthesis was polished, and Petitioner reported improvement. Therefore, his claim for determination of the nature and extent of his injuries are ripe for adjudication. As required by the Act, the Arbitrator considers and weighs the following factors:

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a driver 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 Petitioner was given no permanent restrictions as a result of this injury. The Arbitrator therefore gives ***little*** weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. His advanced age suggests a shorter work life expectancy but also that he may experience the effects of his injuries to a greater degree compared to a younger worker. The Arbitrator therefore places ***some*** weight on this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner suffered no impairment of earnings as a result of this accident. Therefore, the Arbitrator gives ***no*** weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner has not treated since 2017. At the time of his last visit, he related his bottom denture hurt a lot while the upper one was okay. Px4. Areas were marked on the dentures and burred. Petitioner reported feeling much better after. Px4. He was scheduled to follow up, but no follow up record was entered into evidence. At trial, Petitioner said he has dentures and said that the metal plate in his jaw area is permanent and still in place. Petitioner testified that today, part of his face and lower lip are not "what it used to be," explaining that numbness is always there. When he eats, he has to watch hot and cold food. He is sensitive to shaving and pressure. Referring to the right side of his jaw, he stated it was hard to eat on that side. When he touches his right side, he said it lights up like a Christmas tree. As to his dentures, he said a couple are broken right now and he does not know how long they last. The Arbitrator finds that Petitioner's testimony credibly describes impaired hot/cold sensation, impaired chewing sensation, eating lifestyle changes and shaving sensitivity. His testimony is consistent with the record. The Arbitrator therefore gives the ***greatest*** weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of **15%** loss of use of **man as a whole** pursuant to **§8(d)(2)** of the Act.

Signature of Arbitrator

10-15-2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shauntai Switzer,

Petitioner,

vs. NO. 18WC 29320

Pontiac Correctional Center,

20IWCC0501

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 24, 2020 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.

20IWCC0501

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

DATED: SEP 4 - 2020
SJM/sj
8/26/2020
44

Stephen J. Mathis

Douglas D. McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SWITZER, SHAUNTAI Case# **18WC029320**
Employee/Petitioner

20IWCC0501

PONTIAC CORRECTIONAL CENTER
Employer/Respondent

On 2/24/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICE OF PETER FERRACUTI
ALEXIS P FERRACUTI
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

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

6079 ASSISTANT ATTORNEY GENERAL
BRAD DEFREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

FEB 24 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0501

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

Shauntai Switzer
Employee/Petitioner

Case # **18WC 29320**

v.

Pontiac Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Bloomington**, on **December 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/26/2018** Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the first injury, Petitioner earned $**51,400.34**; the average weekly wage was $**988.47.**

On the first date of accident, Petitioner was 29 years of age, ***married*** with **1** dependent children.

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

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

Respondent is entitled to a credit of for all reasonably related group medical under Section 8(j).

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, Respondent shall pay Petitioner permanent partial disability benefits of 4% loss of use of the hand or $593.08 per week for 8.2 weeks because the injuries sustained caused 4% loss of use of the hand under section 8(e) of the Act. Additionally, the Respondent shall pay all reasonable, related, and necessary medical expenses incurred by the Petitioner to his left hand as a result of the work accident which occurred on July 26, 2018.

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

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

Arbitrator

February 3, 2010
Date

FEB 24 2020

STATEMENT OF FACTS

Petitioner testified that he was 30 years old, married and had one dependent child as of the date of the accident.

Petitioner testified that at the time of the accident, he worked for Respondent as a correctional officer but was now currently employed by the Federal Bureau of Prisons as an officer. Petitioner testified that he started working for Respondent on September 19, 2016, and he transferred to the Federal Bureau of Prisons on August 17, 2018.

Petitioner testified that on July 26, 2018, he was working as a correctional officer at Pontiac Correctional Center on the extraction team. Petitioner testified that the extraction team is the team they send in when an inmate is being violent and needs to be extracted from his cell. Petitioner testified that his job on the extraction team would be to hold the shield which pushes the inmate back and prevents the inmate from hurting the rest of the extraction team as they attempt to restrain the inmate that was refusing orders.

The Petitioner testified that on the date of accident he was extracting a violent inmate who was refusing orders and when Petitioner was trying to put the inmate back into his cell, Petitioner's hand was slammed between the cell door.

He was taken immediately to the healthcare unit in the prison where the nurses cleaned up the immediate wounds on Petitioner's hand and placed him on a stent before advising him to report to OSF St. James in Pontiac, Illinois. It was noted at the healthcare unit that Petitioner had bruising and swelling in the hand and all of his nailbeds along with bleeding at the cuticle area of his nailbeds on his left hand.

When Petitioner presented to OSF St. James immediately after seeing the healthcare unit, it was early the next morning. Petitioner testified at hearing that OSF performed an x-ray and diagnosed him with a crush injury to his left hand and his left third and fourth fingers. Petitioner was given Hydrocodone, Tylenol, Ibuprofen and ointment as a result of the injuries and instructed to follow up with his primary care physician.

Petitioner then followed up on August 2, 2018, at Perry Memorial Family Health Clinic to Dr. Faber who performed a physical examination and diagnosed him with a crush injury. During the physical examination, Dr. Faber noted that he was not able to move the joint in Petitioner's third finger and that the Petitioner was reporting numbness in the hand at the time of the evaluation.

Dr. Faber instructed Petitioner to come back to follow up if the problems continued over the next three months. Petitioner followed up on November 1, 2018, at which time Dr. Faber was surprised to see that the hand had not healed in any way. Dr. Faber noted that the Petitioner's injuries remained consistent and referred Mr. Switzer to Illinois Neurological Institute to be assessed for neurological concerns which would causing the numbness and tingling that Petitioner was experiencing in his left hand. Petitioner was then sent home without additional medication and with the referral to INI.

Dr. Faber also referred Petitioner for physical medical and rehab post traumatic neurological pain and numbness of the left hand and neurology. Petitioner presented at Illinois Neurological Institute on April 24, 2019, at which time Petitioner's physician found that there was no evidence of compression neuropathy after performing an EMG and NCV.

Petitioner followed up again on May 16, 2019, with Dr. Faber to review the EMG at which time Dr. Faber found that the patient was still struggling with nighttime numbness and paresthesias. Dr. Faber noted that these injuries had not kept Petitioner from doing his job but that he was having significant discomfort at night.

Dr. Faber did note decreased grip strength in the left hand compared to the right hand at the time of examination and the Petitioner was again assessed with having left hand post-traumatic from a crush injury occurring at work. Petitioner was given gabapentin to try to relieve some of his nighttime pain and numbness.

Petitioner followed up on August 9, 2019, at which time Dr. Faber again reviewed the EMG noting that he had no major neurological trauma but noted that Petitioner was still complaining of discomfort in the hand and the middle three fingers and the fifth finger. Dr. Faber also noted that his strength was not back to pre-injury levels and on exam noted that he had decreased grip strength noticeably in the left hand and decreased strength in the lumbar coma soles of his fingers on the left hand.

Dr. Faber's records indicate at that time that Petitioner should not expect much more relief from his symptoms or much more recovery in his grip strength given the time elapsed since the injury occurred. Dr. Faber also prescribed Topamax instead of gabapentin because Petitioner did not get any relief from the gabapentin prescribed at the last appointment.

The petitioner testified that he still was having pain in his hand for which he took Ibuprofen or Aleve multiple times per week. Petitioner testified that he was often awakened at night by the numbness and tingling in his hand and that it is often difficult for him to sleep as a result of this injury.

Petitioner testified he does still take Topamax intermittently as prescribed by Dr. Faber. Petitioner testified that he still has significant difficulty with grip strength in the left hand but that as a Federal Bureau of Prisons correctional officer he was still able to do his full job duties even with the decreased grip strength.

Petitioner testified that he would be a member of the extraction team or its equivalent at the Federal Bureau of Prisons if it weren't for his decreased grip strength in the left hand and his ongoing pain and numbness in the left hand as a result of the work injury in question. Petitioner testified that being on the extraction team on the Federal Bureau of Prisons would be something that would open up a new line of job opportunities for him and could lead to promotions that he is not currently eligible for.

Petitioner testified that personally he has difficulty picking up his son at times because of the injury in question and that he also has difficulty lifting weights which obviously is an important part of being a correctional officer at any facility as physical fitness is required to protect not only the correctional officers themselves but also the inmates and prison workers.

Petitioner testified that had it not been for these injuries he would have continued on the extraction team, and even though Dr. Faber released him to full duty work, Petitioner has not applied for the extraction team because of his loss of grip strength as noted by Dr. Faber and because he fears that he would not be able to protect himself or others around him.

Petitioner at the time of trial was 30 years old. He testified that he earned approximately the same amount at the Federal Bureau of Prisons as he was at Respondent.

As to the Arbitrator's decision regarding (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, the Arbitrator finds as follows:

Petitioner suffered injuries to his left hand from a crush injury occurring on July 26, 2018, while in the course of his employment with Respondent.

The Arbitrator has taken into consideration the five factors found in Section 8.1(b) of the Act to determine the permanent partial disability of the Petitioner in this case. Those factors include (1) the pro-rated level of impairment pursuant to Subsection (a); (2) the occupation of the injured worker; (3) the age of the employee at the time of the injury; (4) the employee's future earning capacity; and (5) the evidence of disability corroborated by the treatment medical records.

No AMA impairment rating was submitted by either party, so the Arbitrator gives this factor no weight. The petitioner is still employed as a correctional officer now at the Federal Bureau of Prisons. The Arbitrator gives some weight to the fact that Petitioner claims that his job requires significant force for the protection and safety of not only Petitioner but of the inmates and other employees of the prison system as well. The Arbitrator gives more weight to the fact that the Petitioner continues to complain of decreased grip strength and ongoing pain in the hand which requires the use of medication on a weekly basis.

The Arbitrator gives more weight to the fact that Petitioner was only 29 years old at the time of the injury.

There is no evidence of record regarding any earnings impact, but Petitioner claimed that his ability to obtain promotions while working for the Federal Bureau of Prisons was impacted by his limited grip strength in his left hand and ongoing deficits because of the work accident. His treating physician, Dr. Faber, released Petitioner full duty. The Arbitrator gives this factor some weight in considering the Petitioner's disability at hearing.

The Arbitrator gives more weight to evidence of disability presented at hearing by Petitioner as corroborated by the treating medical records. Petitioner testified that he still wakes up almost every night with numbness, pain, and tingling in his left hand and that he continues to have to take Topamax and Ibuprofen on a weekly basis because of his ongoing difficulties. Petitioner also testified that not only has he not applied for the extraction team in his new position due to his strength deficit in his left hand but that he has difficulty picking up his child because picking up that weight can sometimes cause more pain, numbness or tingling in the left hand.

Based on the entirety of the evidence, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 4% loss of use of the left hand or 8.2 weeks PPD at a rate of $593.08.

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 CHAMPAIGN	)	☐ 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

JEANINA HOSKINS,

Petitioner,

vs. NO: 15 WC 07694

KIK CUSTOM PRODUCTS,

Respondent.

20 I W C C 0 5 0 2

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, permanent partial disability, and penalties under §19(l), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed February 10, 2020, 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 $11,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 4 - 2020
o-9/1/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOSKINS, JEANINA
Employee/Petitioner

Case# **15WC007694**

KIK
Employer/Respondent

20IWCC0502

On 2/10/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1551 STOKES LAW OFFICES
JACOB JACKSON
200 N GILBERT
DANVILLE, IL 61832

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN A RUDD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

20IWCC0502

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeanina Hoskins
Employee/Petitioner

v.

KIK
Employer/Respondent

Case # **15** WC **07694**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Urbana**, on **July 17, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20 I W C C 0 5 0 2

FINDINGS

On 2/17/15, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $8,134.50; the average weekly wage was $542.30.

On the date of accident, Petitioner was 49 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 $2,299.44 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $2,299.44.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless for the medical services paid by Medicaid/Medicare.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $361.53/week for 5 and 6/7th weeks, commencing 2/24/15 through 4/5/15, as provided in Section 8(b) of the Act.
Respondent shall be given a credit of $2,299.44 for temporary total disability benefits that have been paid.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $325.38/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Penalties

Petitioner's request for penalties is denied.

Other

Petitioner did not exceed her choice of two treating medical providers.

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 7, 2020
Date

FEB 10 2020

Findings of Fact

This matter was tried before Arbitrator Hemenway on July 17, 2019. Arbitrator Hemenway departed the Illinois Workers' Compensation Commission before a Decision was authored. The Illinois Workers' Compensation Commission re-assigned this matter to Arbitrator Glaub for the purpose of drafting this Decision. Both parties agreed to Arbitrator Glaub drafting this Decision based on his review of the Transcript and evidence. By definition, Arbitrator Glaub makes no determination as to the credibility of any of the witnesses that testified as he was not present at the Arbitration Hearing.

Respondent manufactures cleaning supplies and other consumer goods. Petitioner worked as a floater in Respondent's factory.

On February 17, 2015, Petitioner was pulling a stack of pallets with a pallet jack. The pallet jack became stuck and Petitioner jerked on it to get it to move. When Petitioner did this, she felt pain down her left arm and in her back. Petitioner reported the incident. Petitioner attempted to go home after the incident, but she passed out and an ambulance was called for her.

The ambulance note records a chief complaint of back pain (PX1). The narrative section mentions patient was pulling a pallet jack and hurt her back (PX1). The ambulance took Petitioner to the Presence United Samaritans Medical Center emergency room. The emergency room note references Petitioner's onset of back pain while pulling an object at work (PX2). CT scans of the thoracic and lumbar spine revealed no fractures or dislocations (PX2). Petitioner was discharged with a diagnosis of a lumbar strain (PX2). Petitioner was advised to see her doctor, but no specific referral was given to her at the emergency room (PX2).

Respondent instructed Petitioner to go to Carle Occupational Medicine. Virginia Brown, RNC examined Petitioner on February 18, 2015. Petitioner reported injuring her back the previous day pulling a pallet at work (PX3). Petitioner complained of some burning pain around the midline of the left scapula and tingling in her third and fourth fingers (PX3). The office note reads, "She also is complaining of some numbness and tingling down her leg, but no actual back pain. She states her pain to the mid thoracic back is about an 8/10 at this time" (PX3). Ms. Brown found Petitioner to be tender to palpation to the mid scapular left side of her back (PX3). Ms. Brown diagnosed a thoracic and low back strain (PX3). Petitioner was given work restrictions (PX3). Respondent was willing to accommodate those restrictions.

Petitioner called Carle Occupational Medicine on February 19, 2015 and asked to be taken off work (PX3). Ms. Brown refused to take Petitioner off work (PX3).

Petitioner sought treatment from Dr. John Gorup on February 24, 2015. Petitioner reported developing upper back and lower back pain after pulling a pallet at work (PX4). Petitioner had left-sided leg pain and her back was tender to palpation (PX4). Dr. Gorup's initial assessment was thoracic strain, lumbar strain, herniated cervical disc, herniated lumbar disc, cervical radiculopathy, and lumbar radiculopathy (PX4). Dr. Gorup requested physical therapy (PX4). He also restricted Petitioner from working for four weeks (PX4).

Petitioner returned to Ms. Brown on February 25, 2015. Petitioner reported increasing back pain that was fairly intense (PX3). Petitioner continued to have left leg numbness (PX3). Ms. Brown noted Petitioner was still tender to palpation (PX3). Ms. Brown agreed with Dr. Gorup that Petitioner needed to be taken off work because she was on Norco as prescribed by Dr. Gorup and needed physical therapy (PX3).

Petitioner began physical therapy on February 26, 2015 (PX3). Petitioner reported pulling a pallet jack caused her back pain (PX3). Petitioner was to be seen twice a week for four weeks (PX3). Petitioner was discharged after eight sessions (PX3).

Petitioner returned to Dr. Gorup on March 24, 2015. Dr. Gorup ordered MRI's of the cervical and lumbar spine. (PX4). The lumbar MRI revealed multilevel degenerative disc disease (PX4). The cervical MRI revealed degenerative changes most prominent at C5-6 (PX4).

Dr. William Scott with Carle Occupational Medicine examined Petitioner on April 2, 2015. Petitioner reported feeling sudden pain while pulling a pallet jack (PX3).

Petitioner returned to Dr. Gorup on April 3, 2015. Dr. Gorup referred Petitioner to a pain specialist, released her from his care, and said she could return to full duty work without restrictions on April 5, 2015 (PX4). Petitioner did not return to work for Respondent.

Dr. Ferdinand Ramos examined Petitioner on April 23, 2015. Dr. Ramos found a weaker left lower extremity and bilateral positive straight leg raise tests (PX5). Dr. Ramos scheduled an epidural steroid injection (PX5).

Respondent sent Petitioner to Dr. Jesse Butler on May 15, 2015 for a Section 12 examination. Petitioner reported she was pulling a load of pallets at work and had to jerk the pallets to move them (RX1, Ex. 2). This caused her left arm pain, scapular pain, and left leg pain (RX1, Ex. 2). Dr. Butler diagnosed a lumbar strain as a result of the February 17, 2015 work injury (RX1, Ex. 2). Dr. Butler did not feel Petitioner needed any additional treatment and could return to work without restrictions (RX1, Ex. 2).

Dr. Ramos provided an epidural steroid injection at L5-S1 on June 5, 2015 (PX5). A second injection at L5-S1 was performed on June 25, 2015 (PX5). Petitioner went to the emergency room with lower back pain on August 17, 2015 (PX2). The pain was shooting down her left leg (PX2). Petitioner reported the low back pain was chronic from February 2015 (PX2). The pain worsened after working (PX2). Petitioner reported to working for K-Mart for one day around this time. She was unable to work more than one day because of her low back pain. The diagnosis was a lumbar strain, sciatica, and lumbar radiculopathy (PX2).

Petitioner followed up with Dr. Ramos on September 1, 2015. Dr. Ramos diagnosed low back pain and lumbar radiculopathy (PX5). He ordered another epidural injection (PX5). Dr. Ramos performed the third L5-S1 epidural injection on September 23, 2015 (PX5). The fourth L5-S1 epidural injection was done on October 9, 2015 (PX5). Dr. Ramos saw Petitioner again on November 30, 2015. Petitioner complained of persistent low back pain radiating to the left leg (PX5). Petitioner had a positive straight leg raise test and was tender to palpation in the lumbar spine (PX5). Dr. Ramos provided trigger point injections and scheduled additional epidural injections (PX5).

Petitioner returned to Dr. Ramos on January 19, 2016. She had persistent low back pain and left leg pain (PX5). The physical examination revealed a positive straight leg raise test on the left (PX5). Dr. Ramos performed a transforaminal epidural steroid injection at L3-4 on February 22, 2016 (PX5). A second transforaminal epidural steroid injection at L3-4 was performed on March 7, 2016 (PX5). Petitioner followed up with Dr. Ramos on April 4, 2016. Dr. Ramos was pleased with the injection results (PX5).

Petitioner was seen at the emergency room on April 18, 2016. Her chief complaint was lower back pain (PX2). The pain was made worse by Petitioner's attempted return to work (PX2). Petitioner testified she worked one day at the Pilot Gas Station in Covington, Indiana. The pain in her lower back forced her to stop after one day. Petitioner was diagnosed with sciatica and discharged (PX2).

Dr. Ramos examined Petitioner again on April 26, 2016. She was complaining of low back pain and left leg pain (PX5). Dr. Ramos ordered an EMG and trigger point injections (PX5). The trigger point injections took place on May 16, 2016 (PX5). The May 17, 2016 EMG was interpreted as normal (PX6).

Petitioner began seeing Dr. Siddiqui on June 28, 2016. Petitioner reported low back pain from pulling pallets at work on February 17, 2015 (PX7). Petitioner began treating with Dr. Siddiqui because it was closer to her home. She was referred to Dr. Siddiqui by her primary care physician, Dr. Sharma. Petitioner had a positive bilateral straight leg raise test (PX7). Dr. Siddiqui informed Petitioner to continue taking Norco and Gabapentin (PX7).

Petitioner returned to Dr. Siddiqui on July 26, 2016. Petitioner again had a positive bilateral straight leg raise test (PX7). Dr. Siddiqui changed Petitioner's medications and ordered a pain pump (PX7). The next follow-up visit was September 6, 2016. Petitioner had persistent low back pain (PX7). She was instructed to continue her current pain medication therapy (PX7).

Petitioner began another round of physical therapy at Dr. Siddiqui's request on September 8, 2016 (PX7). The therapy was discontinued on October 25, 2016 due to a lack of progress (PX7). Petitioner returned to Dr. Siddiqui on October 18, 2016. She had a positive bilateral straight leg raise test (PX7). Palpation of her lumbar joints at L3-4, L4-5, and L5-S1 produced lower back pain (PX7). On November 8, 2016, Dr. Siddiqui performed a L5-S1 epidural steroid injection (PX7). Dr. Siddiqui performed a second L5-S1 epidural steroid

injection on December 20, 2016 (PX7). A third L5-S1 epidural steroid injection was done on January 3, 2017 (PX7).

Petitioner began seeing Haley Innocenti, Dr. Siddiqui's physician's assistant, on February 7, 2017. Petitioner reported five days of relief from Dr. Siddiqui's third injection (PX7). Petitioner was given Flexeril and a TENS Unit (PX7). Ms. Innocenti provided trigger point injections on February 14, 2017 (PX7). Petitioner returned to Ms. Innocenti on March 14, 2017 with persistent low back pain (PX7). Ms. Innocenti provided additional trigger point injections on April 11, 2017 (PX7).

On June 6, 2017, Petitioner returned to Ms. Innocenti with persistent low back pain (PX7). She was advised to continue taking her medication (PX7). A sacroiliac joint injection was recommended (PX7). The sacroiliac joint injection was performed on August 29, 2017 (PX7). Petitioner returned to Ms. Innocenti on October 10, 2017 (PX7). Petitioner was interested in a spinal cord stimulator (PX7). Petitioner saw Dr. Siddiqui on October 31, 2017. She was advised to continue taking her medication (PX7). Ms. Innocenti recommended the spinal cord stimulator on December 19, 2017 (PX7).

The spinal cord stimulator trial leads were implanted on January 2, 2018 (PX7). The trial ended on January 8, 2018 (PX7). The note reflects Petitioner had a good result (PX7). Petitioner returned to Dr. Siddiqui on February 27, 2018. She was afraid to proceed with the permanent spinal cord stimulator (PX7). A March 9, 2018 lumbar MRI revealed multilevel degenerative disc disease (PX7). On Petitioner's return to Ms. Innocenti on May 22, 2018, Petitioner informed Ms. Innocenti she wanted to wean off her medication (PX7). Petitioner was doing well with just taking Tylenol and Ibuprofen for pain at the July 17, 2018 office visit (PX7). Petitioner was adamant she did not want another surgery (PX7). Petitioner currently sees Dr. Sharma for any back-related problems.

Petitioner can no longer do things like she could before her injury because of the persistent low back pain. Petitioner manages her low back pain with Gabapentin and over the counter medication. She takes the over the counter medication every four hours. Rainy days give her the most trouble with her low back pain. Her average low back pain is a seven on a ten-point scale. Petitioner is currently receiving social security disability benefits although she s not subject to any medical restrictions related to her injury of February 17, 2015.

Conclusions of Law

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

Petitioner's low back condition is causally related to the February 17, 2015 accident. There is no evidence of any intervening accident or injury. Petitioner testified that while working for Respondent she jerked a pallet jack and injured her lower back.

The medical histories are consistent with Petitioner's testimony. The ambulance note and emergency room note from the date of accident reference Petitioner injuring herself pulling a pallet jack at work (PX1, PX2). The first note with Carle Occupational Medicine records a consistent history (PX3), as do the notes from Dr. Gorup, Dr. Ramos, Dr. Siddiqui, and Dr. Butler (PX4, PX5, PX7, RX1, Ex. 2).

Dr. Butler testified via evidence deposition on June 28, 2019 (RX1). Dr. Butler testified the February 17, 2015 accident caused Petitioner's lumbar strain (RX1, p.17). Dr. Butler also testified that Petitioner's work-related lumbar strain resolved on May 15, 2015 (RX1, p.20). This date is the actual date of Dr. Butler's Section 12 examination (RX1, Ex. 2). The Arbitrator fails to see any medical basis for this statement. There is no evidence that petitioner's low back condition was symptomatic prior to her injury of February 17, 2015. The petitioner had no new injuries or accidents after her work injury. The petitioner received relatively consistent medical care for a consistent set of symptoms that did not resolve after her work injury.

Based on all of the above, the Arbitrator finds Petitioner's current condition of ill-being in her low back is causally related to the February 17, 2015 work injury.

In support of the Arbitrator's decision relating to: **(J) Has Respondent paid all appropriate charges for all reasonable and necessary medical services,** the Arbitrator finds the following:

Respondent claims no liability for Petitioner's medical bills after April 3, 2015. Petitioner's medical bills were admitted into evidence (PX9-14). Based upon the holding above, Respondent is ordered to pay any outstanding medical bills pursuant to the medical fee schedule. (PX9-14). Further, Respondent will hold Petitioner harmless for the bills paid by Medicaid/Medicare regarding her low back condition on and after February 17, 2015. The Arbitrator does take into account that petitioner had a severe degenerative and congenital condition prior to her work injury. This condition involved prior surgery and Harrington Rods remained in petitioner's spine from the mid-thoracic level through the L2 level of the lumbar spine. No evidence was offered that this condition was symptomatic prior to her work injury.

In support of the Arbitrator's decision relating to: **(K) What temporary benefits are in dispute,** the Arbitrator finds the following:

Petitioner is claiming TTD benefits are owed from February 24, 2015 through April 5, 2015. Respondent paid those TTD benefits, but claims they had no liability to do so. Respondent paid a total of $2,299.44 for which they shall receive a credit.

The Supreme Court of Illinois stated, "...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. Ill. Workers' Comp. Comm'n*, 236 Ill.2d 132, 142 (2010).

The Supreme Court provided additional guidance. The Court stated, "...when determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of a work-related injury and whether the

employee is capable of returning to the work force," *Id.* at 146. The Court is also clear that, "...the Commission is limited to those powers granted by the legislature," *Id.* at 145.

Dr. Gorup restricted Petitioner from all work from February 24, 2015 through April 5, 2015 (PX4). Petitioner was off work for the relevant time period because of her work-related injury. Petitioner was previously seen at Carle Clinic on February 18, 2015 at which time petitioner was restricted to light duty work. Petitioner testified at trail that Carle Clinic advised the respondent of these restrictions and that the respondent could accommodate these restrictions. However, after seeing Dr. Gorup on February 25, 2015, the petitioner returned to Carle Clinic on February 26, 2015. Virginia Brown noted that Dr. Gorup had prescribed medication. Specifically, she goes on to state that "I will also go ahead and place her off work since she is now taking Norco on a regular basis, and this could be a definite safety issue" (Px 3; page 5 of 2/25/15 progress note under "PLAN").

Based on the above, the Arbitrator finds Petitioner is entitled to TTD benefits from February 24, 2015 through April 5, 2015 representing a period of 5 6/7 weeks.

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

Petitioner's accident occurred after September 1, 2011, so the nature and extent of the injury must be determined through the five-factor test. Considering Section 8.1(b) of the Illinois Workers' Compensation Act, the Arbitrator analyzes the five factors as follows:

i. No AMA impairment rating was provided; therefore, this factor is given no weight.

ii. The occupation of the injured employee. The Arbitrator notes that Petitioner previously worked as a production worker at the KIK Custom Products Factory. Petitioner left the employment of her own volition and confirmed at trial that she had sought and obtained other employment. No medical doctor has tendered any medical restrictions on the petitioner, but petitioner is currently out of the work force and receiving Social Security Disability Benefits. Based upon the fact that Petitioner elected not to continue her employment with Respondent and based on the fact that petitioner is no longer in the work force, the Arbitrator finds that this factor weighs in favor of decreased permanence.

iii. The age of the employee at the time of the injury – the Arbitrator notes that Petitioner was 49 years old at the time of the injury. At 49 years old, Petitioner is now closer to the end the end of her natural work career than the beginning. The Arbitrator finds that this factor weighs in favor of decreased permanence.

iv. The employee's future earning capacity – the Arbitrator notes that Petitioner was released to full duty work without restrictions by all medical providers. There was

no medical evidence or any evidence for that matter introduced at the Hearing that the petitioner's wages or earnings capacity was affected by the injury. Based on the above, the Arbitrator finds that this factor weighs in favor of decreased permanence.

v. Evidence of disability corroborated by treatment medical records –

The Arbitrator believes petitioner sustained a low back strain (and subjective complaints of radiculopathy) super-imposed on severe pre-existing degenerative and what appear to be congenital defects in her spine. Petitioner had previously undergone surgery to her lower thoracic and upper lumber spine. Harrington Rods from the previous surgery extended from the Thoracic spine through the L2 level of the lumber spine. Petitioner's treating medical providers after the February 17, 2015 work injury attempted multiple treatment regimens to alleviate Petitioner's persistent pain. Petitioner was given nine epidural steroid injections, a SI joint injection, trigger point injections, physical therapy, narcotic pain medication, and a spinal cord stimulator trial (PX3, 4, 5, 7). The Arbitrator finds that this factor weighs in favor of increased permanence

Based upon the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

In support of the Arbitrator's decision relating to: **(M) Should penalties or fees be imposed upon Respondent;** the Arbitrator finds the following:

The petitioner's attorney did file a Motion for Penalties under Section 19(l) of the Act. The Arbitrator notes Petitioner was diagnosed with a lumbar strain at the emergency room. Petitioner was then seen at the Carle Clinic and was once again diagnosed with a spinal strain. Light duty work restrictions were imposed by Carle Clinic. It was also confirmed by the clinic and Petitioner agreed at trial that Respondent was able to accommodate these restrictions. It is well established in Illinois that temporary total disability benefits are not warranted when Respondent is able to accommodate light duty restrictions. Instead of reporting to light duty, Petitioner called Carle Clinic and demanded that she be taken off work entirely.

The provider at Carle refused Petitioner's demand and maintained the light duty restrictions. In response, Petitioner sought further recommendations from another doctor. Petitioner sought treatment with Dr. Gorup. Dr. Gorup did impose restrictions keeping Petitioner off work from February 24, 2015 through April 5, 2015. As stated above, petitioner did return to Carle Clinic on February 25, 2015 at which time, Virginia Brown also authorized the petitioner off work based on the fact that petitioner was taking Norco at Dr. Gorup's recommendation.

Temporary total disability benefits were eventually paid by the respondent on or about October 27, 2015. However, it is unclear from the evidence presented as to when the respondent became aware of the change of opinion by Virginia Brown. Petitioner's attorney submitted

evidence of his request for temporary total disability benefits which included his letters and off work slips from the Office of Dr. Gorup. However, Respondent had previously been denying temporary total disability benefits based on the light duty release from Carle Clinic, respondent willingness to accommodate these restrictions and the petitioner's choice to not attempt to work within her restrictions. Respondent's denial of benefits was legally defendable based on the initial medical opinions of Carle Clinic and the respondent's willingness to provide light duty work. If any proof had been offered that the respondent was aware of the change of opinion by Carle or if petitioner's attorney had forwarded the medical records of Virginia Brown to the respondent along with the medical records of Dr. Gorup, penalties would have been justifiable in the Arbitrator's opinion.

Based on all of the above, the Arbitrator does not believe the penalties are warranted in this case.

In support of the Arbitrator's decision relating to: **(O) Did Petitioner exceed her choice of two treating physicians**, the Arbitrator finds the following:

Section 8(a) of the Act dictates Respondent is liable to pay for all emergency treatment and all treatment provided by Petitioner's chosen physicians. Petitioner is limited to two medical providers plus any medical provider in the chain of referral of her chosen providers.

On the accident date, an ambulance took Petitioner to the emergency room (PX1). The Arbitrator finds this medical provider was not the petitioner's selection.

Petitioner testified Respondent instructed her to go to Carle Occupational Medicine. Respondent offered no rebuttal. The Arbitrator could not find any evidence in the medical records of Carle to rebut petitioner's testimony. The Arbitrator finds that Carle Clinic was not the petitioner's selection of medical providers.

Petitioner's attorney claims that since Virginia Brown, at Carle Occupational Medicine, instructed Petitioner to see own doctor. Petitioner's attorney claims that when the petitioner chose to see Dr. Gorup, this was within the respondent's chain of referral. The Arbitrator finds that this statement by Ms. Brown does not constitute a referral to Dr. Gorup. The Arbitrator finds that Dr. Gorup was the petitioner's first choice of treating physicians. Dr. Gorup did refer the petitioner to Dr. Ramos. Therefore, the Arbitrator finds Dr. Ramos was within the chain of referral of the petitioner's first choice of physicians. Similarly, Dr. Ramos referred petitioner to Hammonds who administered an EMG. The Arbitrator also finds Dr. Hammonds is in the chain of referral of the petitioner's first choice of physicians.

The petitioner next came under the case of Dr. Siddiqui. The Arbitrator finds that Dr. Siddiqui is the petitioner second choice of physicians as allowed by Section 8(a) of the Act.

Based on the above, the Arbitrator finds Petitioner did not exceed her two physician choices.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT STARBUCK,

Petitioner,

20 I W C C 0 5 0 3

vs. NO: 05 WC 51021

CITY OF CHICAGO,

Respondent.

ATTORNEYS' FEE PETITION DECISION AND OPINION ON REVIEW

This matter comes before the Commission subsequent to a Petition for Review of the February 23, 2017, Arbitrator's Decision on the issues of temporary total disability, causal connection, maintenance, permanent disability, prospective medical and attorneys' fee petitions. After Oral arguments, Panel A, consisting of Commissioners Lamborn, Tyrrell and Brennan, being advised of the facts and law, affirmed and adopted the Arbitrator's Decision with respect to all issues except the attorneys' fees. The Commission found that there was no offer of settlement extended to Petitioner immediately prior to the Petitioner's second attorney filing a co-counsel appearance or before Petitioner's first attorney withdrew from the case. Pursuant to the Commission's Decision and Opinion on Review, filed on October 25, 2018, the Petitioner's first attorney, Joseph J. Spingola ("Spingola"), was Ordered to file a Quantum Meruit Petition for Fees before the Commission to assist the Commission in resolving the fee dispute between Petitioner's first attorney and his second attorney, Charles J. Candiano ("Candiano").

Spingola submitted the accounting of his time, filed on December 4, 2018. After appeal to the Circuit Court of Cook County filed on October 30, 2018, Honorable Daniel P. Duffy entered an Order on February 27, 2020, confirming the Decision and Opinion on Review of the Commission. Pursuant to the attorneys' requests, the Commission has reviewed Spingola's accounting in concert with the entire record to assess an equitable apportionment of the attorneys' fees.

The Commission affirmed the Arbitrator's award of $113,643.74, representing $113,574.00 in permanent partial disability based upon 40% loss of use of a person pursuant to §8(d)2 and Petitioner's permanent partial disability rate of $567.87, plus $69.74 for an outstanding medical bill owed to Dr. Goldflies. Petitioner signed Attorney Representation Agreements with both Petitioner's attorneys, wherein each attorney contracted with Petitioner to represent him for a fee of 20% of the amount received in excess of the written offer, or 20% (not to exceed 20%) of the total amount received for compensation for permanent disability caused by the accident, whichever is less; provided, however, if the compensation received for permanent disability, does not exceed the written offer, the attorney shall receive no fee for permanent disability. The Commission declines to award any additional attorney fees above the 20% of the amount of the Arbitrator's award and finds that Spingola is entitled to 70% of the attorney's fees plus his costs, less his payment from the §19(b) hearing, and Candiano is entitled to 30% of the attorney's fees plus his costs, based upon the law and facts set forth below.

§16 of the Act provides as follows:

> The Commission shall have the power to determine the reasonableness and fix the amount of any fee of compensation charged by any person, including attorneys, physicians, surgeons and hospitals, for any service performed in connection with this Act, or for which payment is to be made under this Act or rendered in securing any right under this Act. *820 ILCS 305/16*

Further, germane to this analysis, §16(a) of the Illinois Workers' Compensation Act provides, in pertinent part, as follows:

> **(B)** With respect to any and all proceedings in connection with any initial or original claim under this Act, no claim of any attorney for services rendered in connection with the securing of compensation for an employee or his dependents, whether secured by agreement, order, award or a judgment in any court shall exceed 20% of the amount of compensation recovered and paid, unless further fees shall be allowed to the attorney upon a hearing by the Commission fixing fees, and subject to the other provisions of this Section…
> **(C)** All attorneys' fees in connection with the initial or original claim for compensation shall be fixed pursuant to a written contract on forms prescribed by the Commission between the attorney and the employee or his dependents, and every attorney, whether the disposition of the original claim is by agreement, settlement, award, judgment or otherwise, shall file his contract with the Chairman of the Commission who shall approve the contract only if it is in accordance with all provisions of this Section.
> …**(J)** Any and all disputes regarding attorneys' fees, whether such disputes relate to which one or more attorneys represents the claimant or claimants or is entitled to the attorneys' fees, or a division of attorneys' fees where the claimant or claimants are or have been represented by more than one attorney, or any other

disputes concerning attorneys' fees or contracts for attorneys' fees, shall be heard and determined by the Commission after reasonable notice to all interested parties and attorneys. *820 ILCS 305/16a*

Findings of Fact

Petitioner retained Spingola to represent him and Spingola filed an Application for Adjustment of Claim on November 18, 2005. Spingola filed a §19(b) Petition for Immediate Hearing on April 13, 2006. Spingola represented Petitioner at the §19(b) Hearing before Arbitrator Gilbert Galicia on May 12, 2006, on the issues of causal connection, TTD and future medical care. The accident on May 31, 2005, was stipulated to by the parties.

On May 24, 2006, a §19(b) Decision was filed by Arbitrator Galicia finding a causal connection between Petitioner's left forearm injury and work injury, noting the city's physicians at MercyWorks diagnosed a strain of the left distal forearm and wrist resulting from injury on May 31, 2005. According to Arbitrator Galicia's §19(b) Decision, Petitioner was diagnosed with a strain of the left distal forearm and wrist X-rays taken on June 6, 2005, were negative but showed an internal fixation of a healed radial fracture stemming from a prior accident.

In the Decision, Arbitrator Galicia found that Petitioner's medical records revealed continuing weakness, pain and limited range of motion with respect to the left forearm and that Petitioner was capable of performing heavy manual labor as a cement mixer/laborer for Respondent for at least ten (10) years and he had worked with retained hardware in his left forearm. He was also able to return to work as a movie projectionist after the injury to his forearm in 1990 where he continued to work until he retired in 2004. He was able to perform heavy-duty labor with internal fixation in his left arm since 1990. Petitioner also had prior treatment to his left forearm for similar injuries in July 2000 and in December 2002 and they support the finding of causal connection. He was treated on two occasions and returned to full duty. Therefore, Arbitrator Galicia concluded, the retained hardware is not a cause of Petitioner's strained left forearm. It is irrelevant whether the retained hardware is a contributing factor to his inability to recover from a similar strain this time, it was held. Therefore, Petitioner was awarded TTD from 6/1/05 to 5/12/06, 49-3/7weeks at a rate of $746.61/week. The finding above on causal connection led to a finding that current medical treatment was reasonable and necessary and future and additional medical treatment to resolve the left forearm tendinitis be provided for him. (5/24/06ArbDecision)

Subsequent to Arbitrator Galicia's §19(b) Decision, Spingola again filed §19(b) Petitions for Immediate Hearings on August 6, 2009, and August 4, 2010. Spingola further managed the case on status calls, obtained and reviewed updated medical records from Dr. Goldflies, Swedish Covenant Hospital, Dr. Krupica, Dr. Nora, Dr. Kiokemeister, Dr. Clark, Dr. Vendor, et.al. and communicated with Respondent's first vocational rehabilitation counselors at Vocomotive regarding Petitioner's initial meeting for a vocational rehabilitation assessment and subsequent rehabilitation plan. Eventually Spingola engaged Steven Blumenthal for an opinion regarding Petitioner's employability. This change in vocational rehabilitation counselors was approved by

20IWCC0503

Respondent despite the fact that Vocomotive had opined that Petitioner was virtually non-compliant with their plan. Blumenthal's opinion report was not tendered into evidence as a separate record, however, it was included in Petitioner's primary care doctor, Dr. Krupica's records. (PX2) Spingola also engaged Dr. Chmell for an expert opinion in 2010. While this opinion report was not tendered as a separate exhibit, the report was contained in Dr. Krupica's records. (PX2). Spingola also engaged in two pre-trials according to the record and multiple communications with Petitioner. Spingola also communicated with Respondent's counsel regarding all of the afore-referenced vocational rehabilitation meetings, plan and results. Further, in 2012, Spingola communicated with Respondent's counsel regarding Respondent's §12 evaluations with Dr. Mirkovic, Dr. Tudor and Dr. Ganellen and the respective opinion reports, plus the Functional Capacity Evaluations' scheduling and results (2008 and 2012) and Respondent's proposed resolution of the case.

Respondent sent Petitioner a letter with an offer for an accommodated position on October 12, 2012. Spingola's accounting shows that on January 6, 2013, the parties and Petitioner appeared for a two hour meeting with Arbitrator O'Malley. Petitioner received a letter in February from Respondent advising that his temporary total disability benefits were being terminated as a result of not responding to the letter of employment offer. According to Spingola, he discussed settlement negotiations with Petitioner and the possibility of a wage-differential settlement and they discussed potential trial outcomes.

As was his right to do so, it is apparent from an email exchange between Petitioner and Spingola that Petitioner rejected the discussed settlement resolution of the case, and the Respondent's proposal to prove up the wage-differential. Although normally privileged communication, on February 23, 2013, Petitioner sent an email to Spingola, and copied the email to Dr. Krupica and Dr. Florence. The email, included with the medical records in the trial exhibit, states the following,

> ...You also tried to talk me into taking differential pay. I was told you are a very aggressive attorney, please use this aggression for me not against me... Now as far as the cost of this case, I would like an accounting of how much to date the doctors were paid, (all) of them, and how much the law firm of Hennessy and Roach, and Vocomotive office has been paid. And how much the state of Illinois paid them. If you feel you cannot or will not give me this information, then I feel communications have broken down between you and I (sic). (12/1/15ArbHearing, PX7)

On February 25, 2013, Spingola replied to both Petitioner and his wife, addressing the email to Petitioner's wife,

> I spent 2 ½ hours with each of you only two weeks ago. I'm sorry to say I don't think you heard a word of advice I've given you. I spent another one and a half hours with Bob alone last week. He and I communicate well. When I got your email, I can tell that you have stepped in again. (12/1/15ArbHearing, PX7)

On April 10, 2013, Respondent terminated Petitioner's TTD benefits. On April 12, 2013, Spingola filed a Motion to Withdraw his representation of Petitioner. The matter was set for trial on April 15, 2013, off the status call and the parties again appeared for an almost two hour pretrial and the case was specially set for trial on June 6, 2013, Petitioner represented by Spingola at that time. Weekly payments were initiated by Respondent on April 15, 2013, that Respondent characterized as wage-differential benefits. It is apparent those benefits were initiated as a result of the pretrial conferences before Arbitrator O'Malley.

At the Fee Petition hearing, a letter from Respondent's attorney to Spingola, dated June 10, 2013, was introduced into evidence. The letter states:

> I will not agree to spending additional hours beyond the three hours that we have already spent before Arbitrator O'Malley listening to your client complain that they are not receiving the benefits that they feel that they are entitled to. (5/12/16FeePetHearing, PX4)

On June 12, 2013, the day Petitioner signed a new Attorney Representation Agreement, Petitioner wrote a letter to Spingola advising that he had a new attorney. On June 14, 2013, Candiano filed an Appearance, however, he filed as co-counsel as opposed to filing a substitution of attorneys.

Arbitrator Simpson's Decision sums up the testimony, evidence and procedural history as follows:

> This matter was specially set for hearing on June 6, 2013. At that time, a pre-trial with Arbitrator O'Malley took place. The petitioner's benefits were previously reinstated to "wage differential benefits" based on the petitioner's representation that he would be willing and able to perform the job previously offered in the letter of October 11, 2012. According to the "differential" payment ledger, benefits began on April 15, 2013. (RX 4) Shortly thereafter, the petitioner's representation by Mr. Spingola was terminated by the petitioner, and the petitioner retained the services of Mr. Candiano. The petitioner testified that since he hired Mr. Candiano, no 19(b) petitions for immediate hearing were filed, and nothing was done on his case for a year. (TX 72)
>
> The respondent then filed a motion to dismiss on December 16, 2014, for the March 24, 2014, status call before Arbitrator Luskin due to the petitioner's failure to move the matter forward to a hearing for a year. (RX 11) The matter was set for trial on April 9, 2014, and was then again specially set for trial on June 11, 2014, because the petitioner's attorney requested additional time to set depositions in the case. At that time, the petitioner stated that it was his understanding that in order to have his benefits changed, he would need to proceed to trial. (TX 71) Eventually, the petitioner did schedule the deposition of Dr. Krupica which took place on August

18, 2014. Subsequently, the depositions of Drs. Ganellan and Tuder took place on December 18, 2014, and March 6, 2015, respectively.

The matter was dismissed on August 7, 2015. Even though five months had passed since the depositions were completed in this case, the petitioner still did not take steps to prosecute his claim. Eventually, the matter did finally proceed to trial on December 1, 2015. (2/23/17ArbDec, p. 9)

Respondent alleged $57,930.48 had been paid as wage-differential benefits by the time the matter proceeded to trial. (12/1/15ArbHearing, ArbX1, RX4) At the Fee Petition Hearing, the parties stipulated Respondent paid an additional $5,508.01 between the December 1, 2015, Hearing date until February 10, 2016. (2/23/17ArbDec, p. 16)

Conclusions of Law

...a discharged attorney is entitled to be paid a reasonable fee on a *quantum meruit* basis for services rendered before termination...

Factors to consider in determining *quantum meruit* fees include "the time and labor required, the attorney's skill and standing, the nature of the cause, the novelty and difficulty of the subject matter, the attorney's degree of responsibility in managing the case, the usual and customary charge for that type of work in the community, and the benefits resulting to the client."

Will v. Northwestern Univ., 378 Ill. App. 3d 280, 304, 881 N.E.2d 481, 317 Ill. Dec. 313 (2007).

The Commission's decision in the subject fee petition matter is based on its consideration of each of these factors. According to his attestation, Spingola's accounting of 119.67 hours of his time was constructed from his computer notes, correspondence, medical records, and law diary but did not include what he estimates was 30% of his time on phone calls. At a rate of $250.00 per hour, Spingola's fees would total $29,917.50 excluding telephone call time. At a rate of $200.00 or higher, the amount is greater than 20% of the award. Spingola provided copies of his subpoena invoices, and for payment to his experts Blumenthal and Dr. Chmell, and his calculated costs totaled $3,876.00.

While unusual, in this case there is evidence, in the form of a letter and payment of what Respondent's payment ledger characterized "wage-differential" benefits, that Respondent was willing to explore settlement on the basis of a wage-differential while Spingola represented Petitioner, so that settlement option was of great benefit to the client.

Based on the totality of the record, the Commission finds that Spingola, who represented the Petitioner for almost eight years and through the first §19(b) hearing, is entitled to 70% of the

20IWCC0503

attorney's fees, $15,910.12 and all of his costs, $3,876.00 less the amount he already was paid for the §19(b) hearing, $2,325.15, for a total of $17,460.97 for his fees and costs.

Despite the fact that the Arbitrator's award was less than the amount discussed during settlement negotiations when Spingola represented Petitioner, the Commission finds that Candiano, who represented the Petitioner for approximately two and one-half years before the Arbitration hearing, is entitled to 30% of the attorney's fees, $6,818.63, for representing the Petitioner through the final Arbitration hearings, preparing for and proceeding to trial including, but not limited to, obtaining complete sets of certified medical records, taking doctors' depositions, and drafting the proposed Arbitration Decision, plus he is entitled to all of his costs.

The attorney fees and costs so awarded are recoverable, pursuant to Section 16a of the Act, from the compensation paid to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that Spingola is entitled to 70% of 20% of the Arbitrator's award of $113,643.74, or $15,910.12, plus his costs, $3,876.00, less the amount he already was paid for the §19(b) hearing, $2,325.15, for a total of $17,460.97.

IT IS FURTHER ORDERED BY THE COMMISSION that Candiano is entitled to 30% of 20% of the Arbitrator's award of $113,643.74, or $6,818.63, plus his costs, $2,133.80 for a total of $8,952.43.

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

DATED: SEP 8 - 2020
KAD/bsd
O7/22/20
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PEGGY MALOTT, as Executor of
the Estate of FRANCES JOANN GRIGSBY,

Petitioner,

vs. NO: 15 WC 08798

FREEMAN UNITED COAL MINING COMPANY, **20 I W CC 0504**

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 including exposure, arising out of and in the course of employment and last date of exposure, permanent disability, causal connection, legal and evidentiary error, Section 1(d) - Section 1(f) and burial expenses, and being advised of the facts and law, finds that the Commission does not have jurisdiction to review this matter and therefore vacates the Decision of the Arbitrator and remands the case to the Arbitrator for the reasons set forth below.

Frances Joann Grigsby, the widow of deceased coal miner, Frederick O. Grigsby, signed an Application for Adjustment of Claim on February 23, 2015, that was filed on March 19, 2015, and alleged her husband's death was caused in whole or in part by coal mine dust and/or coal dust, rock dust, fumes and vapors. (ArbX2) While the matter was pending, Mrs. Grigsby died, on May 9, 2017. An Arbitration hearing was held on August 8, 2019. The parties stipulated at the time of arbitration that Frederick O. Grigsby, Sr. was employed by Respondent, and was married to Frances Joann Grigsby at the time of his death on May 24, 2014, and that Mrs. Grigsby did not remarry prior to her death on May 9, 2017. (JX1)

No trial testimony was introduced at the Arbitration hearing. In addition, it appears that the parties amended the Application for Adjustment of Claim at the time of the hearing, however, there is no evidence of the request on the record. At the time that Joint Exhibit One, the Request for Hearing form documenting the trial stipulations, was entered into evidence, the Arbitrator requested a copy of the document appointing the Grigsby's daughter, Peggy Malott, as executor of her mother's estate. However, the document was never introduced into evidence; instead, it was to be offered at the time the parties submitted proposed decisions.

In finding that the Commission does not have jurisdiction to review this appeal, the Commission relies upon the Court's holding in the matter of *Ill. State Treasurer v. Estate of Kormany, 2019 IL App (1st) 180644WC, 140 N.E.3d 821, 435 Ill. Dec. 771 (Ill. App. Ct. 1st Dist. March 29, 2019).* In *Estate of Kormany,* the Illinois State Treasurer (Treasurer), as *ex officio* custodian of the Injured Workers' Benefit Fund (Fund), was named as a co-Respondent. Prior to the arbitration hearing, the Petitioner died of causes unrelated to his workers' compensation claim. Petitioner's attorney amended the Application for Adjustment of Claim and substituted "the Estate of Kormany" for the Petitioner. The Arbitrator awarded medical and permanent partial disability benefits after finding that Petitioner sustained his burden of proving an accident that arose out of and in the course of his employment with Respondent A-Tech.

The Arbitrator concluded "that the Fund was liable for payment of the award because, although Respondent A-Tech had workers' compensation insurance at the time of the accident, it failed to provide coverage within the meaning of *section 4(d)* of the Act (*820 ILCS 305/4(d)* (West 2008)) by breaching the insurance contract." *Estate of Kormany, 2019 IL App (1st) 180644WC, ¶ 1, 140 N.E.3d 821, 822-832.* The Commission and the Circuit courts confirmed the Arbitrator's Decision and the Fund appealed.

Regarding Petitioners and Plaintiffs who predecease the resolution of a pending case, the *Kormany* court held as follows:

> When confronted with similar circumstances, Illinois courts have found that the plaintiff's death suspended the court's jurisdiction until the appointment of a proper party plaintiff. See *Voga v. Voga, 376 Ill. App. 3d 1075, 1079, 878 N.E.2d 800, 316 Ill. Dec. 708 (2007)* (finding that party's death suspended the trial court's jurisdiction until the court appointed a proper successor plaintiff); *Washington v. Caseyville Health Care Ass'n, 284 Ill. App. 3d 97, 100-01, 672 N.E.2d 34, 219 Ill. Dec. 719 (1996)* (holding that client's death terminated attorney's authority and, since there was no plaintiff, the court's jurisdiction was suspended until a party plaintiff was appointed). Accordingly, we hold that Kormany's death suspended the Commission's jurisdiction over his claim until such time as a personal representative of Kormany's estate was properly appointed and substituted as the petitioner. In the absence of such an appointment and substitution, the

> Commission's decision was premature and therefore improper. As a result, both the decision of the Commission and the judgment of the circuit court must be vacated.

Id. ¶ *2.*

The Kormany court went on to explain that while *section 25-1 of the Probate Act of 1975 (Probate Act)* (*755 ILCS 5/25-1* (West 2008)), which provides for the payment or delivery of a small estate upon affidavit and undoubtedly permits the *distribution* of an estate's assets by means of a small estate affidavit, "[t]his is separate and distinct from the requirement that a personal representative of the decedent's estate be appointed to *prosecute* a workers' compensation claim that is pending and unresolved at the time of the employee's death." *Id.* ¶ *3.*

The *Kormany* court, in vacating the Commission's award, reasoned as follows:

> Indeed, this circumstance is no different from when a plaintiff in a pending common law action dies. In such circumstances, a personal representative of the deceased plaintiff's estate is appointed and substituted as the party plaintiff. See *735 ILCS 5/2-1008(b)* (West 2008); *In re Marriage of Fredricksen, 159 Ill. App. 3d 743, 744-45, 512 N.E.2d 1080, 111 Ill. Dec. 539 (1987)*. Thus, while the proceeds of a judgment may be distributed pursuant to the small estate procedure outlined in the Probate Act, no authority has been cited to us that would permit the prosecution of an action absent the appointment of a personal representative. *Id.,* ¶¶ *3-4.*

Based upon the holding in *Kormany,* the Commission finds it has no jurisdiction to address the instant Petition for Review. Therefore, the Commission vacates the Decision of the Arbitrator filed October 2, 2019, and remands the matter to the Arbitrator solely to allow a court appointed representative of the estate of Frances Joann Grigsby to be substituted as the Petitioner and for further proceedings consistent with the Arbitrator's Decision filed October 2, 2019, thereafter.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 2, 2019, is vacated and the case remanded to the Arbitrator solely to allow a court appointed representative of the estate of Frances Joann Grigsby to be substituted as the Petitioner and for further proceedings consistent with the Arbitrator's Decision filed October 2, 2019, thereafter.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. As there are no monies due and owing, there is no bond set by the Commission for the removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 9 - 2020
KAD/bsd
O07/14/20
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

STATE OF ILLINOIS)	☐ Affirm and adopt (with explanation)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRYSTAL BEAL,

Petitioner,

vs. NO: 19 WC 2119

AISIN MANUFACTURING, ILLINOIS, LLC,

Respondent.

DISSENT

I respectfully dissent from the Decision of the majority and would have affirmed and adopted the Arbitrator's permanent partial disability award of 17.5% MAW.

Shortly after Petitioner's March 8, 2019 cervical surgery, Dr. Rutz released her to return to full duty work without restrictions on April 30, 2019. Although Petitioner no longer worked for Respondent at the time of the hearing, no testimony was provided as to her current job duties or income at her new job with Securitas. There was no evidence presented to indicate that Petitioner had any difficulty performing any of her present job duties. Petitioner also did not present any evidence regarding her inability to do the job she was injured performing, the differences between her employment with Respondent and Securitas, and whether there was any need for her to change her job due to her injury. Likewise, no evidence was offered to establish that Petitioner's future earning capacity was adversely affected in any way by her work injury. Based on these factors, I do not find that the record supports an increase in Petitioner's permanent disability award of 17.5% MAW and would have affirmed and adopted the Decision of the Arbitrator accordingly.

DLS/met
46

SEP 8 - 2020

Deborah L. Simpson
Deborah L. Simpson

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

	Case Nos.
BOBBIE GRANGER v. ILLINOIS MASONIC,	07 WC 3834
YOLANDA CAUSBY v. CITY OF CHICAGO,	12 WC 40893, 14 WC 34781
PEDRO VILLA v. HOIST LIFT TRADE,	15 WC 7030
CORNELL HENTZ v. WAREHOUSE DIRECT,	16 WC 21105
DAVE HOWARD v. CHICAGO PARK DISTRICT,	13 WC 22638
MALLORY GRANTHAM v. K&G SUPERSTORES,	09 WC 32656, 10 WC 29892, 11 WC 316
DIESHA SWANSEY v. CELADON TRUCKING,	16 WC 16749
MUSTPAHA SHERIFF v. DISPATCH TAXI MANAGEMENT,	13 WC 22193
SEDAREEL HOWARD v. PROFICIENT TRUCKING CO.,	14 WC 20449
DOMINICK DENOVELLIS v. BRIDGESTONE FIRESTONE,	14 WC 33565
LATONYA HARPER v. FORD MOTOR COMPANY,	14 WC 16663
SHERRY HICKMAN v. COOK COUNTY DOC,	16 WC 14848
LEONEL GARZA v. NESTLE DREYERS ICE CREAM,	09 WC 42369
AKINOLA CHARLES v. YELLOW CAB,	14 WC 7127
MONCEF BEDRI v. YELLOW CAB COMPANY,	16 WC 16745
ALI BILAL v. FLASH CAB,	14 WC 19927
MEHMET CIFTCI v. RAY CAB CO.,	13 WC 11832
ANDREW SMITH v. CLARION CONSTRUCTION,	16 WC 19010, 18 WC 19971
LAURA WILLIAMS v. EBY REALTY GROUP,	16 WC 12330
ANN MARIE JORDAN v. ADDUS DAYTIME CENTER,	15 WC 17672

ORDER

This matter is heard on the petition to adjudicate Joel Bell's claims for quantum meruit made on cases before Bell was disbarred from the practice of law. The Attorney Registration and Disciplinary Commission (ARDC) intervened in the matter and have petitioned this Commission for the fees or a share thereof towards re-payment to the ARDC Client Protection Program Fund.

The total fees requested by Bell for quantum meruit are $64,632.00 plus costs expended by Bell in the prosecution of the cases. The parties have agreed that the ARDC will receive $32,316.00 of the funds for their share of reimbursement to the Client Protection Fund and Bell will receive $32,316.00 plus the costs he expended in the prosecution of the cases before his disbarment. The funds shall be disbursed from the Seidman, Margulis & Fairman IOLTA Trust Account. (SMF Trust Account) and SMF is directed to make said disbursements immediately. Upon disbursement of said funds the matter is terminated.

DATED: SEP 9 - 2020

D. Douglas McCarthy

D. Douglas McCarthy

DDM/tdm
r: 9/8/20
052

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSHUA GREER,

Petitioner,

vs. NO: 18 WC 2332

MBL (USA) CORPORATION,

Respondent.

ORDER

This matter came before Commissioner Douglas McCarthy on September 8, 2020 pursuant to the Commission's Rule to Show Cause. During said hearing, the Petitioner, by his counsel, requested the dismissal of the Petition for Review filed by Petitioner on February 28, 2020. Respondent offered no objection.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition for Review, filed on February 28, 2020, is hereby dismissed.

DATED: SEP 9 - 2020
DDM/tdm
r: 9/8/20
052

D. Douglas McCarthy
Commissioner D. Douglas McCarthy

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEPHEN KIRCHGESSNER,

Petitioner,

vs. NO: 19 WC 07504

GREATER PEORIA,
MASS TRANSIT DISTRICT (GPMTD),

20IWCC0505

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 23, 2020 is hereby affirmed and adopted.

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

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

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

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

DATED: SEP 9 - 2020
o- 8/4/20
KAD/jsf

Maria E. Portela

Thomas J. Tyrrell

DISSENT

I disagree with the majority's decision finding Petitioner proved the act of turning a steering wheel aggravated or accelerated his pre-existing condition requiring surgery. The evidence shows Petitioner's pre-existing degenerative cervical condition was symptomatic leading to atrophy, wasting and dysfunction, and his condition already required surgical intervention before the subject incident.

On January 10, 2019, Petitioner was operating a bus for Greater Peoria Mass Transit/Citylink. The bus was functioning properly and operated by power steering. He worked a split shift, beginning his first shift at 4:58 a.m. and ending at 9:00 a.m. (T.13) After his first shift ended, Petitioner went home and returned at 2:08 p.m. to start his second shift. At approximately 3:00 p.m., Petitioner was operating the bus, chiefly using his left hand to steer before this time. He was approaching the intersection at Main Street and Washington intending to make a right-hand turn and, as he was turning the steering wheel, using his right hand/arm, he felt extreme pain and numbness from his neck down to his right arm. (T. 14) Petitioner was diagnosed with cervical spondylosis with radiculopathy and recommended to undergo an anterior cervical decompression and fusion from C4-C7.

A claimant must establish his current condition of ill-being is causally related to his asserted accident. *Sisbro, Inc. v. Industrial Comm'n.*, 207, Ill.2d 193, 203 (2003*); Land and Lakes Co. v. Industrial Comm'n.,* 359 Ill.App.3d 582, 591-92 (2nd Dist. 2005). More is required than the fact of an occurrence at the employee's place of work. *Greater Peoria Mass Transit District v. Industrial Comm'n* (1980), 81 Ill. 2d 38, 43. A claimant must show that the injury is due to a cause connected to the employment to establish that it arose out of the employment. *Elliot v. Industrial*

Comm'n (1987), 153 Ill.App.3d 238, 242. Although a pre-existing condition does not prevent recovery of benefits if that condition was aggravated or accelerated by claimant's employment, recovery is denied where the claimant's health has so deteriorated that any normal daily activity is an overexertion, or where the activity engaged in presents risks no greater than those to which the general public is exposed. *Caterpillar Tractor Co. v. Industrial Comm'n* (1982) 92 Ill.2d 30, 36.

Respondent admitted into evidence a video of Petitioner operating the bus on the date of the subject incident. It reveals Petitioner was symptomatic before the incident and, despite being right-hand dominant, refrained from using his right hand/arm to operate the bus as frequently as he did with the left hand/arm, while favoring his dominant arm. Indeed, Petitioner held his right arm in his lap or down at his side as he drove the bus with his left hand, and closed and opened his right fist and rubbed his right arm before the subject incident. This video is compelling as it clearly shows Petitioner was symptomatic for a condition necessitating surgery even before the work incident and should be afforded great weight in determining whether Petitioner met his burden.

Petitioner's testimony is also compelling evidence that cannot be ignored. He testified that before the incident, he experienced pain, numbness or difficulty with the right arm, specifically, in the right bicep and up in the right shoulder. (T.14-15) It was present both on the date of the incident and before the date of the incident. *Id.* Petitioner indisputably had symptomology before he turned the wheel with his right arm. Although he testified he had not experienced the type of pain he felt after turning the wheel, clearly the condition had advanced to such a state to cause pain and numbness requiring him to favor his arm before the work incident. The video footage of Petitioner before the incident corroborated by Petitioner's own testimony shows his symptomatic condition had so deteriorated by the time he resumed his second shift, that any exertion was an overexertion. Consequently, the disabling condition and that requiring surgery was the result of the normal degenerative process and not a work accident.

The findings and opinions of Petitioner's treating physicians, Drs. Mahoney and Mulconrey, further substantiate the pre-existing condition was symptomatic and warranted surgery. Dr. Mahoney examined Petitioner on January 22, 2019, 12 days post incident, and found significant atrophy of the right bicep and wasting of the right upper extremity that was of grave concern. (PX1) Dr. Mulconrey examined Petitioner on February 11, 2019, 4 weeks post incident, and also found weakness and wasting of the right bicep and weakened grip strength. (PX1, pp. 9-10) Dr. Mulconrey testified that these findings pre-dated the work incident. (PX1, p. 25) Further, he conceded this muscle wasting was caused by cervical spondylosis, a pre-existing condition that in and of itself required surgery irrespective of the January 10 incident. (PX1, p. 34-35)

Dr. Stephen Weiss testified on behalf of Respondent. Dr. Weiss reviewed the video of Petitioner operating the bus on the date of the incident. He viewed Petitioner turning the steering wheel with his right hand/arm to make the right-hand turn. He testified that the incident of turning the steering wheel was not a causative factor in Petitioner's cervical condition and the need for surgery. (RX1, p. 12) Dr. Weiss explained that the forces he [Petitioner] described, which is turning the steering wheel, in the absence of any mechanical malfunction, are not sufficient to

cause or aggravate cervical degenerative disc disease, cervical stenosis or cervical radiculopathy. Second, he found, with the atrophy noted only one month and one day after the injury, that the condition predated the alleged date of injury (RX1, p. 12-13) Finally, Dr. Weiss testified that he observed the Petitioner in the video having "problems" with his right upper extremity and neck before the incident. Specifically, Petitioner was observed favoring the right arm, rubbing the right arm, which indicated the arm was paining him, and flexing the fingers of the right hand. He concluded Petitioner was having difficulty with his hand. (RX1, p. 14) He agreed Petitioner was a surgical candidate because he had radiculopathies with atrophy and wasting but nothing was done at work that aggravated or caused the surgical condition. (RX1, p.15)

Dr. Weiss' observations of Petitioner on the video are consistent with Petitioner's own testimony that he had pain and numbness in the right arm before the incident. This evidence is further supported by Dr. Mulconrey's testimony that the clenching, opening and closing of the fist and rubbing of the right arm, are consistent with patients who have pain and dysfunction in the right arm. (RX1, p. 31)

In addition, the activity engaged in by Petitioner, the act of turning a power steering wheel, is an activity that presented no greater risk than that to which the general public is exposed. Dr. Weiss viewed the video and the specific mechanism of injury. He testified:

> Yeah, I think he had been having a problem with the right arm all along. He was favoring the right arm. He was not using it as much as the left. He was rubbing it. He was flexing his fingers. And he did use it for the turn. And that was a continuation of the problem that he had been having all along. But I looked at the turn, and there was nothing that I haven't seen bus drivers do all the time. It was nothing of particular force or any difficulty. There was nothing overhead. There was nothing that should have caused or aggravated his stenosis, his radiculopathy, his cervical degenerative disc disease. Just it wasn't enough. (RX1, p. 15)

Dr. Mulconrey based his causation opinion on Petitioner's history that he was able to work with this condition before January 10 and was unable to work after the twisting injury to his arm on that date. (PX1, p. 20) However, Dr. Mulconrey never viewed the video which clearly shows Petitioner refraining from using his right arm as frequently as the left, which is indicative of a symptomatic pre-existing condition, a condition Dr. Mulconrey testified required surgery. The video thus undermines the basis for Dr. Mulconrey's causation opinion; therefore, Dr. Mulconrey's opinion is unreliable.

Based on the foregoing, Petitioner has not met his burden of proof and the decision should be reversed. Therefore, I respectfully dissent.

Kathryn A. Doerries

Kathryn A. Doerries

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

KIRCHGESSNER, STEPHEN Case# **19WC007504**
Employee/Petitioner

GREATER PEORIA MASS TRANSIT DISTRICT
Employer/Respondent

20IWCC0505

On 1/23/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2249 HARVEY & STUCKEL CHTD
J KEVIN WOLFE
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

0102 CASSIDY & MUELLER
TIMOTHY CASSIDY
416 MAIN ST SUITE 323
PEORIA, IL 61602

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)

STEPHEN KIRCHGESSNER,
Employee/Petitioner

Case # **19** WC **7504**

v.

GREATER PEORIA MASS TRANSIT DISTRICT,
Employer/Respondent

20 IWCC0505

An *Application for Adjustment 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 **December 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 10, 2019**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,338.00**; the average weekly wage was **$1,006.50.**

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

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

ORDER

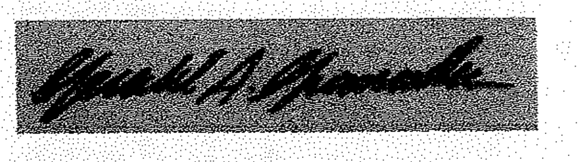
Respondent shall pay reasonable and necessary medical services of $64.00, subject to the Fee Schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize further treatment for Petitioner's cervical spine condition, including but not limited to any and all examinations, diagnostic studies and C4-C7 anterior cervical decompression as recommended by Dr. Daniel Mulconrey.

Respondent shall pay Petitioner temporary total disability benefits of $671.00/week for 30 5/7 weeks, commencing May 16, 2019 through the date of hearing, (December 16, 2019), as provided by Section 8(b) of the Act.

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

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



Signature of Arbitrator Gerald Granada

1/22/20
Date

JAN 23 2020

FINDINGS OF FACT

This case involves Petitioner Stephen Kirchgessner, who alleges to have been injured while working for Respondent Greater Peoria Mass Transit District on January 10, 2019. Respondent disputes Petitioner's claims, with the issues being: 1) accident; 2) causation; 3) medical expenses; 4) prospective medical care; and 5) TTD.

On January 10, 2019, Petitioner was employed by Respondent as a bus driver and had been so for nine years and three months. He was driving a split shift, which began at 4:58 A.M. through 9:00 A.M. and then from 2:08 P.M. to 7:00 P.M. During the afternoon shift, Petitioner was driving a bus in downtown Peoria on Main Street as he approached the intersection with Washington Street. When he came to make a right turn on Washington Street, he turned the steering wheel with his right arm making a clockwise maneuver and spinning it a few times. As he turned the steering wheel, he noticed immediate and severe pain in his right arm which went from his neck down through his shoulder and into the right elbow area. It was of such intensity he had to lay his arm down. He continued to flex the arm until he brought the bus to the bus terminal where he ended his shift early.

Petitioner testified he had never experienced this type of pain in his right arm prior to the incident of turning the bus at Main and Washington Street. While Petitioner has had some pain in his right arm for a few months prior to this incident he had not had any similar problems with neck pain radiating down into his arm.

After reporting the incident to his supervisor Petitioner went to OSF Center for Occupational Health, where he saw Dr. Moody, who referred him to Midwest Orthopaedic Center in Peoria. At Midwest Orthopaedic Center, Petitioner saw Dr. Mahoney, an orthopedic doctor who treats upper extremities. Dr. Mahoney thought Petitioner suffered a right arm problem and ultimately referred Petitioner to Dr. Daniel Mulconrey. Dr. Mulconrey eventually diagnosed Petitioner with a cervical spine issue and recommended surgery. Further, it is Petitioner's understanding that Dr. Mulconrey has Petitioner on a five pound lifting restriction with his right arm and no commercial driving pending surgery. Petitioner testified that he would like to undergo the surgery recommended by Dr. Mulconrey.

Petitioner presented a video from Respondent, which shows the incident in question. (Pet. Ex. 4) The video is in military time and shows Petitioner driving the bus from approximately 2:37 P.M. to 3:04 P.M. on the date of the incident. (Pet. Ex. 4, at 14:59:44 through 14:59:52) It depicts Petitioner driving the bus and making a right hand turn. As he makes the clockwise overhand motion of turning the large steering wheel on the bus, he immediately clutches his right elbow, drops his arm to his lap and continues to drive the bus only with his left hand. In prior instances contained within the video, Petitioner appears to rub his right arm or flex his hand. After the incident, Petitioner picks up the phone and radios someone, talking for a period of time. (Pet. Ex. 4 at 15:00:40 through 15:01:01) Petitioner appears to be grimacing as he makes a right turn, while using his right arm to turn the steering wheel. (Pet. Ex. 4 at 15:01:20) Petitioner is seen shaking out and rubbing his hand. (Pet. Ex. 4 at 15:01:23 through 15:02:24) Petitioner is again seen grabbing his arm again after turning (at 15:02:46) before stopping the bus (around 15:03:03) and addressing a person who gets on the bus to whom Petitioner demonstrates what happened while continuing to hold his arm throughout the end of the video.

Petitioner also provided evidence of his prior care and treatment before the incident involved in this case. (Pet. Ex.3). Between September 7, 2009, and September 12, 2018, there is no indication of complaints of neck, right shoulder or right arm pain or discomfort. The last office visit of September 12, 2018, was for FMLA paperwork regarding gout in the right foot. (Pet. Ex. 3, p.62). Review of systems noted normal range of motion in the

musculoskeletal region. There is no mention of any difficulties similar to the symptoms Petitioner describes as having arisen out of the January 10, 2019, accident. Petitioner's last examination was approximately 4 months prior to the accident of January 10, 2019.

OSF Center for Occupational Health notes of January 10, 2019 give a history of Petitioner making a right hand turn while driving his bus when he experienced pain and numbness in his right shoulder extending down to the arm. "It is noted he had been having generalized milder shoulder soreness for a couple of days but nothing of this magnitude." (Pet. Ex. 2). Assessment at this time was right shoulder impingement syndrome with possible biceps tendinopathy as the pain generator. On January 17, 2019, Dr. Moody reviewed an MRI which he reported showing a distal bicep tendon partial low-grade tear. (Pet. Ex. 2). This resulted in a referral to Dr. John Mahoney of Midwest Orthopaedic Center.

On January 22, 2019, Petitioner saw Dr. Mahoney at Midwest Orthopaedic Center. Dr. Mahoney reviewed an MRI of the right elbow and assessed Petitioner as having cervical spondylosis with myelopathy and recommended consult with his colleague. Dr. Mahoney did not think Petitioner's bicep tendon was injured and suggested an MRI and follow up for the cervical spine. On February 11, 2019, Dr. Daniel Mulconrey examined Petitioner upon referral from Dr. Mahoney. Petitioner gave a history of driving a City Link bus and making a turn and a twisting injury to the right upper extremity, causing severe pain in the right bicep as well as the right upper extremity. He reviewed the MRI and noted significant wasting of the right bicep when compared to the left. Following physical examination, x-ray and review of the MRI, he recommended further study including an MRI of the right shoulder and EMG of bilateral upper extremities and continued Petitioner's restrictions. In a follow up exam of March 25, 2019, Dr. Mulconrey noted the minimal findings on MRI of the right shoulder and noted continued severe weakness of the right deltoid, right bicep and triceps muscles. Petitioner had multi-level radiculopathy of the right upper extremity, severe limitations secondary to loss of range of motion, and severe pain and spasm in the right upper extremity. Dr. Mulconrey recommended anterior cervical decompression and fusion at C4-C7 due to his right upper extremity paralysis, severe limitation of activities and daily living, uncontrolled pain, and progressive weakness since the date of the accident. (See, Dep. Ex. 2 to Pet. Ex. 1, Evidence Dep. of Dr. Daniel Mulconrey).

Dr. Daniel Mulconrey testified via evidence deposition November 4, 2019. (Pet. Ex. 1). Dr. Mulconrey is a board certified orthopedic surgeon who practices medicine with the Midwest Orthopaedic Center in Peoria, Illinois. He saw Petitioner on February 11, 2019 and noted Petitioner had spasms in the right biceps but also clear weakness and wasting on the right biceps compared to the left. There was swelling associated with the right elbow, weakened grip on the right compared to the left and biceps weakness on the right compared to the left along with deltoid weakness. He had mild loss of sensation on the right. (Pet. Ex. 1, pgs. 9-10). In reviewing MRI results he felt that level C4-5, 5-6 and 6-7 correlated with the dysfunction Petitioner was having in his upper extremities. (Pet. Ex. 1, pg. 12). His plan was to have an MRI of the right shoulder and an EMG to rule out upper extremity difficulties and he placed Petitioner on a five pound lifting restriction with no driving of a commercial vehicle. (Pet. Ex. 1, pg.13). The EMG showed some denervation of the muscle groups distal in the arm and the MRI was essentially negative for upper extremity problems. (Pet. Ex. 1, pgs. 13-14). He followed up with Petitioner on March 25, 2019, noting Petitioner was unable to return to work due to severe limitations secondary to the loss of range of motion and severe pain and spasm in the right upper extremity. He felt this was related to a work injury. (Pet. Ex. 1, pg. 15). His assessment was a work reported injury, cervical spondylosis with radiculopathy and right upper extremity paralysis. Petitioner was a surgical candidate for anterior cervical decompression and fusion from C4 – C7 due to pain, weakness, chronicity of problem and the

lack of positive findings on other radiographic exams, as well as EMG and evaluation by an upper extremity specialist. (Pet. Ex. 1, pg. 16). As of March 25, 2019, he placed him on a restriction of no lifting greater than five pounds with the right upper extremity and no driving of a commercial vehicle pending surgical approval. (Pet. Ex. 1, pg. 17). That surgery has yet to be scheduled.

Based upon the Petitioner's history that his symptoms became so severe that he was unable to continue at that point, it appeared to Dr. Mulconrey that the Petitioner's cervical spine condition was aggravated by the event to the point of surgery. (Pet. Ex. 1, pgs. 17-18). The doctor noted that prior to the incident, Petitioner was able to do his job despite his pre-existing wasting condition - which was related to an underlying degenerative condition that could occur without symptomology. (Pet. Ex. 1, pg. 19). Dr. Mulconrey explained that Petitioner's cervical condition requiring surgical attention were bulging discs that are compressing the nerve roots and creating the weakness in his right arm. On cross-examination, Dr. Mulconrey testified that Petitioner would have been a surgical candidate notwithstanding his pain complaints based on the findings from the MRI and his degenerative condition. However, he added that it was Petitioner's complaints of pain that led him to seek medical attention, which then resulted in the current recommendation for surgery and the recommendation that he remain off work.

Dr. Stephen F. Weiss testified via evidence deposition on July 16, 2019. (Resp. Ex. 1) Dr. Weiss is a medical doctor with specialization in orthopedic surgery and board certification in orthopedic surgery and arthroscopic surgery. (Resp. Ex. 1, pg. 4). He is licensed to practice in Illinois. (Resp. Ex. 1, pg. 5). Dr. Weiss no longer does surgeries and he stopped treating patients in 2008. (Resp. Ex. 1, pg. 23). He stopped doing anything with the neck probably right before 1990 and anything with the low back in the early 1990's. (Resp. Ex. 1, pg. 23). He does not have a private practice now and he has not done any treating after 2008. (Resp. Ex. 1, pg. 24). He stopped doing surgeries around 2003. (Resp. Ex. 1, pg. 24). His practice is providing opinions such as this case. He would say that 99 percent of the work he does in workers' compensation is for respondents. (Resp. Ex. 1, pgs. 24-25). Dr. Weiss reviewed a number of medical records and also performed an examination under Section 12. He opined that the act of turning the steering wheel while making a right turn on January 10, 2019 was not a causative factor in the Petitioner's problems and the need for surgery. (Resp. Ex. 1, pg. 12). The act of turning the steering wheel absent any mechanical malfunction was not sufficient to aggravate the cervical degenerative disc disease, cervical stenosis or radiculopathy. He believed there was clear evidence of atrophy as confirmed by the video that showed Petitioner having problems with his right arm prior to the incident of turning the steering wheel and showed him rubbing the arm, flexing the fingers of his hand and having generalized difficulty with the hand. (Resp. Ex.1, pgs.13 -14). On cross-examination Dr. Weiss stated the video shows Petitioner making a right hand turn in a movement that is called "circumduction." When he does this circumduction maneuver he drops his arm a bit more and its more pronounced. (Resp. Ex. 1, pg. 18-19). Dr. Weiss explained that when Petitioner was turning the steering wheel, he was circumducting his arm at least twice, which was beyond Petitioner's capabilities given his existing condition. (Resp. Ex. 1, pg. 19) Notwithstanding his opinion on causation, Dr. Weiss believed the Petitioner was a surgical candidate.

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, the video evidence, and the preponderance of the medical evidence that all show that Petitioner was steering a bus when he experienced pain radiating from his neck down into his right arm. Although both the Petitioner and the medical evidence

show that the Petitioner had a pre-existing, degenerative condition, Petitioner credibly testified that he had never experienced such pain prior to his described incident. The video evidence shows that Petitioner was operating a steering wheel that is much larger than the steering wheel of an average automobile and thus exposed to a risk of injury incidental to his job as a bus driver. A risk is incidental to one's employment when it belongs to or is connected with what the employee has to do in fulfilling his duties. Sisbro, Inc., v. Industrial Commission, 207 Ill. 2d. 193, 797 N.E. 2d. 665 (2003). In this case, the Petitioner's act of turning a much larger steering wheel or "circumducting" his arm rose to the level of a work accident. Accordingly, the Arbitrator concludes that the Petitioner sustained an accident while working for the Respondent on January 10, 2019.

2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and a preponderance of the medical evidence, which show that the Petitioner had a pre-existing, degenerative cervical condition that was clearly aggravated by his January 10, 2019 work accident. Specifically, the Arbitrator finds persuasive the opinions of Dr. Mulconrey on this issue. "[A]n accident need only be *a* cause of a condition of ill-being for a claimant to recover under the Act... [W]here an accident accelerates the need for surgery the claimant may recover under the Act." Schroeder v. Illinois Workers' Comp. Comm'n, 2017 IL App.(4th) 160192 WC (May 31, 2017). In this case, there is no dispute that the Petitioner had a pre-existing degenerative cervical condition that arguably could have required surgical attention notwithstanding the Petitioner's accident in question. However, the evidence shows that Petitioner was able to work full duty prior to the accident. There was no evidence that Petitioner had prior complaints of radiating pain similar to his current complaints. Nor was there evidence indicating a medical recommendation for surgery prior to the accident. The evidence shows that after the January 10, 2019 accident, Petitioner's pain symptoms increased to the point he could no longer perform his job and would require surgical intervention. Based on the evidence, it is clear that the Petitioner's January 10, 2019 work accident was a cause in the increase of the Petitioner's pain symptoms and accelerated his need for surgery. Accordingly, the Arbitrator concludes that the Petitioner's current condition of ill-being is causally related to his January 10, 2019 work accident.

3. Consistent with the Arbitrator's conclusions regarding the issues of accident and causation, the Arbitrator further finds that the Petitioner's medical treatment as set forth in the evidence have been reasonable and necessary in addressing his conditions stemming from his work-related accident. Respondent's IME, Dr. Weiss opined that Petitioner's treatment has been reasonable and necessary in addressing his condition. Accordingly, Respondent shall pay any and all related medical expenses subject to the medical fee schedule.

4. Based on the findings above, the Arbitrator further finds that the Petitioner's request for prospective medical care is both reasonable and necessary in addressing his work-related condition stemming from his January 10, 2019 work accident. Both Dr. Mulconrey and Dr. Weiss are in agreement that surgery is reasonable and necessary to address Petitioner's current condition. Therefore, Respondent shall authorize and pay for the prospective medical care recommended by Dr. Mulconrey, including but not limited to the proposed surgery to Petitioner's cervical spine.

5. Consistent with the findings above, the Arbitrator further finds that the Petitioner was temporarily totally disabled from May 16, 2019 through present. The dispute on this issue is based on the question of causation and having found in favor of the Petitioner on this question, the Arbitrator awards the Petitioner TTD benefits from May 16, 2019, through the date of arbitration in the amount of $671.00 per week, for a period totaling 30 5/7 weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathryn Westbrook,

Petitioner,

vs. NO: 18 WC 14824

Gilster-Mary Lee Corp.,

20 I W C C 0 5 0 6

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, notice, causation, temporary total disability, medical expenses and prospective medical treatment, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Kathryn Westbrook (hereinafter "Petitioner"), a 50-year old line worker, testified that she is currently employed as a line worker at Gilster-Mary Lee (hereinafter "Respondent"). (T.7). She noted that she has worked for Respondent for a little over five years, and that she has held the same position and performed similar duties the entire time she has been so employed. (T.8). She indicated that she is right-hand dominant and that she performs the more strenuous job duties with her right arm/hand. (T.8).

She indicated that prior to October of 2017 she had not had any medical treatment for her right shoulder, including surgeries, and that she had never been diagnosed with any structural damage to her right shoulder. (T.9). She also noted that she had never undergone an MRI on her right shoulder prior to October of 2017. (T.9). She stated that in September/October 2017 "[w]e were on 8-hour shifts, and then we went to 12-hour shifts." (T.10). She also noted that most of the time she worked 40-49 hours a week, but sometimes 60 hours a week. (T.10).

Petitioner agreed she works on a marshmallow production line. (T.10-11). When asked to explain her job with respect to the stacking of marshmallows, she testified that "… it comes off the line. You take the marshmallows out of the bowl, put it in a box, then you push the box through. It puts a code on it, and then you stack them however it be, 3, 3, 4, and then you reverse it, the other side it would be 4, 4, 3, until you have three stacks, unless you do the regular or jumbos, then it's six high, and then you jack it up and take it out, and then you start all over again." (T.11). She agreed that the marshmallows are already packaged and that they fall off the line into a bowl. (T.11-12). She stated that she would grab them "[f]our, two in each hand" and place them in a box. (T.12). She noted that the little package weighs 10 ounces and that you put 24 in a box. (T.13). She also testified that the 16 ounce go 12 in a box and are stacked 6 high. (T.13). She indicated that the box then gets taped and goes to the end of the line to be placed on a blue skid. (T.13). She noted that 30 of the 24-packs go on a skid while it's 36 for the 16-ounce. (T.13). She agreed that she then is required to operate a hand jack, noting that "[y]ou push the jack in, you jack it up, and then you take it out to the other side since it's on hold side, it goes beyond the yellow pylons that they have, and then you put it down, and then the dock takes it." (T.14). She indicated that she is manipulating "[m]aybe 10, 15 pounds" while operating the hand jack. (T.14). She agreed that this was just one of her primary duties. (T.14-15).

Petitioner noted she is also charged with "catching" marshmallows "… when you have to change the paper or there is [*sic*] problems with the Teflons or there is [*sic*] holes in the bag." (T.15). She stated the line shuts down sometimes more than twice a day. (T.15). When asked to explain what catching marshmallows entails, she noted: "You have a table and a bucket, a white bucket with a bag. You put the bag in the bucket. Then you pull up on a lever, and all the marsh-mallows will start coming down, and you catch them. When the bucket is full, you reach back up and pull the lever back down, tie off the marshmallows, pull them out of the bag and put them in a white tote… And then you proceed to start all over until the line starts back up." (T.15-16).

Petitioner agreed that in catching marshmallows she would reach up to pull a lever with her right hand, or at least she used to. (T.16-17). She noted that she stands maybe 5'3" and that she has to "stand on my tippy toes" to reach the lever. (T.17). She indicated the marshmallows are not in a bag at that time, and that once the bag is full she has to reach up to shut it down. (T.17). She agreed that this happens basically every day that she's working. (T.17). With respect to the pallet jack, Petitioner noted that it's easy to move "… as long as there's not marshmallows on it", and when there are marshmallows on it "[i]t's harder to move because the marshmallows get around the wheels of the jack, and then it's hard to push" because it's sticky. (T.18). She noted that she performs these activities all day and that the line is fast paced, noting that "… it's a factory. It just keeps coming until the end of the day." (T.18-19). She agreed that there are different sized marshmallows, from little to jumbo. (T.19).

She agreed that once the bag is full she is required to lift it out of the container. (T.19-20). She noted that before the accident she would do so using her right arm. (T.20). She indicated that the weight of the bag varies, but that it could be up to 20, 25 pounds. (T.20). She also agreed that she would have to hold down the container that the bag was in in order to pull it out with her right arm. (T.20).

20 I W CC0506

Petitioner agreed that she was seen in the ER on or about 10/4[/17] complaining of chest pain. (T.20-21). She agreed that she also complained of right shoulder pain at that time, and that she was told that there really was nothing seriously abnormal with her heart. (T.21).

Petitioner agreed that she followed up with her primary care physician, Dr. Molnar, on or about 10/6[/17] at which time she was having right shoulder pain. (T.21). She indicated that Dr. Molnar eventually recommended an MRI of her right shoulder. (T.21). She stated that she would not disagree with the records if they show this study took place on 12/8/17. (T.22). She noted that the MRI showed that she had "… a rotator cup [*sic*] tear." (T.22). She agreed that this was the first time she thought she might actually have a work-related injury, noting that she "… thought I had just pulled a muscle." (T.22-23).

Petitioner was shown a Gilster-Mary Lee Accident/Incident Report that she signed and which was dated 12/12/17. (T.23). She noted she was working full-duty from 10/6/17 to around 12/12/17. (T.23-24). She agreed she basically just worked through her right shoulder pain. (T.24).

Petitioner recalled seeing Dr. Christopher Rothrock on or about 1/29/18 at the request of her employer. (T.24). She agreed that Dr. Rothrock ordered a second MRI of her right shoulder, and that this took place on 2/5/18. (T.25).

Petitioner agreed that she was eventually referred to orthopedic surgeon Dr. J.T. Davis. (T.25). She noted that she underwent physical therapy in November [2017] in order to have the first MRI done. (T.25). She agreed that Dr. Davis ultimately operated on her right shoulder in March of 2018. (T.25-26). She also agreed that Dr. Davis kept her off work following surgery from March to June of 2018 whereupon he released her to light-duty work. (T.26). She indicated that she is still working light duty. (T.26). She noted that she also underwent physical therapy following surgery, and that she believed the surgery helped to alleviate some of the immediate pain she was having. (T.26). She indicated that Dr. Davis's current recommendations include trying to "… work my muscles more, so I try to pack a little bit more every day, but to pick up a case and stack it in a box, I can't do it." (T.26-27). She stated that he has not released her from treatment and that "[h]e doesn't want me to lift over 2 or 3 pounds." (T.27). She agreed that she is willing and able and ready to follow the recommendations of Dr. Davis as far as treatment is concerned. (T.27).

On cross examination, Petitioner agreed that the symptoms in her right shoulder began in early October of 2017, and that on 10/6/17 she told Dr. Molnar that she was sitting at work talking to a boss when she started having some numbness in her arm. (T.28). When asked whether she was attributing that to her work activities, Petitioner replied: "I thought it was weird that I started going numb in my right shoulder… I thought I might have strained it at work doing too much." (T.29). She indicated that it was a different type of shoulder numbness than when she went to the ER for chest pains. (T.29).

When asked whether she told Dr. Rothrock in January of 2018 that she did not have a sudden onset of pain like from falling down or from one particular incident, she stated: "No, because I never fell down." (T.29). She agreed that it was not one particular incident, noting that

"… it was continuous pain." (T.30). She agreed that the last time she saw Dr. Davis was in May of 2019. (T.30). When asked whether she has another appointment scheduled, she noted: "I'm waiting for them because they want to do another MRI on my right shoulder, and I have to have it approved through my insurance." (T.30).

Petitioner agreed that when she fills the boxes with bags of marshmallows, she pushes them down a roller line and that when they get to the end of the line they are placed onto a pallet. (T.30). She noted that "[i]f I'm not packing, somebody else has to" and that "[i]t's 30 minutes packing, and then when you're done, the other person takes your spot, and then you're supposed to do 30 minutes of stacking." (T.31). She indicated that those boxes are stacked three high, and that the 10-ounce minis are 30 on a skid and packed three high. (T.31). However, she was not really sure how tall a case was. (T.31). She also noted that she is allowed two 15-minute breaks and a 30-minute lunch break during a given shift. (T.32).

Testimony of Steve Landholt

Mr. Landholt testified that he is the supervisor of the workers' comp department for Respondent. (T.33). He noted that he has held that position since March of 1980. (T.33-34). He indicated that every injury report is sent to his office and that their job is to gather all the facts for preparation of a First Report of Injury to be submitted to the third-party administrators. (T.34). He stated that "[t]he process actually begins at the plant level. The employee [i]s instructed to notify their supervisor of an injury immediately. And the supervisor then completes an injury report, and then it gets submitted through the safety supervisor back to our office." (T.35). He noted that this is spelled out in the employee handbook, which all employees receive and have to sign for, and explained during orientation. (T. 36).

Mr. Landholt noted that he reviewed Petitioner's work comp file, including the Accident/Incident report admitted at PX1 & RX6. (T.36-37). He noted that the report was dated 12/12/17 for an alleged injury on 10/6/17. (T.37). He indicated that was the date (12/12/17) that the incident was reported at the plant and forwarded to his office. (T.37). When asked if he was aware of anyone in the plant receiving notice prior to that date, he replied: "No, no one had prior notice." (T.37). He also indicated that based on the attendance records that he reviewed (admitted at RX6) "[o]ther than a noted date of illness on October the 4th, [2017] it appears that she worked…" (T.38). He noted that he was aware that Petitioner returned to work in June 2018 on restrictions and that "[t]he plant's been able to meet their restrictions." (T.39).

On cross examination, Mr. Landholt agreed that as work comp coordinator he would be on the management side at Gilsters. (T.40). He also agreed that he reviewed Petitioner's report once she filed it and was able to fully investigate her claim. (T.40-41). He likewise agreed that an IME was scheduled. (T.41). He believed that Petitioner was working the entire time leading up to March of 2018, "… other than whatever day she may have missed on the attendance record for other reasons potentially." (T.41).

When asked if, generally speaking, someone has to notify their supervisor or someone if they are going to take off for medical treatment, Mr. Landholt stated: "If they're going to be absent, yes, they're supposed to call in every day if they're going to be absent from work for

whatever reason, provide some kind of an excuse." (T.42). He indicated that while he would have to look at the attendance chart again to make sure, he was not aware of any write-up for Petitioner between October and December for no call, no show or not letting her supervisor know she was going to be out for something. (T.42-43).

Medical Records

In a Chester Memorial Hospital "ER Physician Documentation" record dated 10/4/17, it was noted that the patient presented "... with a chief complaint of sudden onset sharp pain in lower sternal and epigastric area in the last thirty minutes. Pain is currently scored 9/10, nonradiating, started when she rose form [sic] bed, increases with physical exertion. She has associated shortness of breath, tingling sensation in right arm, but no nausea and no diaphoresis. She experienced similar symptoms in the past but in lesser intensity..." (RX5). In the Review of Systems section of the report, it was noted that the patient "[d]enies: joint pain, joint swelling, muscle pain, back pain, neck pain, upper extremity pain, lower extremity pain, hip pain." (RX5). Upon physical examination, it was noted that her extremities were "non-tender, normal range of motion, normal inspection, normal capillary refill, no calf tenderness, no pedal edema." (RX5). Petitioner received a GI cocktail and MS04 4 mg IV with complete relief of pain, and was discharged after EKG and cardiac enzymes were found to be within normal limits. (RX5).

In a Chester Clinic office note dated 10/6/17 Dr. Joseph Molnar recorded a chief complaint of "tingling in arm, sharp pains in chest" along with the following history: "the patient is seen in follow up. [She] [r]eports that she was in the [ER] earlier this week with chest pain. [S]he was in the er, felt to be gi, given gi cocktail, with bneefit [*sic*] of symptoms. [S]he reports that she has some 'tightness in her chest', without exacerbation or alleviating factors. [S]he reports laying down has no effect. [S]he reports it is non exertional. ***[S]he reports right arm numbness. [S]he reports that she was sitting at work, talking to a boss, and started having arm numbness. [S]he reports that those symptoms have been worsening, and is numb all the time now. [S]he reports no exacerbating or alleviating factors with her arm numbness.*** " (Emphasis added) (PX2). Upon examination exquisite tenderness over the bicipital groove of the right arm was noted as well as negative Tinels at the wrist and elbow. (PX2). The assessment was arm paresthesia and biceps tendonitis. (PX2).

In a follow up office note dated 10/23/17, Dr. Molnar recorded that Petitioner's "... chest pains and heartburn is improved. [S]he has ongoing numbness and tingling in her right arm. [S]he was given prednisone, with limited benefit. ***[S]he reports that she gets numbness in the right arm, extending from the shoulder down. [S]he reports that she has been working a lot.*** " (Emphasis added) (PX2). The assessment was arm paresthesia and biceps tendonitis, along with unspecified abdominal pain. (PX2). An MRA of the shoulder was ordered and the patient was referred to physical therapy. (PX2).

A Chester Memorial Hospital Physical Therapy Department report dated 10/30/17 recorded that the "[p]atient presents to therapy with c/o right UE pain from UT to hand as well as N/T into hand. ***No known cause for onset stating she woke up with the pain one morning.*** " (Emphasis added) (PX3). Petitioner attended therapy sessions on 10/31/17, 11/10/17, 11/16/17, 11/17/17 and 11/22/17. (PX3).

In a Chester Memorial Hospital "ER Physician Documentation" record by Dr. Stephen Platt dated 11/30/17 it was noted that the "[p]atient is a 50 year-old F with a chief complaint of right shoulder pain with numbness that extends down the right upper extremity and a tingling sensation in her right hand. The patient was seen in the emergency room October 4 for a chest discomfort complaint that was evaluated as noncardiac and subsequent cardiac stress test demonstrated no vertebral ischemia. An element of right shoulder discomfort was present at that time. The patient followed up with an appointment with Dr. Molnar on October 6 where her right shoulder discomfort was the primary concern. The patient's discomfort did not resolve with oral steroids and a followup visit October 23 [2017] prompted recommendations for an MRA of her shoulder that was refused by insurance coverage. Physical therapy was recommended and an x-ray of the right shoulder ordered but was not completed. The patient has been attending physical therapy without benefit." (PX3). This history goes on to state that "***[t]he patient notes no right shoulder problems prior to early October and no injury in her past or present to explain her discomfort.*** She notes pain at the glenohumeral joint with surround[ing] discomfort in the trapezius and deltoid to range of motion or palpation. She denies crepitation but has remarkably limited range of motion both actively and passively. Additional complaints are that of numbing and tingling paresthesias that extend down the extremity including her hand." (Emphasis added) (PX3). It was also noted that x-rays were negative and that "Pt shows clinical signs of Biceps tendontis [*sic*] and Deltoid bursitis of the right shoulder. No true rotator cuff signs on today's exam." (PX3).

In a follow up office note dated 12/4/17, Dr. Molnar recorded that the patient "... reports that she has ongoing pain and numbness in her arm. [S]he rpeorts [*sic*] that she has been going to pt, without benefit. [S]he had xrays of the shoulder, that were unremarkable. [S]he reports that her whole arm is still going numb, escpecially [*sic*] when she moves her shoulder backwards. [S]he reports that she feels that it is worse now compaired [*sic*] to starting pt." (PX2). The assessment was right arm paresthesia and right shoulder pain. (PX2). It was noted that "the patient needs a[n] mri of the shoulder, has failed conservative measures including rest, watchful waiting, and pt. [S]he has had xrays that were unremarkable. [An] mra is necessary. [I]f mra does not show etiology, then emg/ncv should be considered." (PX2).

An MRI of the right shoulder performed on 12/8/17 was interpreted as follows: "suspicious for a small full thickness tear through the distal anterior supraspinatus tendon, best seen on the coronal fat sat. Mild amount of bursal fluid. Mild degenerative change at the AC joint." (PX2).

In a Chester Memorial Hospital "ER Physician Documentation" record by Dr. Sangoseni dated 12/8/17 it was noted Petitioner presented with "... a chief complaint of chronic pain right shoulder with a flare up today [a] few hours ago. She has not taken prescribed pain medication because she has to be at work and had a scheduled MRI study of right shoulder. She denies recent fall or injury to the joint, also denies chest pain and difficulty with breathing." (PX3).

A Gilster-Mary Lee Corp. "Accident/Incident Report" dated 12/12/17, signed by Petitioner, her supervisor and the safety representative, shows a date of accident of 10/6/17 at 9:30 am and describes the incident as ***"[p]acking marshmallow[s] and shoulder started hurting."*** (Emphasis added) (RX6). When asked why the accident occurred, it was noted

"[p]acking & [r]epetitive motion." (RX6).

In a "Workers Compensation – First Report or Injury or Illness" dated 1/2/18, Respondent's Sally Crowder recorded a date of injury of 10/6/17 and a date the employer was notified of the injury of 12/12/17. (RX4). Ms. Crowder also described the injury as "[p]acking marshmallow[s] and right shoulder started hurting." (RX4).

In a Chester Memorial Hospital "ER Physician Documentation" record by Dr. Michael Miller dated 1/29/18 it was noted that Petitioner presented with "… a chief complaint of ***right deltoid muscle pain for the last 4-5 months, ever since she thinks that she hurt it at work, but cannot recall a specific instance at which time the injury may have occured [sic].*" (Emphasis added) (PX3). Petitioner was diagnosed with a right deltoid muscle strain. (PX3).

An MRI of the right shoulder performed on 2/5/18 was interpreted as revealing the following: 1) moderate to severe supraspinatus and moderate infraspinatus and subscapularis tendinopathy of the right shoulder with high-grade partial-thickness and full-thickness insertional tearing of the supraspinatus tendon spanning 1.1 cm in width as well as thin partial-thickness undersurface tearing of the infraspinatus tendon and no muscle atrophy; 2) tear of the superior labrum involving the undersurface of the bicipital labral anchor and extending posteriorly to the 10 o'clock position; and 3) mild acromioclavicular osteoarthritis. (PX2).

In an office note dated 2/7/18, Dr. Molnar recorded that the patient "… has been having ongoing shoulder pain. [S]he has been seeing workman's comp doctor in [D]es [P]eres hospital. [S]he had a most recent mri showing labral tear and supraspinatus tear. [S]he needs referral to ortho." (PX2). Under assessment, it was noted that "the patient has ongoing issues with her shoulder, and has been progressive. [W]e will refer to orhto [*sic*] down in [C]arbondale. [S]he is given work restrictions including no use of right arm. [S]he reports that she has severe pain in her shoulder, and will be given norco." (PX2).

In an Orthopaedic Institute of Southern Illinois office note dated 2/22/18, physician assistant Jeremy Palmer recorded that the patient "… presents with complaints of right shoulder pain. States that she began having pain on 10/05/2017 at work. She works at Gilster-Mary Lee and does repetitive work in packaging. She is having persistent pain. She was evaluated by a St. Louis area orthopedist who did not feel she sustained a traumatic injury… Her pain is currently at 8 on a pain scale of 0-10, achy in nature over the anterolateral shoulder. She does get some occasional numbness in the shoulder, but nothing radiating down, no radicular pain and no distal paresthesias. Her pain is achy predominantly in nature, worse with any kind of repetitive use, lifting, pushing, pulling, and reaching behind back. She has been on light duties at work, not using the arm. She had no preceding complaints before her injury and has only been through some formal physical therapy since the injury, no injections. She did have an MRI followed by an MR arthrogram and is here today for orthopedic evaluation." (Davis Dep.[PX4], Group Ex.2).

Following his examination and review of the MR arthrogram, Mr. Palmer's assessment was "… right shoulder traumatic full thickness rotator cuff tear, subacromial impingement, long head of biceps tendinopathy and SLAP tear." (Id.). Surgery was discussed and it was noted that "[a]t this point she is interested in having this repaired. I did outline with her today shoulder

20IWCC0506

arthroscopy with rotator cuff repair, subacromial decompression, labral debridement and biceps tenotomy." (Id.). This report was later electronically signed by Dr. John T. Davis on 2/28/18. (Id.).

In an operative report dated 3/13/18 it was noted that Dr. Davis performed the following procedures: 1) right shoulder arthroscopic rotator cuff repair, 2) right shoulder arthroscopic biceps tenotomy, and 3) right shoulder arthroscopic extensive debridement of residual biceps tendon stump, degenerative superior labral tearing and SLAP tearing, and subacromial and subdeltoid adhesions, as well as extensive debridement of partial-thickness subscarpularis tendon tearing. (Davis Dep.[PX4], Group Ex.2). The postoperative diagnosis was 1) right shoulder traumatic rotator cuff tear, 2) right shoulder subacromial bursitis and adhesions, and 3) right shoulder degenerative SLAP tear. (Id.).

Petitioner returned to the Orthopaedic Institute of Southern Illinois in follow up on 3/28/18 and 5/9/18, at which time physical therapy was prescribed. (Davis Dep.[PX4], Group Ex.2).

In an Orthopaedic Institute of Southern Illinois office note dated 9/19/18, physician assistant Mr. Palmer recorded that the patient "... says she is doing a little better with the shoulder, still achy and sore and some stiffness, but she is progressing. She recently had a cardiac stent placed for an 80% blockage she states though. She is recovering from that well. No new concerns today with the exception of her work status and intolerance to any repetitive lifting or heavy work. Unable to do overhead work either." (PX5). The assessment was "[s]lowly improving right shoulder aches and pains and stiffness following rotator cuff repair and biceps tenotomy done on 03/13/2018 in a diabetic with recent cardiac stenting." (PX5). Mr. Palmer noted that "[a]t this point in time, we are going to continue with conservative treatment... We will consider [a corticosteroid injection] in the coming months if she is doing well from the medical perspective [i.e. controlling blood sugars and post cardiac stent]. Otherwise, we did discuss the expectation for her shoulder to continue to improve with persistent home exercises, which she needs to continue with. Continue with protective body mechanics and her current work restrictions. She should not work longer than an 8 hour day in addition to the restrictions she has been on." (PX5). This note was electronically signed by Dr. Davis on 11/6/18.

In an office note dated 11/20/18, physician assistant Mr. Palmer recorded that the patient "... is progressing with her motion and strength, but still lacking some endurance and tolerance of work type activities. She cannot do repetitive activities for very long and is unable to do heavy lifting yet. No new concerns otherwise." (PX5). Mr. Palmer recommended that she "... continue to work on a regular home exercise program and protective body mechanics. She is not able to tolerate her full 12 hour work shift that would be normal for them, so we are going to have her continue on protective activities at work and we will see her back in 2 months to check on her progress. If she is doing well at that point in time then we discuss giving her a full release." (PX5).

In an Orthopaedic Institute of Southern Illinois "Work Status and Restrictions" note dated 1/22/19, Dr. Davis indicated that Petitioner was seen in the office on that day and could "[c]ontinue current restrictions." (PX5).

In an office note dated 5/8/19, Dr. Davis recorded that the patient had persistent complaints of pain following surgery on 3/13/18. (PX5). Dr. Davis concluded that "[w]ith her persistent pain, we are going to obtain an MRI scan. If, in fact, there is a full tear healing from the repair site, then we will discuss MMI with or without FCE." (PX5). In a separate "Work Status and Restrictions" note dated 5/8/19, Dr. Davis continued Petitioner on light duty restrictions. (PX5).

Testimony of Dr. J.T. Davis (8/13/18)

Board certified orthopedic surgeon Dr. Davis testified that he focuses his surgical practice to arthroscopic procedures of the shoulder, elbow and knee. (PX4, pp.4-5). He noted that Petitioner first presented to him for medical treatment on 2/22/18, at which time she presented "… with complaints of right shoulder pain, says that she works at Gilster-Mary Lee doing packaging, having pain relative to that and was here for evaluation." (PX4, p.7). Following his examination, and review of x-rays and an MRI scan, Dr. Davis diagnosed "… a right shoulder full thickness rotator cuff tear with impingement, a SLAP tear, and a long head of the biceps tendinopathy." (PX4, pp.7-10).

Dr. Davis subsequently performed surgery on 3/13/18 in the form of a rotator cuff repair, a biceps tenotomy or release of the tendon and a debridement. (PX4, pp.10-11). Petitioner was authorized off work following surgery and underwent physical therapy. (PX4, pp.13-14). He noted that at her most recent visit "[s]he reported she was improving, still had some tightness and aches and pains, by [*sic*] overall was happy with her progress. At that time her physical exam showed some improvement in motion relative to her last visit, improvement in strength relative to her last visit, obviously not normal as of yet. The plan was to continue with the therapy, follow up and see her in the coming months, continue to monitor her progress as she continued to heal." (PX4, p.15). He agreed that generally speaking she was improving as he would probably expect postoperatively. (PX4, p.15).

Dr. Davis believed that the treatment he provided was reasonable and necessary in light of his diagnosis "[b]ased on the history she provided, physical exam findings, and the enhanced imaging, as well as the arthroscopic findings at the time of surgery." (PX4, p.16).

When asked whether he believed the condition for which he rendered treatment was causally connected to an alleged work injury on or about 10/6/17, Dr. Davis responded: "My answer based completely on the history provided to me by the patient is, yes, her work was the reason for her to seek treatment and have the care that we provided." (PX4, pp.16-17). He indicated that to his knowledge he did not have any prior medical records to review during the course of his treatment. (PX4, p.17). He also agreed that it was his understanding that Petitioner worked at Gilster-Mary Lee and did repetitive work in packaging. (PX4, p.17). He indicated that the findings he made during the arthroscopic surgical procedure could have been brought on by repetitive trauma. (PX4, p.17). However, he noted that "… it's really not possible even with the arthroscopic direct visualization to differentiate acute traumatic ruptures from other more long-term problems that may have been more repetitive in nature." (PX4, p.18). He stated that "[w]ithout having basically two looks at it, one before an incident and one after an incident relative to either arthroscopically seeing it before an injury after the injury or enhanced imaging

with an MRI before and after, ... it would be near impossible to differentiate acute traumatic versus something more repetitive in nature." (PX4, pp.18-19).

Dr. Davis testified that "[w]hen a patient comes in and says I was injured at work, I wasn't having problems before and after my work I had shoulder problems that required treatment, that's what I base my medical opinion on." (PX4, pp.19-20).

On cross examination, Dr. Davis acknowledged that he has not seen the records of Chester Clinic or Dr. Molnar, Chester Memorial Hospital, Chester Hospital Physical Therapy or Dr. Rothrock. (PX4, pp.21-22). He indicated that he reviewed the MR arthrogram from 2018 but did not have a record of seeing the MRI from 2017. (PX4, p.22). He noted that he used the word "traumatic" in his operative report to describe the rotator cuff tear because "... with the ICD-10 coding you have to designate traumatic versus nontraumatic. And when we have patients come in with injuries related to work and/or falls then that's a designation we use." (PX4, pp.22-23). It was also his understanding that the rotator cuff was the one that had to be designated traumatic or nontraumatic. (PX4, p.23).

Dr. Davis conceded that he could not say whether or not Petitioner had an acute traumatic injury or whether she had a repetitive trauma-based injury based on the objective evidence. (PX4, p.24). When asked whether he would expect someone with a traumatic tear to have pain immediately after the event, Dr. Davis stated: "It's highly variable... It can be an immediate can't use the arm to I didn't have a problem until, you know, later and then my shoulder started getting sore and then I started getting weak." (PX4, p.24).

When asked what part of her history he based his opinion on, Dr. Davis replied: "The one she provided in clinic that indicated her symptom presentation began relative to her work." (PX4, pp.24-25). He noted that "I think she indicated that on October 5th, 2017, in my note, she began having pain while working at Gilster-Mary Lee. I don't have on record if your question is the specific one time incident other than just that specific one time date when she noted her pain began while at work." (PX4, p.25). He went on to state that "[i]f you're asking is there a specific activity that she described that indicated why her pain began on October 5th of 2017, I don't have that recorded in my notes." (PX4, p.26). He agreed that people with traumatic or repetitive trauma rotator cuff tears can just have sudden onset of pain for any reason or no reason and all of a sudden it starts hurting. (PX4, pp.26-27). However, he stated that "... I don't know if it means that nothing triggered it, I think it may mean that they didn't recognize what triggered it. In my head just using common sense to go from no symptoms to symptoms something has to trigger it." (PX4, p.27).

When asked if he would expect to see symptoms of repetitive trauma develop over a long period of time or all of a sudden, Dr. Davis stated: "I think either or. If you have an incident let's say where the tendon attachment, which is a centimeter thick, is holding on by a thread and you have an event or a movement or an activity that takes that final thread off, that might be the straw that broke the camel's back and triggered everything. It is – there's no way to define it." (PX4, pp.27-28). When asked if Petitioner described such an event, Dr. Davis replied: "No, just what I've indicated in my note and we've reviewed, that's the only information I have." (PX4, p.28). He agreed that he did not have any recorded history of Petitioner describing exactly what she

was doing while she was at work and the pain started. (PX4, p.28).

When asked whether it was his understanding that Petitioner had a sudden onset of pain while working on 10/5/17, Dr. Davis testified: "The only thing I can state there is that she indicated she began having pain on the specific date of 10/5 of '17 while at work, beyond that I don't have any additional information." (PX4, p.28). He noted that "... I don't have any of the specifics of the work activities on that day reported in my history, if that answers your question." (PX4, p.29). When asked if she gave him any type of job detail or information regarding her actual job duties, other than telling him she performed repetitive work, Dr. Davis responded: "I don't have any of that documented." (PX4, p.29). He also agreed that he did not look at a job description, and that he did not know how much weight, if any, she was required to lift at work or the frequency with which she performed her various job tasks during an average shift. (PX4, pp.29-30).

Dr. Davis agreed that there is no way to date pathology on an MRI unless you have a previous MRI to compare it to; thus, he could not tell based on either of the MRIs in this case exactly when the tear occurred. (PX4, pp.30-31).

When asked if it would affect his causation opinion if Petitioner told Dr. Rothrock that she was at home on the evening of 10/5 or 10/6 when she woke with right arm paraesthesia, and that she told the physical therapist on 10/30/17 that she had no known cause and woke up with pain one morning, Dr. Davis stated: "Yes, the patient had – prior to that had told me that her pain began while working and if you're telling me that she says her pain did not occur while working, then that would alter my opinion." (PX4, pp.31-32). He explained that "[t]he patient provided a history to me indicating that her pain began while at work and doing her work activities, therefore, I relate it to work. If her pain began not related to her work, then I would not relate it to her work." (PX4, p.32).

When asked if it would change his opinion if Petitioner told Dr. Molnar that she started having arm numbness while sitting down talking to her boss, Dr. Davis testified: "Well, arm numbness is different than shoulder pain so we have to be careful that we're describing the same pathology. Again, if her symptoms began while at work and the patient wasn't having symptoms prior to work, that's what I would relate it to." (PX4, p.33). He also indicated that "typically speaking" he would not relate symptoms of just numbness to a rotator cuff tear or a shoulder injury, but he noted that "... other providers elicited those response[s] ... [so] sometimes you're not talking apples to apples." (PX4, pp.33-34). However, he indicated that arm numbness "... is not a typical complaint for our description of rotator cuff pain. It's usually achy, tooth ache, sometimes sharp pain that's based on the outside part of the shoulder, usually doesn't radiate down below the elbow... Certainly there's variability patient to patient, but there's some commonality there as well." (PX4, pp.34-35). He stated that "[t]ypically patients will report side shoulder pain, or side arm pain rather than pain that radiates down below the elbow. That often is more indicative of nerve discomfort than shoulder pain." (PX4, p.35).

Dr. Davis noted that as of Petitioner's last visit on 7/18/18 "[s]he was progressing as anticipated at that time, had not reached maximum recovery as of yet." (PX4, p.35). He also noted that her range of motion had improved relative to her last visit and that she was scheduled

to return within a couple of months of that visit. (PX4, pp.35-36).

On re-direct examination, Dr. Davis indicated that it does not change his opinion in any way if it happened on 10/5 or 10/6. (PX4, p.36). He also agreed that he does not expect his patients to be dead on specific as far as where their pain is coming from or what their symptoms are, noting that "... our job as care providers are to elicit history, and perform a physical exam, review any diagnostic imaging studies available, and then render a diagnosis and treatment plan." (PX4, p.37). He likewise agreed that, with respect to the reference to sitting down with her boss and noticing the pain in her right shoulder, it could have been related to the work she had just done before she sat down. (PX4, p.37). He also indicated that based on the patient's history provided to him he still believed it was more likely than not that this injury occurred at work as indicated. (PX4, p.38).

On re-cross examination, Dr. Davis agreed that he relies on patients to provide him with a description of what kind of symptoms they're having and where they're having them, noting that "... that's part of the history taking process." (PX4, p.39). He indicated that "... it is an asked and an answer and a listening process." (PX4, p.39). He noted that it was standard practice to question patients as to where their pain is and perhaps use a pain diagram. (PX4, pp.39-40). He stated that he did not have a specific recollection as to whether he was in the room when the exam was performed or whether his PA did it; however, he noted that his PA "... is A plus and I'd trust them with my mother were she still alive." (PX4, pp.39-40).

Testimony of Dr. Christopher Rothrock (9/25/18)

Board-certified orthopedic surgeon Dr. Rothrock testified that he examined Petitioner on two occasions – 1/29/18 and 2/5/18. (RX1, pp.4-6). He noted that he also reviewed the medical records and personally reviewed MRI films from 12/8/17 and 2/5/18. (RX1, pp.6-7). He also noted that he recorded a history wherein "... she basically told me that she worked during her normal workday on October 6, 2017, and throughout that workday she denied any significant trauma or heavy lifting or any sudden onset of pain within her shoulder as a result of her regular work duties. She then reported to me that she woke during the evening hours at home with right arm paresthesias and then she was seen and evaluated in the Memorial Hospital emergency room." (RX1, pp.8-9). He also indicated that it does not matter to him if the alleged date of injury was 10/5 or 10/6, noting that "[h]er story is more important than the date to me... unless something traumatically happened October 5th or something happened in substance on that day, that would be important for me to know..." (RX1, p.9).

When asked whether Petitioner provided any information as to her work duties, Dr. Rothrock testified that "I don't have anything listed specifically here, but as a line worker for Gilster-Mary Lee, I know there is a lot of repetitive work in terms of movement of her arm and lifting both down, up and sometimes overhead, but as I review my report, I don't see that, but I do know what a line worker does for Gilster-Mary Lee and I do know the repetitive nature of what they do." (RX1, p.10). He agreed that Petitioner did not provide any further detail than what he noted under chief complaint – namely, she was packing and stacking. (RX1, p.10).

Dr. Rothrock noted that on the date of his [first] exam "... she continued to experience

pain when lifting her right arm away from her body and overhead, and she also complained of associated intermittent paresthesias." (RX1, pp.10-11). He indicated that she reported no prior history with regard to her right shoulder. (RX4, p.11). He also noted that the first MRI was "... readable, but I asked for a second MRI to confirm what was seen on that MRI, also to add contrast to make sure that we could highlight any other condition." (RX4, p.11). He stated that in the December MRI films he "... saw the suggestion of a full thickness rotator cuff tear of the anterior supraspinatus tendon associated with associated bone edema." (RX4, p.11). X-rays on that date "... showed a Type 1 acromion, moderate arthritis of her AC joint and a reduced glenohumeral joint." (RX4, pp.11-12). He noted that "... the x-rays confirmed that that was her shoulder as a 50-year-old woman, nothing really out of the ordinary, quite honestly. Everyone over the age of 25 develops arthritis in their AC joint. A Type 1 acromion is what you're born with and her shoulder was not dislocated..." (RX3, p.12). He noted that he performed a physical exam on 1/29/18, but not on 2/5/18, that revealed pain and AC joint pathology. (RX4, pp.12-13). He also indicated that Petitioner was working full duty at the time of his 1/29/18 exam and that "... I just kept her working at full duty." (RX4, p.14).

Dr. Rothrock testified that he saw Petitioner again on 2/5/18 and reviewed the MRI arthrogram performed earlier that day which "... showed a high-grade partial thickness tear of the rotator cuff, and when I looked at that tear, that tear which was very similar to the tear pattern that was shown back on December 8th [2017], meaning it looked like a clean cut of the rotator cuff off of the bone with associated bone edema which, in my opinion, looked like it comes from acute trauma, either a sudden heavy lift, a fall onto it, and she denied that." (RX4, pp.14-15).

He also indicated that he can differentiate between an acute trauma and a repetitive one in two ways, the first being that "... the acute trauma pattern really shows up with clean cuts, associated bone edema and it doesn't have this wearing away look. The other thing I look at is the musculature, so when we have a tendon attached to a muscle, you have – you're looking for fatty infiltration of the muscle, and so what I'm creating in my mind and what I look for is is this something that happened acutely, looking like an acute trauma and it would not have any associated atrophy of the muscle versus someone that had more of a chronic repetitive injury, there would be a thinning, sort of a gnawing away look, a thinning of the rotator cuff musculature, and so ... those are the only real sharp delineations that you can truly make on the MRI and MRI arthrograms." (RX4, p.15). By clean cut he meant "... an avulsion of the cuff. It's ... like the sleeve of tissue was just popped right off in totality. It's not sort of worn away where it [is] ... like if you're going at a weed in your yard and you're just sort of pulling it, you see sort of strands when you do it versus if you chop a tree down and you just look at the two edges, it has a clean cut, and on her MRI it looked that way." (RX4, pp.15-16).

He noted that he would still see the cleanness of the cut and associated bone edema on MRI in December from an injury in October, although he "... would assume less bone edema, quite honestly, in both December and February than I did see, but it was there." (RX4, p.16). He also indicated that it is "... very hard to differentiate [between an acute trauma and a repetitive one arthroscopically] because in the arthroscopic view you are seeing torn tissue... [while] [t]he MRI looks so clean and cut, but when I look at that arthroscopically, it just looks like torn tissue because everything's just so blown up from that standpoint." (RX4, p.17).

20 I W CC0506

When asked his diagnosis, Dr. Rothrock noted that Petitioner "... clearly has a rotator cuff tear that clearly needs to be operated on, but ... I was asked specifically is her injury pattern consistent with repetitive use, and I did not feel that there was a medical causal relationship between her work-related activities and the type of tear that I saw on her MRI and MRI arthrogram." (RX4, p.17).

When asked what type of injury would have produced this type of pathology, Dr. Rothrock testified that "... I would expect her story to have told me I did something at work, I felt my arm give out, it became painful and weak and I couldn't move it well the rest of the workday. That's sort of what I would have associated with that MRI versus a chronic repetitive injury, I would expect she would have told me I've had intermittent pain at work over the years, this day was just a little more than normal, I went home, tried to sleep it off and it just hurt like hell when I woke up the next day and I had pain and weakness in my arm, so what you're hearing from me is putting two different stories together and the MRI didn't match the story." (RX4, pp.17-18). He noted that he thought the acute trauma would have been from "... like a fall onto an outstretched arm, a landing with your arm at the side, lifting something heavy or trying to pull down something or a box falls and your arm travels with it. Those are the things that I have seen and heard and correlate very acutely with her MRI" and a clean cut. (RX4, pp.18-19).

In addition, Dr. Rothrock noted that Petitioner related that "... when she woke, she awoke with right arm paresthesias instead of sudden weakness or pain. Her arm just sort of felt numb, and not that that's irrelevant, but I would say it wouldn't be expected when I put the whole story together. When she complained to me of intermittent paresthesias when I saw her, that would be consistent because her exam was very consistent with a rotator cuff tear when I saw her, okay, in January, but in her initial presentation she didn't describe to me my arm was suddenly weak, I couldn't move it, it was incredibly painful. She just described numbness in her hands." (RX4, p.19).

When asked if it would affect his opinion on causation if she told Dr. Davis that she began having pain at work on 10/5/17, Dr. Rothrock replied: "That would have value to me because that wasn't what she described to me... [However,] with this tear pattern I would expect something sudden to have happened, just what I'm seeing on MRI, so if she gave someone else a history that said hey, I had this, I was lifting this box, boom, arm hurt, felt weak, like that history would be very important to correlate to the MRI that I saw, but if she just said oh, just sort of ached a little, it still wouldn't be consistent with the MRI that I saw." (RX4, p.20). He noted that "... it would be valuable information, but it wouldn't correlate, in my opinion, with the sharp clean cut of how the rotator cuff looked which was more of an acute traumatic injury." (RX4, p.20).

When asked the amount of weight it would take for a rotator cuff to tear, Dr. Rothrock noted that "I've seen it with as little as 10 or 15 pounds quite honestly... [I]t's sort of the positioning of the arm away from your body and overhead, that is a high stress for a rotator cuff, and so 10 to 15 pounds is all you'd really need to do something like that." (RX4, pp.20-21). He also indicated that the lifting can be "... away from your side if you're trying to catch something down below... [I]t's just more the story of acute trauma, arm away from the body or you could

20 I W CC0506

fall onto your shoulder with your arm at your side and puts pressure on the shoulder and cause the same tear pattern. These were things that I'm actively looking for in every history and physical examination. I just didn't get them from her." (RX4, p.21).

Dr. Rothrock also stated that it would not affect his opinion if Petitioner told Dr. Molnar that she began having arm numbness while sitting down talking to her boss, noting that "… it would still not line up with all the other data I have." (RX4, pp.21-22). In addition, he indicated that he would not relate arm numbness alone to a rotator cuff tear "… if it's not associated with pain, weakness with shoulder motion. I mean, it could come from the neck. It could come from nerve damage in the hand. I think of those things without associated pain and weakness about the shoulder." (RX4, p.22).

When asked whether Petitioner's work duties might or could have been a cause or contributing factor in Petitioner's right shoulder condition, Dr. Rothrock stated that "… in my opinion, the answer would be no and it's specifically related to how the MRI tear pattern looks." (RX4, pp.22-23). He explained that by tear pattern he meant that "… the MRI injury pattern that I saw shows an acute sharp tear which I would not associate with chronic repetitive activity." (RX4, p.23).

Dr. Rothrock stated that he "… definitely thought that [Petitioner] needed further treatment", but that it was not associated with work. (RX4, p.23). He also noted that "… any treatment she had … would be for an acute injury that I'm not saying she had versus the chronic injury that I don't think it was caused by." (RX4, p.24). In addition, he stated that as of 2/5/18 "… I thought she could work full duty at time because she had been working full duty, and I didn't believe that she needed to be limited based on any injury that she possibly sustained at work." (RX4, p.24).

On cross examination, Dr. Rothrock noted that he presently "… sees[s] one IME a week versus I will see about 30 to 40 patients a week…" (RX4, p.26). He indicated that IMEs are "… not an incredible bulk of my practice" and that "… primarily at this point in my career I'm doing exclusively shoulder and knee arthroscopy." (RX4, p.26).

Dr. Rothrock testified that he has never physically been to the Gilster-Mary Lee facility or any of the plants at Gilster, although he stated that he's "… had the privilege of treating patients from all of the facilities..." (RX4, p.27). He stated that "… I spend a lot of time with the patients that I'm treating long term asking them to show me what will you do and … I sort of know the movements and, you know, the line work, and I would say very similar but more arduous than an automobile assembly line, in my opinion." (RX4, pp.27-28). He indicated that he did not ask Petitioner about the specific weight of the boxes or packages she worked with. (RX4, p.28).

He agreed that he saw medical records leading up to the date of injury from Chester Clinic and Chester Memorial Hospital. (RX4, p.28). He agreed that he did not see any medical records that predated 10/5/17 or 10/6/17. (RX4, p.28). He noted that the only record he has seen post 2/5/18, the date he last saw Petitioner, was the operative report of Davis dated 3/13/18 which was provided to him a half hour before his deposition. (RX4, pp.28-29). He also noted

that he did not see photos from the arthroscopic procedure, just "... two sheets of paper describing the operative note that was probably submitted for billing purposes." (RX4, p.29).

When asked whether his testimony was that you can see more on MRI than the scope, Dr. Rothrock responded: "... in terms of looking at a specific type of tear pattern, I feel that I can see that more clearly on the MRI than when I go in there, in my mind, it's just torn... I don't feel that I can say – I could see acute versus chronic, meaning an acute one will have more of a complete pattern of tear versus a chronic will have more fraying associated with it, so I would say an MRI, to me... I'm going off the MRI which, to me, has this acute pattern, and I read through this operative note and he doesn't really describe was it a frayed pattern. He just says it was torn which – and that's not to fault him. That's what all of us would say except if there was something like, oh, the tissue was really friable or it peeled in some way, you know, or it was a complex tear that sort of went in different patterns. Those would be what we'd see on the op note, so long-winded answer in saying I believe that the MRI at times gives me a very clear-cut pattern versus looking at torn tissue in the OR. That's what I mean by that." (RX4, pp.29-30). He also indicated that you cannot date a tear based on an MRI, noting that "[t]he only thing that gives you the ability to date it or not date it is the atrophy of the musculature... If there was an atrophy of the muscle associated with the tear, that would be more consistent with more of a chronic pattern than an acute pattern..." (RX4, pp.30-31).

With respect to any reports of pain at work, Dr. Rothrock stated "[t]o me, she didn't report anything, and I asked her multiple times, are you sure nothing happened? I remember specifically with her." (RX4, p.31). He noted that "[t]he only thing that would alter my opinion is if she told someone else hey, I was moving this box and my arm just gave out and I had sharp pain and my arm collapsed. That would be consistent with what I saw on her MRI." (RX4, p.32). He also noted that patients are always asked if they were having intermittent pain in that shoulder leading up to accident and Petitioner "... specifically denied any prior history of pain or dysfunction or trauma to her right shoulder." (RX4, p.32).

Dr. Rothrock indicated that he did not know how many hours a week Petitioner worked, but "[m]y gut is that it's more than 40 because that is what Gilster does... I'd say it wouldn't shock me if you told me that she was in the 50, 60-hour range routinely." (RX4, p.33). He also stated that it would not shock or surprise him to hear that people just keep working through an injury, noting "... that's why when the question was always asked to me could she work full duty, the answer is she will work full duty because she has to... It's a unique patient population that really, quite honestly, doesn't have a choice. They have to work." (RX4, p.33).

Dr. Rothrock testified that, generally speaking, for a patient with a rotator cuff tear with associated symptoms of pain and weakness "I would offer her surgery for treatment of her condition. I would recommend an arthroscopic shoulder surgery. I would probably do everything very, very similar to what Dr. Davis did on the 13th. Following that, she'd go through physical therapy. She'd return to work full duty, no limitations, somewhere between four to six months from the day of her operation. I would expect her to tell us after it's all said and done I have less pain; I have good strength, but I'm not 100 percent; I still feel some twinges when lifting away from my body." (RX4, pp.34-35).

He agreed that he saw nothing in the medical records to indicate that anything significant happened between 10/5 or 10/6/17 and 1/29/18 (the date of his first exam). (RX4, p.37).

On re-direct examination, Dr. Rothrock indicated that it is possible to have degenerative changes and be asymptomatic in your shoulder. (RX4, p.37). He noted if that occurs, and then all of sudden one day you start having pain, "I would expect a less clean cut of the tendon, meaning it probably has some partial interstitial tearing and then sort of a frayed appearance because we know that anyone ... between 40 and 60 has a 25 percent chance of partial tearing of the rotator cuff and they have no symptoms. I mean, that's if you take a hundred people with MRIs of the shoulders that don't hurt, ... I would expect to see some more chronic changes on the MRI..." (RX4, pp.37-38).

Conclusions of Law

An employee seeking benefits for gradual injury due to repetitive trauma must meet the same standard of proof as a petitioner alleging a single, definable accident. *Three "D" Discount Store v. Industrial Commission*, 144 Ill.Dec. 794, 797, 556 N.E.2d 261, 264 (Ill.App. 4 Dist. 1989); citing *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 109 Ill.Dec. 634, 510 N.E.2d 502 (1987). The petitioner must prove a precise, identifiable date when the accidental injury manifested itself. "Manifested itself" means the date on which both the fact of the injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. *Three "D" Discount Store*, 556 N.E.2d at 264; citing *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026 (1987). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Id.*, at 264; citing *Luttrell v. Industrial Commission*, 154 Ill.App.3d 943, 107 Ill.Dec. 620, 507 N.E.2d 533 (1987).

The Commission notes that Petitioner's theory of recovery in the present claim appears to be one of repetitive trauma, given that there is no evidence that she injured her right shoulder as the result of a single, identifiable event on the date in question. Instead, Petitioner testified to the various tasks she would perform on the marshmallow production line – including, her primary job of placing packages of marshmallows weighing from 10 to 16 ounces in boxes and stacking the boxes on pallet jacks as well as "catching" marshmallows when the line shuts down by pulling a lever and collecting them in a bag. Along these lines, Petitioner provided little if any information as to which particular task or tasks allegedly caused her right shoulder symptoms. She likewise provided scant evidence as to the frequency with which she was asked to perform these functions during the course of any given day. Indeed, while Petitioner testified that in September/October of 2017 she went from 8-hour shifts to 12-hour shifts, she acknowledged that she would not do the same job continuously throughout the day, noting that she would do 30 minutes of packing and then change spots and do 30 minutes of stacking, in addition to having two 15-minute breaks and a 30-minute lunch break. Furthermore, the medical histories reflect differing accounts as to how and when Petitioner's symptoms began -- including an initial history recorded by Dr. Molnar on 10/6/17, the date of the alleged accident, wherein she noted right arm numbness while sitting and talking to her boss (PX2), a physical therapy note dated 10/30/17 wherein she referenced no known cause and simply related waking up one morning with pain in her right upper extremity (PX3), and an ER record dated 11/20/17 which stated that

"[t]he patient notes no right shoulder problems prior to early October and no injury in her past or present to explain her discomfort." (PX3).

As a result, the Commission finds that Petitioner failed to sustain her burden of proving by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on 10/6/17.

Furthermore, the Commission finds that Petitioner failed to prove that she provided proper and timely notice within 45 days of the alleged accident per the dictates of §6(c) of the Act. Along these lines, Respondent's workers' compensation coordinator, Steve Landholt, credibly testified that Respondent was not made aware of the alleged work injury until it was reported by Petitioner and forwarded to his office on 12/12/17 (or 67 days following the alleged date of accident), at which time an Accident/Incident Report was prepared. (T.36-39).

Finally, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that a causal relationship existed between her current condition of ill-being with respect to her right shoulder and the alleged accident on 10/6/17. In support of this holding, the Commission finds the opinion of Respondent's §12 examining physician, Dr. Rothrock, to be more persuasive than that of treating orthopedic surgeon Dr. Davis. Specifically, the Commission relies on the opinion of Dr. Rothrock to the effect that the diagnostic studies reflect an acute injury in that the MRI showed a clean cut of the rotator cuff, as opposed to the fraying typically found in a chronic tear due to repetitive trauma. Petitioner's treating orthopedic surgeon, Dr. Davis, was unable say whether Petitioner had suffered an acute traumatic injury or whether she had a repetitive trauma injury based on the objective evidence. In addition, Dr. Davis' opinion that Petitioner had suffered a work-related injury was admittedly based completely on the history provided to him by the patient – a history, as reflected in the treating medical records, that was by no means consistent and which Dr. Davis acknowledged he did not review.

Therefore, based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on 10/6/17, failed to prove that she provided proper and timely notice to Respondent of the alleged accident, and failed to prove that her current condition of ill-being with respect to her right shoulder is causally related to the alleged accident on 10/6/17.

Accordingly, Petitioner's claim for compensation is denied, and the Arbitrator's award of temporary total disability benefits, medical expenses and prospective medical treatment is hereby vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated 9/30/19 is vacated and Petitioner's claim for compensation is hereby denied.

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

DATED: SEP 1 1 2020
o: 7/14/20
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Octavio Campagne,

Petitioner,

20IWCC0507

vs.

Nos. 13 WC 13911
13 WC 13912
15 WC 37105

Vanee Foods Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

On April 29, 2013, Petitioner filed two applications for adjustment of claim, which received case Nos. 13 WC 13911 and 13 WC 13912. In case No. 13 WC 13911, Petitioner alleged that on August 28, 2012, he injured his low back in the scope of employment. In case No. 13 WC 13912, Petitioner alleged that on April 19, 2013, he injured his low back, legs and person as a whole in the scope of employment. Subsequently, on November 17, 2015, Petitioner filed an application for adjustment of claim, which received case No. 15 WC 37105, alleging that on November 4, 2015, he injured his low back, legs and person as a whole in the scope of employment.

Petitioner, who was 42 years old at the time of the arbitration hearing, testified through a Spanish interpreter that he began working for Respondent in April of 2011. On August 28, 2012, Petitioner was working as a mixer, a job he described as heavy. Petitioner described his job duties as follows: "We had to always put a certain quantity of sugar and salt. Sometimes at times 350 pounds of salt, 350 pounds of sugar. We had the pallet. We have to open up the bags of 350 pounds. We load them

and then have to carry them over to the carts." The bags Petitioner picked up weighed 50 pounds each. When asked how many bags he typically handled during his shift, Petitioner responded: "We do, approximately, 18 batches, an average of 14 bags of 50 pounds per batch." Petitioner also added 50-pound bags of spice and 50-pound containers of oil. With the bags of sugar, salt and spice, Petitioner "would lift it, open it and pour it into the carts." He had no help with lifting the bags. When the cart was full, Petitioner and his coworkers would empty it into the mixer.

Petitioner further testified that he sustained a work accident on August 28, 2012, when he slipped on some grease. Petitioner described the accident as follows: "I slipped. I split my legs. One leg went forward, the other went backwards. I felt like that way I twisted my back with my back going backwards. I felt that something popped in my low back." Petitioner felt a sharp pain in the back, followed by pain in the right leg. He reported the accident to his supervisor, who completed an accident report and called for a taxi to take Petitioner to the company clinic, Advanced Occupational Medicine. Petitioner received urgent treatment on August 28, 2012, and followed up on September 5, 2012. He then returned to work full duty, and his back got better over time.

Petitioner testified that he worked full duty until April 19, 2013, when he suffered another work accident. Petitioner described the accident as follows: "I bent down for a box of 50 pounds that I was going to put it up on a table that we have there. I bent down and I wanted to raise it. I felt like something popped again in my back." Petitioner felt a strong pain in the middle and right low back. He reported the accident to his supervisor, who completed an accident report and referred him to the company clinic, which had changed its name to U.S. Health Works of Illinois. Petitioner underwent imaging studies, physical therapy and two epidural steroid injections. At some point, Petitioner came under the care of Dr. Alexander Ghanayem, who recommended against surgery and referred Petitioner to Dr. Prempreet Bajaj for pain management.

On November 4, 2015, Petitioner returned to work, which was supposed to be light duty. Petitioner testified the job assignment was actually not light duty, explaining: "They sent me over to another department to clean the [mixing] carts." Petitioner continued: "They lined them up over there after they had taken away all the product from them. We had to push them to insert them into a type of steel machine, raise them like this (indicating) in order to throw soap on them. * * * So each one has his own cart. So each one by himself has to handle the cart. There is no help." A cart weighs "[u]pwards of 100 pounds." Petitioner cleaned the carts with a power washer. "[W]e had to bend down so that the water would go down afterwards. Then when they were finally clean and dry, we had to bend down to lift them up so that they were with the wheels down."[1] The lifting and moving was "nonstop. One does not stop." Petitioner had to lift each cart twice, and each cart would be in the cleaning machine for approximately three minutes. Petitioner estimated he cleaned 18 to 20 carts per hour. Petitioner described the accident as follows: "All of the sudden the pain came, pain, more and more pain." Petitioner reported the accident to a supervisor, Arturo, who completed an accident report. Respondent then called a taxi to take Petitioner to Dr. Maria Vlahos at Midwest Orthopaedics in Westchester. Dr. Vlahos released Petitioner to return to work with a 10-pound lifting restriction. However, Petitioner was in a lot of pain and sought emergency treatment at MacNeal Hospital.

---

[1]On cross-examination, Petitioner clarified that by "lifting" he meant tilting the carts.

Petitioner testified that he followed up with Dr. Ghanayem and Dr. Bajaj and underwent additional physical therapy and injections. One of the doctors referred Petitioner to Dr. Konstantin Slavin, with whom Petitioner began treating on June 6, 2016. Dr. Slavin performed two more injections, which did not help. On October 28, 2016, Petitioner underwent surgery, followed by more physical therapy and another injection. In November of 2017, Dr. Slavin placed a spinal cord stimulator. Petitioner stated the surgery helped a little bit, but the spinal cord stimulator did not help. Dr. Slavin removed the spinal cord stimulator in June of 2018. Petitioner last saw Dr. Slavin on July 9, 2018. Dr. Slavin recommended pain management and a cane for stability.

Petitioner has not worked since November 4, 2015. Petitioner described his current condition as follows: "[I have] a sharp pain [in the back] and in the leg also." Petitioner has difficulty "[m]oving [his] legs, walking, raising them, the pain, it comes out like pins and needles." He can walk for only 10 to 15 minutes or stand for approximately half an hour before the back starts to hurt. The pain wakes him up at night. He takes hydrocodone and a muscle relaxer. Petitioner was recently awarded Social Security disability benefits.

On cross-examination, Petitioner testified that in August and September of 2015 he looked for another job. He did not recall the specifics of his job search, other than applying online. The job search logs are in evidence. On redirect examination, Petitioner testified that his education ended after eighth grade in Mexico. He does not know how to use a computer. Petitioner never received any response to his job search. Respondent never provided a vocational rehabilitation counselor.

Beatrice Pranger, Respondent's human resources manager, testified that in September of 2015 she offered Petitioner a job at his pre-accident rate of pay. Petitioner initially did not accept the job. Ms. Pranger thought Petitioner was unhappy with the schedule. In October of 2015, Ms. Pranger again met with Petitioner about returning to work. Petitioner did not return to work until November 3, 2015, when he came for orientation. Ms. Pranger understood Petitioner's work activities on November 4, 2015, as follows: "[T]hey sent him to use a hose to blow water out of a cart. But he did it for a couple of hours that day. I believe three hours exactly." According to Ms. Pranger, Petitioner was not required to lift anything other than the air hose, which weighed three to four pounds. After leaving work early, Petitioner "came in that next morning, but he went straight to the break room. * * * He asked for a supervisor. So the supervisor met with him and he went home from there. I'm sorry. He asked to go to the clinic." Petitioner never returned to work. Ms. Pranger did not observe Petitioner work on November 4, 2015 and did not know anything about Petitioner turning the carts over. The carts, which had the capacity to hold a thousand pounds of product, were made of stainless steel. Respondent did not offer Petitioner light duty work after November 4, 2015.

The medical records in evidence show that on August 28, 2012, Petitioner sought treatment at U.S. HealthWorks for low back pain after slipping on some oil and almost falling at work. The attending physician diagnosed a strain, prescribed medication and imposed a 20-pound lifting restriction.

On April 19, 2013, Petitioner returned to U.S. HealthWorks for treatment of low back pain and leg weakness, giving a history of lifting a 50-pound box from the floor at work. Petitioner stated his prior back pain from the 2012 injury had resolved before this accident. Petitioner was prescribed

medication and restricted to sedentary duty. Petitioner underwent physical therapy in May of 2013, followed by right-sided S1 transforaminal epidural steroid injections on May 29 and June 11, 2013. A lumbar MRI performed May 6, 2013, showed: "Mild disc bulge and annular fissure L3-4. Mild disc bulge and annular fissure L4-5. Shallow broad-based right paracentral disc protrusion L5-S1. Degenerative facet changes throughout the lumbar spine." On July 11, 2013, Petitioner was referred to Dr. Ghanayem and taken off work.

The medical records from Loyola Medicine show that on July 8, 2013, Petitioner presented with complaints of low back pain with occasional radiation to the right leg, giving a history of the work accidents and reporting no relief from the physical therapy and the injections. Dr. Ghanayem's physical examination findings were as follows: "He ambulates into the office today with a normal gait and a normal posture without the use of an assistive device. *** He does have some tenderness to palpation about the lumbar spine, specifically at the lumbar base. The lumbar range of motion is normal although both forward flexion and extension do cause some discomfort. Strength is 5 out of 5 throughout the muscle groups of the lower extremities. Light touch sensation is intact throughout the lower extremities. The straight leg raise maneuver is negative. The ankle jerk and knee jerk reflexes are 2+ throughout. There is no evidence of ankle clonus." Dr. Ghanayem interpreted the MRI as showing "a small right-sided disc herniation at L5-S1 as well as degenerative changes at L3-4, L4-5 and L5-S1." Dr. Ghanayem diagnosed degenerative disc disease with a small right-sided disc herniation at L5-S1, opining "this is likely just an aggravation of his degenerative changes," and recommended a course of physical therapy. He kept Petitioner off work.

Physical therapy records from Accelerated Rehabilitation Centers show Petitioner underwent physical therapy from July 15 through July 24, 2013, complaining of severe low back pain and reporting no improvement.

On August 12, 2013, Petitioner followed up with Dr. Ghanayem, reporting he had to stop physical therapy because he was not making progress. "He is having a lot of back pain and bilateral leg pain. The back pain is most prevalent. On exam today, he is able to stand with normal posture and walk with a normal gait. He is tender in the mid and lower lumbar region. He is more tender on the left side than he is on the right side. He does have low back pain with axial compression of the head, truncal rotation through the knees, and distraction through the shoulders. His range of motion is limited to 10 degrees of extension and 20 degrees of flexion. Neurologically, I do not find any focal motor or sensory deficits. His tension signs cause back pain, but no leg pain." Dr. Ghanayem was unsure what to do for Petitioner. He did not think surgery would be helpful and referred Petitioner to a rehabilitation medicine specialist in his practice.

On March 3, 2014, Petitioner returned. "He continues to complain of diffuse back pain with bilateral leg pain. * * * On physical examination, he is able to walk around the examination room with a normal gait, upright posture, and without the use of an assistive device. He has tenderness to light palpation of the entire lumbar spine. He has very limited range of motion. He continues to have no more than 10 degrees on forward flexion and 10 degrees on extension. Strength to his lower extremities remains at 5/5. He has no complaints of numbness or tingling to light touch. He has a negative straight leg raise." Dr. Ghanayem reiterated his previous opinion and recommendation.

Physical therapy records from ATI show Petitioner underwent physical therapy from March 18 through April 11, 2014, complaining of significant low back pain and limitations, and reporting no improvement.

On April 14, 2014, Petitioner followed up with Dr. Ghanayem, reporting no improvement after 12 sessions of physical therapy at ATI. "He reports 0% improvement in his symptoms and continues to have difficulty with simple tasks, range of motion, and pain. * * * On physical exam, he walks with a limp today, upright posture, without the use of an assistive device." Dr. Ghanayem reiterated that he did not think surgery would help, and discharged Petitioner from his practice.

A functional capacity evaluation ordered by Dr. Ghanayem and performed May 15, 2014, placed Petitioner at the light physical demand level. During the functional capacity evaluation, Petitioner complained of significant symptoms and limitations.

Petitioner underwent a vocational assessment by Susan Entenberg. In a report dated June 18, 2014, Ms. Entenberg noted Petitioner's limited English proficiency, lack of transferrable skills, and complaints of significant pain and disability. Ms. Entenberg opined Petitioner was not capable of returning to his job as a mixer. Ms. Entenberg further opined Petitioner was not a candidate for vocational rehabilitation and no stable job market existed for him.

The medical records from Midwest Orthopaedics at Rush Occupational Health Clinic, Westchester office, show that on November 4, 2015, Petitioner saw Dr. Vlahos with the chief complaint of severe low back pain. Dr. Vlahos noted the work accidents in 2012 and 2013. Dr. Vlahos further noted: "He states he had increased level of low back pain today, from his usual 7/10 to 10/10 related to standing for 3 hours during his work shift today. Then after break time he had difficulty getting up from his chair due to low back pain. He denies any direct trauma, a slip and fall or any specific incident today. Pain is constant, worse with prolonged standing, better with sitting. Pain radiates to both testicles. Pain is worse when he moves his toes or his legs or moves his neck. He notes numbness in the legs, primarily anterior thighs to the feet with prolonged sitting. *** Today was his first day back to work in over one year." Petitioner felt unable to work due to the pain. Physical examination findings were as follows: "He is able to move with slight to moderate difficulty. He is holding his hand on his low back. Lumbar Spine: *** Heel walking cannot be performed and toe walking cannot be performed due to low back pain. Pain on motion is present over the back. Range of motion is limited to 15 degrees in all directions. Squatting can be performed. Sensation in the lower extremities is normal. Tenderness is present in the midline and bilateral lumbar paraspinals." Reflexes were normal. Strength in bilateral hips was mildly decreased. Dr. Vlahos prescribed medication and noted a previous 10-pound lifting restriction. Lastly, Dr. Vlahos charted: "The cause of this problem is related to work activities."

The medical records from MacNeal Hospital show the evening of November 4, 2015, Petitioner presented at the emergency room with complaint of back pain. The attending physician noted the following history: "[The patient] with hx of herniated disc 2 year ago c/o back pain after standing for prolonged period of time at work today – states pain radiates to left buttock. No new injury." "The presenting problem is chronic." "Complains of lumbosacral pain. No trouble walking. Denies radicular numbness or tingling. Has shooting pain into the left leg. Back pain is worse with movement. *** These symptoms developed gradually and is described as a pain which is sharp, which seems to be

getting worse." Physical examination was unremarkable, with the exception of tenderness to palpation of the lumbar paraspinal muscles. The attending physician diagnosed acute low back pain and prescribed medication.

On November 16, 2015, Petitioner returned to Dr. Ghanayem. "He was returned back to work, and as he got back to work, he started having increased back pain." Dr. Ghanayem referred Petitioner to Dr. Bajaj, a physical medicine and rehabilitation specialist, for nonoperative treatment.

On February 4, 2016, Petitioner began treating with Dr. Bajaj, rating the pain an 8-10/10. Dr. Bajaj noted a history of work accidents in 2012 and 2013. On physical examination, Petitioner complained of severe pain and discomfort with diagnostic maneuvers. Straight leg raise test was normal, however. Dr. Bajaj ordered an updated MRI and took Petitioner off work. The MRI, performed March 14, 2016, showed "[m]ultilevel degenerative disc disease, most prominent in the lower lumbar spine." Petitioner was evaluated for physical therapy on March 8, 2016, and attended seven sessions. He reported no improvement and was discharged on April 8, 2016. At the time of discharge, Petitioner "demonstrat[ed] a worsening score on the Oswestry scale."

On April 21, 2016, Petitioner followed up with Dr. Bajaj, reporting he could not finish physical therapy due to pain. "He has ongoing pain in the low back which can radiate down the right leg involving the whole leg. This worsens with sitting. He also has problems with standing and walking. He rates his pain at a level of 5-6/10 when he does not move and worsens to higher levels with movement." Physical examination was limited by pain. "SLR causes back pain even with mild elevation of the leg." Dr. Bajaj noted the MRI findings and symptom exaggeration, and recommended electrodiagnostic studies. In the interim, he kept Petitioner off work. The electrodiagnostic studies, performed May 11, 2016, were normal.

Petitioner then sought treatment from his primary care physician, Dr. Francisco Avalos. Dr. Avalos referred Petitioner to UIC/Dr. Slavin and took him off work from May 20 through August 20, 2016, or until released by orthopedics.

On June 6, 2016, Petitioner began treating with Dr. Slavin for chronic pain in the back, legs and testicles. "The patient tells me that all of his symptoms started after a work-related injury in April of 2013 when he lifted a heavy object and started having pain in his back going into his legs. *** One of the first injections resulted in worsening of pain when he had to essentially stay in bed for an entire week and could not stand and walk without assistance. As time went on, the patient stopped getting the injections. He has been now 3 years since he had any kind of injections done, and throughout all this time, he has not been able to work and is now seeking other treatment options." Petitioner had "a whole bunch of neurological complaints including pain in his back and numbness, pain in the testicle, and when they asked to draw the pain, he circled the area around his lower back and in his groin and shaded the entire right leg. When asked where the pain is worse right now, he, however told me that most of the pain is now on the left side and the right side is definitely not as severe." Physical examination findings were as follows: "The patient has good strength in both arms and legs. He has no problems ambulating without assistance, however, after 20 minutes of standing or walking, he starts having pain that goes all the way into his testicles usually on both sides. He also has pain that travels from his back all the way into his legs and usually it is one side that is worse than the other." Dr.

Slavin interpreted the MRI from March of 2016 as clearly showing degenerative changes at L3-L4, L4-L5 and L5-S1. He recommended pain management.

On June 28, 2016, Petitioner was seen by Dr. Khalid Malik for pain management. Dr. Malik noted the following history and complaints: "The patient [presents] with mainly axial chronic LBP with some radiation to right > left LE since 4/2013 after a work-related injury in April of 2013 when he lifted a heavy object. The patient was diagnosed with a herniated disk at that time and out of work since then. Had injections in the back x 2 in 2013 which did not help, also PT. Pain is severe, unabated with change in body positions, interferes with ADLs and refractory to prior treatments." Petitioner underwent lumbar injections on July 21 and September 15, 2016.

On October 3, 2016, Petitioner followed up with Dr. Slavin, reporting no improvement after the injections. Dr. Slavin recommended surgery. On October 28, 2016, Dr. Slavin performed bilateral laminotomies, foraminotomies and medial facetectomies at L4-L5 and L5-S1.

On November 14, 2016, Dr. Slavin noted the surgery was uneventful. However, "it appears that instead of getting better, he actually got worse. He has more pain in his back and his legs, and has a hard time standing and walking without assistance." Dr. Slavin recommended physical therapy, expecting Petitioner to make a complete recovery.

Postoperative physical therapy records from MacNeal Hospital from November 22 through December 29, 2016, note minimal progress.

On February 13, 2017, Petitioner followed up with Dr. Slavin, rating the pain a 5/10 and reporting radiation of the back pain into his right buttock and leg. On physical examination, "[t]he patient has normal strength and sensation, but the pain stops him from normal ambulation and when he stands up and moves around, he tends to bend forward in order to relieve his pain." Dr. Slavin recommended pain management. Petitioner underwent additional injections on March 23, 2017.

On June 5, 2017, Petitioner complained to Dr. Slavin of continued pain in the back and legs, which worsened with standing up and moving around. On physical examination, Dr. Slavin did not see any new motor or sensory problems. "However, the pain seems to be most disabling part of his presentation." Dr. Slavin ordered a repeat MRI. On July 10, 2017, Dr. Slavin reviewed the MRI, "which clearly shows that both levels are well decompressed." However, Petitioner ambulated with a cane. Dr. Slavin recommended a spinal cord stimulator.

On October 30, 2017, Dr. Slavin declared Petitioner disabled for the purpose of Social Security disability benefits.

On November 7 and November 14, 2017, Dr. Slavin implanted a spinal cord stimulator.

On January 29, 2018, Dr. Slavin noted: "The patient noticed about 60% improvement in his pain during the trial. However, ever since this new device was inserted, his pain relief was not as impressive. As a matter of fact, he tells me that right now the device is not helping him at all even though he tries to use it almost all the time." Dr. Slavin strongly supported Petitioner's claim for

disability.[2] On March 26, 2018, Dr. Slavin had a representative from the spinal cord stimulator company reprogram the stimulator. On May 21, 2018, Petitioner requested that the spinal cord stimulator be removed because it was of no benefit. On June 15, 2018, Dr. Slavin removed the spinal cord stimulator.

The last note from Dr. Slavin is dated July 9, 2018. Physical examination findings were as follows: "[H]e has strength of 5/5 in both arms and 4/5 in both legs. There are no obvious sensory deficits. His sensation appears to be intact to light touch and vibration. His gait is straight. His ambulation is normal; however, there is some antalgic part in this movements, and straight leg raising test remains positive at 45 degrees bilaterally." Dr. Slavin recommended continued pain management and following up as needed.

Dr. Slavin, a neurosurgeon, testified by evidence deposition on March 7, 2017 and June 12, 2018. Dr. Slavin opined the treatment he rendered was reasonable, necessary and causally connected to the history of accident Petitioner provided. On cross-examination, Dr. Slavin was unsure whether he had reviewed any prior medical records, other than the MRI from March of 2016. Dr. Slavin was unaware of Petitioner's treatment with Dr. Ghanayem. Dr. Slavin acknowledged that it appeared Petitioner did not have a good result from the surgery, qualifying: "Surgery was the best option. It just didn't work." Dr. Slavin further testified the spinal cord stimulator was reasonable, necessary and related to the work injury Petitioner described. Dr. Slavin continued to opine Petitioner was unable to return to work.

Respondent had Petitioner examined by Dr. Andrew Zelby, who testified by evidence deposition on June 19, 2017 and August 23, 2018. Dr. Zelby, a neurosurgeon, testified that he first examined Petitioner on August 3, 2015, and reexamined him on April 6, 2016. During the first examination, Petitioner described the work accidents in August of 2012 and April of 2013, and "reported that he still had constant pain in the low back with occasional pain going into the testicles, more on the right. He had no pain radiating into the legs but had intermittent and daily numbness and tingling in the entire circumference of the right lower extremity down to the ankle. He occasionally got much less severe and much less frequent numbness and tingling in the entire circumference of the left lower extremity down to the ankle. ¶ [The claimant] felt that his symptoms were exacerbated by any movement and any activity. And even with fixed postures or doing nothing, he found nothing that gave him relief. He said he was able to drive but was not able to put on his shoes or socks. He said he had no prior episodes of those or any similar symptoms." Physical examination findings were as follows: "The lumbar spine appeared normal. There was tenderness to palpation in the lower lumbar and right upper gluteal regions, even with non-physiologic light touch. ¶ The range of motion was markedly diminished in every direction. Squatting was done about halfway down. Lying straight leg raise was positive bilaterally in the back only. Sitting straight leg raise was negative. Toe walking and heel walking were normal. The Patrick's test is a test of the hip which was normal. Gait was slow and antalgic. ¶ However, when [the claimant] walked, he favored the left leg, not the right leg. Posture was normal for body habitus. There was no paraspinal muscle spasm. Strength in the lower extremities was normal with encouragement. Sensation to pin and vibration were diminished in the entire right lower extremity but

[2]An award letter from the Social Security Administration states Petitioner was awarded disability benefits retroactive to February of 2015.

otherwise preserved. ¶ Reflexes in the lower extremities were normal bilaterally, including the right Achilles reflex. The toes were downgoing bilaterally, and clonus was absent. Inconsistent behavioral responses were positive for pain on superficial light touch, pain on simulation, diminished pain on distraction and non-anatomic sensory changes. ¶ Measurements of the extremities demonstrated they were symmetric and without atrophy. The distal pulses were normal and symmetric." Dr. Zelby diagnosed degeneration in the lumbosacral spine, a herniated disc at L5-S1, obesity and significant symptom amplification. Dr. Zelby noted Petitioner's complaints were in a non-dermatomal distribution, and a normal ankle reflex ruled out radiculopathy. "[J]ust the fact that he has no atrophy and a normal reflex is pretty good objective evidence for a normal neuromuscular relationship and function."

Dr. Zelby provided the following causation opinion: "[B]ased on the obvious disparity between his subjective complaints and his objective condition, [the claimant's] condition appears related to symptom amplification as opposed to the fairly small herniated disc and mild degenerative disc disease seen on MRI. ¶ *** [H]is normal neurological exam, normal right Achilles reflex further highlight the tremendous disparity between his subjective complaints and objective condition." Dr. Zelby did not recommend any further treatment, opining that Petitioner had reached maximum medical improvement from the April 19, 2013 work accident "by September or October 2013 at the latest." Dr. Zelby disagreed with the functional capacity evaluation, opining that Petitioner could work at the medium to heavy physical demand level. If Petitioner's job as a mixer was at the medium to heavy physical demand level, Petitioner could return to work full duty.

On April 6, 2016, Petitioner "reported that he was sent back to full-duty work at the beginning of November 2015. He worked for less than a couple of hours but when lifting, he felt a return of the same low back pain that he had before. He reported the pain was in the middle of the low back going toward the left more than the right without any radiation into the legs. ¶ He still reported intermittent but daily numbness and tingling going into the entire circumference of the right lower extremity all the way down to the middle of his foot but not going into his toes. He had no symptoms in the left leg. ¶ [The claimant] said he was sent to the company clinic but got no treatment. He went to an emergency department that night because of severe pain, was given medications, treated, and released. ¶ He went to his family physician and then a spine specialist. He had gone to physical therapy. And at the time I saw him, he had completed four weeks of a six-week course of therapy. He felt this gave him no improvement." Petitioner stated any movement, even just moving his toes or ankles, caused constant 10/10 low back pain. Dr. Zelby stated: "I think it's just wildly inconsistent, potentially contrived stories about pain that make no sense in terms of the spine." Physical examination was fairly similar to the previous examination, except now Petitioner favored the right leg. 4+/5 Waddell findings were positive. Dr. Zelby's diagnosis and opinions did not change. Dr. Zelby continued to opine "the obvious disparity between his subjective complaints and objective findings indicates the ongoing complaints are related to symptom amplification and not any condition of infirmity in the spine or nervous system." Dr. Zelby therefore had "no expectation that any kind of surgical procedure would provide meaningful or sustainable relief for [the claimant]." Dr. Zelby continued to declare Petitioner at maximum medical improvement and able to return to work full duty.

The Arbitrator found all three claims compensable and awarded: "maintenance benefits of $490.69/week for 224-3/7 weeks for the periods 8/4/14-9/26/14, 8/8/15-11/2/15 and 11/5/15-10/9/18

date of hearing and continuing through to the present date, totaling to $110,125.06;" "odd-lot" permanent total disability benefits; and medical expenses in the sum of $314,230.07 pursuant to sections 8(a) and 8.2 of the Act.

The Commission finds Petitioner was at maximum medical improvement as of May 11, 2016, when the electrodiagnostic studies ordered by Dr. Bajaj proved to be normal, consistently with Dr. Bajaj's objective findings on April 21, 2016, Dr. Zelby's findings on April 6, 2016, and Dr. Ghanayem's earlier findings. The Commission awards temporary total disability benefits accordingly.

The Commission agrees with the Arbitrator that the work injuries caused Petitioner to become "odd-lot" permanently totally disabled, but effective May 12, 2016. The award of "odd-lot" permanent total disability is supported by the opinion of Susan Entenberg and Petitioner's unsuccessful job search. The Commission vacates the award of maintenance benefits as duplicative of the awards of temporary total disability and permanent total disability benefits.

Turning to medical benefits, the Commission awards reasonable and related medical bills in evidence through May 11, 2016, pursuant to §§8(a) and 8.2 of the Act. No further medical benefits are awarded.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2019 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $490.67 per week for a period of 159 6/7 weeks, from April 19, 2013 through May 11, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and related medical bills in evidence through May 11, 2016, pursuant to §§8(a) and 8.2 of the Act. No further medical benefits are awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent total disability benefits of $490.67 per week for life, commencing May 12, 2016, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry to this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 1 2020
o-08/05/2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAMPAGNE, OCTAVIA
Employee/Petitioner

Case# **13WC013911**
13WC013912
15WC037105

20IWCC0507

VANEE FOODS CO
Employer/Respondent

On 2/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2988 CUDA LAW OFFICES
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

5074 QUINTAIROS PRIETO WOOD & BOYER
JULIE M SCHUM
233 S WACKER DR 70TH FL
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

Octavio Campagne,
Employee/Petitioner

v.

Vanee Foods Co.,
Employer/Respondent

Case # **13** WC **13911**
13 WC **13912**
15 WC **37105**

An *Application for Adjustment 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 **10/9/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Findings

On **8/28/12, 4/19/13, and 11/4/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On all of these dates, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***were*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**38,272.00**; the average weekly wage was $**736.00**.

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

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

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

Respondent shall be given a credit of $**54,746.29** for TTD, $**0** for TPD, $**0** for maintenance, and **$21,992.57** for other benefits (medical paid), for a total credit of **$76,738.86.**

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

Order

Respondent shall pay Petitioner maintenance benefits of $490.69/week for 224-3/7 weeks for the periods 8/4/14-9/26/14, 8/8/15-11/2/15 and 11/5/15-10/9/18 date of hearing and continuing through to the present date, totaling to $110,125.06 as provided in Section 8(b) of the Act.

Petitioner is found to be a permanent total under the "Odd-Lot" theory pursuant to Section 8(f) and is awarded weekly benefits of $490.69 for the duration of his lifetime.

Respondent shall pay reasonable and necessary medical services of $314,230.07 for unpaid bills as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit as noted.

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

Feb. 22, 2019
Date

FEB 25 2019

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Octavio Campagne ("Petitioner") Petitioner has been employed with Vanee Foods ("Respondent") since April 2011. (TA11). Prior to August 28, 2012, Petitioner never had surgery, physical therapy, nor was placed on any restrictions for his back. (TA12, TA70). On August 28, 2012, Petitioner was assigned to his regular work duties as a mixer. (TA12-13). Petitioner's duties as a mixer were considered heavy duty work consisting of opening and carrying bags of sugar and salt that weighed 50lbs each. (TA13). On average, in an eight hour shift Petitioner would complete about 18 batches, lifting and pouring an average of fourteen 50 pound bags of ingredients per batch. (TA13-15). In addition to lifting bags of salt and sugar, he also lifted 50 pound spice bags, 50 pound containers of oil, and 50 pound containers of water and would pour them into the carts. (TA14-15). Petitioner would then go to get product such as chicken or meat from another department. (TA16). The workers in the other department would weigh 800 to 1000lbs of meat, which then Petitioner and his co-workers would carry the meat back to his room and start to pour it into the mixer or blender. (TA16-17).

On August 28, 2012, Petitioner walked to go get the chicken and he slipped on grease and one leg went forward, the other went backwards and he twisted his back and felt a pop in his lower back. (TA17). Petitioner immediately noticed a sharp pain in his back and his leg began to hurt as well. (*Id.*). Petitioner then proceeds to speak to his supervisor, who generated a report and ordered a taxi to take Mr. Petitioner to the company clinic, Advanced Occupational Medicine. (TA18).

Advanced Occupational Medicine took x-rays and took Petitioner off work for a few days. (*Id.*). Petitioner returned to Occupational Medicine on September 5, 2012 and was released to full duty work. (TA18-19). Petitioner was not under a doctor's care and was not under restrictions

relative to his back from September 5, 2012 through April 19, 2013. (TA19). Petitioner returned to his job in a full duty capacity on September 5, 2012. (TA19).

On April 19, 2013, Petitioner was engaging in the same job duties as previously described; lifting bags of sugar, salt and spices. (*Id.*). Petitioner bent down for a box which weighed fifty pounds to put it up on the table and when he attempted to raise it he felt a pop in his back. (TA20). The pain was in Petitioner's lower back in the middle and right side; he felt a very strong pain. (*Id.*).

Immediately following his injury, Petitioner advised his supervisor, Jose Castillo. (*Id.*). Mr. Castillo generated a report, and Petitioner then went to the Company clinic, U.S. Health Works of Illinois. (TA21). U.S. Healthworks recommended a MRI, which Petitioner underwent on May 6, 2013. (TA21, PX3). The MRI revealed a disc bulge and annular fissure L3-L4 and L4-5. (PX3). Petitioner also had a shallow broad-based right paracentral disc protrusion at L5-S1. (PX3). Based upon the MRI, Petitioner had physical therapy and two epidural steroid injections over the course of three months. (TA21, PX1, PX5).

Petitioner then began treating with Dr. Ghanayem of Loyola University Medical Center. (TA22, PX4). Dr. Ghanayem ordered additional physical therapy and kept Petitioner off of work. (PX4). Following therapy, Petitioner remained in pain so Dr. Ghanayem referred Petitioner to Dr. Bajaj. (TA22). Petitioner then returned to work on November 4, 2015 with restrictions. (TA22-23).

Petitioner received a letter from Respondent stating it had a light duty job within Petitioner's restrictions. (RX5). When Petitioner returned to work on November 4, 2015, he was not actually given a light duty position. (TA24-25). Petitioner was sent to another department to clean carts. (TA25). After product was taken from carts, they are lined up and Petitioner had to

push them into a steel machine, lifting them, put soap on them and rinses them under pressurized water. (*Id.*). Each cart weighs upwards of 100lbs. (TA26).

In order to clean the carts, Petitioner had to bend down to power wash the bottom of the cart, then once they were clean and dry he had to bend to lift them so they were situated with the wheels down. (*Id.*). Petitioner did these repetitive motions of cleaning the carts non-stop during the day. (*Id.*). Petitioner would turn each cart twice, and clean 18-20 carts per hour. (TA28). As Petitioner was cleaning the carts, Petitioner experienced sudden pain in his back. (*Id.*). Petitioner then went to Arturo, the supervisor of the department and created a report. (TA29). Respondent's witness, Beatrice Pranger, never saw what the task of cleaning carts actually entailed, and she was unaware that the carts required turning. (TA45-46). Parnger was unaware of the size of the cart and did not know how much they weigh. (TA47). The only information Pranger had of what Petitioner did on November 4, 2015 was from what a supervisor explained to her. (*Id.*). Respondent did not produce any evidence to refute Petitioner's description of the work her performed or his subsequent injury.

After Petitioner reported the injury, Respondent sent him to a doctor at Midwest Orthopaedics in Westchester, Maria Vlahos. (*Id.*, PX7). Following examination, Dr. Vlahos returned Petitioner to work with a 10lbs weight restriction. (TA30, PX7). Petitioner was in significant pain as a result, so he went to the emergency room at MacNeal Hospital later that day. (*Id.*). Petitioner was given an injection in the hospital and the next day he reported to his family doctor, Dr. Francisco Avalo for a follow up. (TA30, PX9). Dr. Avalo kept Petitioner off of work and referred Petitioner to Dr. Ghanayem. (TA31, PX9 at 362). Dr. Ghanayem referred Petitioner to pain management with Dr. Bajaj. (*Id.*, PX4). Petitioner underwent another MRI which showed a L3-L4 central disk protrusion, a L4-L5 right paracentral disc protrusion and a L5-S1 broad based

disk herniation. (PX4). These findings confirm the changes from the previous MRI. Petitioner completed additional physical therapy, and then was referred to Dr. Slavin at the University of Illinois. (*Id.*).

Petitioner first saw Dr. Slavin on June 6, 2016 who referred Petitioner to the pain clinic. (*Id.*). Petitioner received two injections from the University of Illinois pain clinic. (*Id.*, PX10). Petitioner did not feel any improvement following the injections. (TA31-32). On October 3, 2016, Dr. Slavin recommended Petitioner have surgery on his back. (TA32, PX10).

On October 28, 2016, Petitioner underwent a bilateral L4-L5 laminotomies with foraminotomies and medial facetectomies, L5-S1 bilateral laminotomies with medial facetectomies and foraminotomies, and intraoperative fluoroscopy. (TA32, PX10 at 573). Petitioner felt a little better following his surgery; however, he still had pain. (TA33). Petitioner followed up with Dr. Slavin and completed physical therapy. (TA32). Petitioner then had another injection at the University of Illinois Pain Medicine center. (*Id.* PX10 at 440). Dr. Slavin then ordered a spinal cord stimulator for Petitioner. (*Id.*).

The spinal cord stimulator was placed in two steps, first on November 7, 2017, then on November 14, 2017. (*Id.* PX10 at 412 & 407). Petitioner had inconsistent relief from the spinal cord stimulator. (TA33). Petitioner continued to treat with Dr. Slavin, and still has not had any relief. (*Id.*). On June 15, 2018, Petitioner had his spinal cord stimulator removed. (*Id.* PX10 at 370). The doctors now recommend additional injections or a different type of spinal cord stimulator and to return to the pain management clinic. (*Id.*).

Petitioner continues to suffer from pain today. Petitioner has sharp pain in his back and his leg. (TA34). Petitioner now ambulates with the permanent need of a cane, because he has had falls due to severe back pain. (*Id.*). Petitioner has been unable to return to work. (*Id.*). Petitioner now

takes pain medication and a muscle relaxer daily to help with his pain. (TA34-35). The pill causes him to have dizziness, drowsiness, and it irritates his stomach. (TA35-36). Due to the stomach irritation, Petitioner now takes an additional medication to assist with the nausea.

Petitioner cannot be in one position for a long amount of time. (TA36). Petitioner has difficulty moving his legs, walking, and raising them as he feels a sensation of pins and needles. (TA36). Petitioner can walk for only ten to fifteen minutes before he experiences pain in his back. (*Id.*). Petitioner can only stand or sit for thirty to thirty-five minutes before his back begins to hurt. (TA36-37). Petitioner has difficulty sleeping because he is constantly getting up and changing his position and is awoken by pain. (TA37). The longest Petitioner can stay asleep for before experiencing pain is four hours. (*Id.*). When Petitioner gets up in the mornings he feels as if he hasn't rested at all and he has to gather himself in order to stretch and move. (TA38). Respondent did not produce any credible evidence to refute Petitioner's on going complaints, restrictions or loss of the ability to perform activities.

Petitioner has had no improvement from the spinal cord stimulator, no improvement from physical therapy, and no improvement from injections. (TA62-63).

Petitioner testified he completed a significant amount of job searches with the assistance of his wife. (TA55-57). Respondent did not provide any evidence from a licensed vocational rehabilitation expert to refute the integrity or accuracy of the job searches Petitioner performed. Therefore, Petitioner's testimony regarding his job searches remains unrebutted.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (2), WHETHER PETITIONER'S ACCIDENTS AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Based upon Petitioner's unrebutted testimony and after a review of the entire record, the Arbitrator finds and concludes that Petitioner's injuries of August 28, 2012, April 19, 2013 and November 4, 2015 arose out of and in the course of his employment with Respondent; Petitioner has proven he was engaged in performing his job duties during all instances. The Arbitrator notes Respondent only disputes the third claimed accident of November 4, 2015.

An injury arises out of a claimant's employment where 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,* 207 Ill. 2d 193, 203 (2003). There are three types of risks to which an employee may be exposed: "(1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics." *First Cash Financial Services v. Industrial Comm'n,* 367 Ill. App. 3d 102, 105 (2006). "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago v. Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010 (2011). "Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public." *Id.*

On August 28, 2012, Petitioner was lifting 50 lbs. bags of ingredients. On April 19, 2013, Petitioner was lifting a 50 lbs. box of ingredients and on November 4, 2015, Petitioner was bending over and engaged in the demanding physical activity of cleaning carts. All three activities were part of Petitioner's job duties and all three activities placed Petitioner at a greater risk of injury

than that of the general public. The risks involved in his repetitive lifting and bending were risks distinctly associated with his employment with Respondent.

WITH RESPECT TO ISSUE (3), WAS RESPONDENT GIVEN NOTICE OF THE ACCIDENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Based upon the Petitioner's unrebutted testimony, the Arbitrator finds and concludes Petitioner gave Respondent timely notice of the accidents of August 28, 2012, April 19, 2013, and November 4, 2015. Respondent's human resource manager did not provide any evidence to the contrary. Respondent provided no evidence to the contrary.

WITH RESPECT TO ISSUE (4), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY CONNECTED TO THESE INJURIES, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Petitioner has proven by a preponderance of the evidence his current condition of ill-being concerning his back is causally related to his injuries of August 28, 2012, April 19, 2013 and November 4, 2015. This conclusion is based upon Petitioner's credible, unrebutted testimony and an examination of the medical records.

To establish causation under the Illinois Workers' Compensation Act, 820 ILCS 305/1 et seq. (2012), a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n*, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453.

An injury arises out of a claimant's employment where 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,* 207 Ill. 2d 193, 203

(2003). There are three types of risks to which an employee may be exposed: "(1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago v. Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010 (2011). "Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public." *Id.*

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63 (1982). The evidence establishes based upon Petitioner's unrebutted testimony and the records that for at least the past ten years he has been in good health. An accident occurred on August 28, 2012 which initially injured his back. Petitioner was able to return to work in a full duty capacity following this first incident. There are no disputed regarding this. On April 19, 2013, Petitioner was lifting a fifty-pound box at work and re-injured his back. Petitioner treated and ultimately returned to work on November 3, 2015. There are also no disputes regarding this. On November 4, 2015, Petitioner was washing carts and felt intense pain and suffered an additional injury to his back. This accident is disputed. However, the facts presented make it clear (although the precise details are somewhat confusing likely due to translation issues)

that Petitioner sustained a new injury on November 4, 2015 when he aggravated his pre-existing lumbar spine condition.

A claimant may be entitled to benefits under the Act even though he suffers from a preexisting condition of ill-being. *Sisbro, Inc.*, 207 Ill. 2d at 205). "In preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Id.* at 204-05. "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being." *Id.* at 205.

At Respondent's request, Petitioner underwent three Section 12 examinations with Dr. Andrew Zelby at Neurological Surgery & Spine Surgery; August 3, 2015, April 6, 2016 and February 26, 2018. Dr. Zelby was also deposed on two dates; June 19, 2017 ((RX1) and August 23, 2018 (RX 2). (Inexplicably, RX 1, Dr. Zelby's evidence deposition of June 19, 2017, does **not** have attached Dr. Zelby's April 6, 2016 Section 12 report, which was identified as Dep. Exhibit number 3. Further, this deposition transcript inexplicably also does **not** have attached Dep. Exhibit number 1, Dr. Zelby's CV. Further, the deposition transcript has attached not one, but **five copies** of Dr. Zelby's August 3, 2015 Section 12 report, indicated as Dep. Exhibit number 2). Further, the Arbitrator notes that Dr. Zelby's second evidence deposition of August 23, 2018, RX 2, is missing all even-numbered pages.

The Arbitrator highlights that Dr. Zelby's opinions were generally in opposition to **all** of Petitioner's treating physicians, including, Dr. Ghanayem, Dr. Slavin, Dr. Garala as well as Dr. Petroski. (RX1 at 44, 67). Dr. Zelby also appears to have made considerable efforts to find

Petitioner exaggerated his symptoms, had non-organic symptoms and exhibited symptoms not corroborated by his injuries. In this instance, and in opposition to virtually all of the other medical evidence, the Arbitrator does not find this to be a credible scenario.

Dr. Zelby referred to Petitioner's bulging disk, as a "modest bulging disk" without any explanation as to what the meaning of modest is in the medical field. (RX1 at 49). Dr. Zelby simply states "I guess looking at it for 29 years you have a sense of the severity" without further explanation. (*Id.*). Dr. Zelby admits that he never asked Petitioner about his pain levels, in the three times he saw him. (RX2 at 33-34). Dr. Zelby opines to psychological findings ("suggestion of some psychological overlay") when Dr. Zelby lacks a background in psychology or psychiatry. (*Id.* at 37). The Arbitrator does not find this to be a credible scenario.

A review of the medical records shows they are very consistent in that the records indicate Petitioner's injuries were causally related to his work incidents of August 28, 2012, April 19, 2013 and November 4, 2015. Presently, Petitioner is suffering from injuries that resulted from the combination of accidents he was involved in while working for Respondent. Petitioner has followed doctors' orders and attended all forms of treatment. Petitioner underwent injections, therapy, surgery, and a spinal cord stimulator, but thus far, Petitioner has not been provided with nor has he reached the necessary relief.

WITH RESPECT TO ISSUE (7), IS THE RESPONDENT LIABLE FOR THE CLAIMED UNPAID MEDICAL BILLS, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Respondent is liable for the outstanding medical bills incurred from the dates of accident August 28, 2012, April 19, 2013 and November 4, 2015. The Arbitrator finds and concludes that in accord with Petitioner's credible and unrebutted testimony as well as the evidence presented,

Respondent is liable for the claimed outstanding medical bills. Causal connection has been found; therefore Respondent is liable for all outstanding medical bills admitted into evidence and payment of the Equian and Medicare liens. Respondent shall receive credit for all bills it has paid.

WITH RESPECT TO ISSUE (8), TTD AND MAINTENANCE, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

After the accident of April 19, 2013, Petitioner's unrebutted testimony, supported by the medical records, indicates Petitioner was temporarily totally disabled and unable to work from August 4, 2014 through September 26, 2014, representing 7-5/7 weeks and August 8, 2015 through November 2, 2015 representing 12-2/7 weeks.

After the accident of November 4, 2015, Petitioner's unrebutted testimony, supported by the medical records, indicates Petitioner was temporarily totally disabled and unable to work from November 5, 2015 through October 9, 2018 representing 204-3/7 weeks and continuing to the present time.

The evidence shows Petitioner conducted a diligent job search and provided weekly reports indicating same to Respondent. (PX 14, literally hundreds of pages documenting Petitioner's job search effort). Respondent offered no evidence to challenge – let alone rebut – this extensive record of job searches; this record of job searches is credible and proves he engaged in a diligent, albeit admittedly imperfect, job search. Further, Respondent offered no credible rebuttal opinion to challenge both the diligence of Petitioner's jobs search and his expert vocational opinion. Respondent offered no lay or expert rebuttal evidence and no vocational rehabilitation expert was presented in rebuttal. **Further, Respondent offered no written report by a vocational expert to challenge - let alone rebut – the finding that Petitioner engaged in a diligent job search or**

his employment capabilities. Respondents efforts to dispute the validity of Petitioner's job searches must fail due to a lack of sufficient credible evidence in the record to challenge same.

As such, Respondent shall further pay Petitioner temporary total disability benefits/maintenance from August 4, 2014 through September 26, 2014, August 8, 2015 through November 2, 2015 and November 5, 2015 through October 9, 2018.

WITH RESPECT TO ISSUE (10), NATURE AND EXTENT, THE ARBITRATOR FINDS AND CONCLUDES AS FOLLOWS:

Based upon Petitioner's unrebutted and credible testimony, the medical records and evidence deposition of Dr. Slavin, the Arbitrator finds and concludes Petitioner has sustained serious compensable injuries to his lower back.

Petitioner was under the care of Dr. Ghanayem, Dr. Bajaj, and Dr. Slavin who continually recommended physical therapy, injections and ultimately surgery and a spinal cord stimulator. Petitioner underwent multilevel surgical procedures with Dr. Slavin and did not receive necessary relief. Petitioner then had a spinal cord stimulator, which also did not provide relief.

Dr. Slavin opined the treatment he recommended for Petitioner was reasonable and necessary to treat his injury. (PX16 at 22-23). Dr. Slavin further opined to a reasonable degree of medical and neurological certainty that the history Petitioner described was a competent cause of his complaints. (PX16 at 23). Dr. Slavin based his opinions on the patient's description of the onset of the phenomena, like pain, along with his presentation, and radiographic findings. (*Id.*). Dr. Slavin's opinions developed over a two-year period examining and treating Petitioner with multiple office consultations, review of diagnostic evidence, as well as "real-time" visual evidence during the course of the surgeries. Dr. Slavin as a treating physician is charged with the care and

responsibility of Mr. Petitioner. Dr. Slavin has a duty to give proper medical advice and treatment to Mr. Petitioner. Further, Dr. Slavin opined to a reasonable degree of medical and surgical certainty that the spinal cord stimulator was related to the work injury as described by Petitioner and that it was reasonable and necessary to treat Mr. Petitioner's chronic pain. (PX17 at 27).

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992).

Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992). **That is what the Arbitrator decides in this case.** The weight and credibility of the opinions of the treating physicians shall be afforded greater weight and credibility than the lone opinions of Respondent's examiner Dr. Zelby. The conflicting medical opinions shall be decided in Petitioner's favor.

Petitioner was seen by Dr. Zelby for three Section 12 examinations. Dr. Slavin specifically disagreed with Dr. Zelby in his testimony in Petitioner's Exhibits 16 and 17. Further, the Arbitrator in this matter questions Dr. Zelby's credibility. Therefore, Dr. Zelby's opinions are afforded little weight. Dr. Zelby has no doctor-patient relationship with Petitioner and therefore his opinions

have no personal consequences, unlike those of a treating doctor. Further, Dr. Zelby failed to answer repeated questioning as to whether the treatment prescribed by Dr. Slavin was within the standard of care.

Dr. Zelby's opinions were basically opposite of all doctor's Petitioner treated with, including, Dr. Ghanayem's, Dr. Slavin's, Dr. Garala's as well as Dr. Petroski's. (RX1 at 44, 67).

Dr. Zelby stated he would not opine as to whether Dr. Slavin's treatment violated any medical standards. Dr. Zelby stated, the since the treatment did not help, it was not needed. This is further evidence that Dr. Zelby failed to rely on any medical evidence in formulating an opinion within a reasonable degree of medical and surgical certainty.

It is evident from the medical records and Petitioner's unrebutted testimony that due to his injuries of August 28, 2012, April 19, 2013 and November 4, 2015, Petitioner has suffered severe and chronic injuries to his back. The evidence, taken as a whole, indicates Petitioner cannot resume his normal work duties and this becomes and odd-lot permanent total. Thus, he should be awarded permanent total disability benefits for life.

Under *Waldorf Corp. v. Industrial Comm'n*, 303 Ill. App. 3d 477 (1999), the Appellate Court stated once Petitioner provided evidence that he was not employable and so handicaped that he will not be employed regularly in any well-known branch of the labor market, then the burden shifts to the employer to show that suitable work available to him. *Id.* at 484. In Waldorf, Petitioner provided 106 attempts to find suitable employment. The Appellate Court found that this was enough to shift the burden to the employer. *Id.* In this case, Petitioner Campagne has literally performed **hundreds of job searches without success**. Therefore, this number is clearly more than sufficient to find and conclude Petitioner has engaged in a diligent but unsuccessful job

search. Therefore, the Arbitrator finds Petitioner has met the requirements of fitting into the odd-lot permanent total disability classification.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois, Inc., Aero Mayflower Transit Co. v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). If, as in this case, a claimant's disability is of such a nature that he is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove by a preponderance of the evidence that he fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that he is not regularly employable in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n*, 84 Ill. 2d 538, 546-47 (1981). A claimant ordinarily satisfies his burden in one of two ways: (1) by showing diligent but unsuccessful attempts to find work or (2) by showing that, because of his age, skills, training, and work history, he will not regularly regularly employed in a well-known branch of the labor market. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Once a claimant establishes that he falls within an "odd lot" category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.* Petitioner has met his burden, and Respondent failed to rebut this establishment and failed to prove Petitioner is employable in a stable labor market and that such a market exists under his circumstances. The Arbitrator specifically finds and concludes that Dr. Zelby's opinions that Petitioner can return to work at full duty lacks all credibility and in no manner serves to prove that the claimant is employable in a stable labor market or that such a market exists.

The Arbitrator finds highly credible and places great weight and reliance on the results of the May 15, 2014 FCE (PX 6) which was found to be valid and which placed and restricted Petitioner in a "modified" LIGHT Physical Demand Level during his assessment.

In addition, Section 7110.10 Vocational Rehabilitation of the Illinois Workers' Compensation Rules provides specific rules required by the employer in Vocational Rehabilitation Plans. Specifically, Section 7110.10(c) states:

> At least every 4 months thereafter, provided the injured employee was and has remained totally incapacitated for work, or until the matter is terminated by order or award of the Commission or by written agreement of the parties approved by the Commission, the employer or his representative in consultation with the employee, and if represented, with his or her representative shall:
>
> 1) If the most recent previous assessment concluded that no plan or program was then necessary, prepare a written review of the continued appropriateness of that conclusion; or
> 2) If a plan or program had been developed, prepare a written review of the continued appropriateness of that plan or program, and make in writing any necessary modifications.

IWCC 50 Illinois Administrative Code 7110.10.

Respondent failed to follow the specific guidelines directed by the rules set forth in section 7110.10. Therefore, in light of the *Waldorf* Case and the Section 7110.10, the Arbitrator finds and concludes Petitioner is found to be classified as an "Odd-Lot" permanent total under Section 8(f) of the Act and is therefore entitled to his TTD rate under Section 8(b) of the Act or the duration of his life.

Robert M. Harris

Arbitrator Robert M. Harris

Dated: February 22, 2019

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Herrera,

Petitioner,

vs. No. 17 WC 08945

20IWCC0508

AG Drainage, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner's application for adjustment of claim alleges that Petitioner sustained multiple injuries when a "[h]ole collapsed & buried employee" on December 2, 2016. Petitioner testified through a Spanish interpreter that in December of 2016, he worked as a "hole man" on a drainage project. Petitioner described the accident on December 2, 2016, as follows: "I was inside a hole that was eight feet deep. And that day it was very cloudy and *** it was raining very hard and it was very cold, and there was a lot of water coming out from all the different parts of the hole. I told the foreman that was in charge of us, it's very dangerous because the walls are tumbling down very easily. He told me to cut the 12-inch valve to reduce it to a 10-inch valve. So I was on my knees and I was connecting the T-valve from a 12 to a 10, and that's when everything, the walls started to come in on top of me. I had a great deal of weight that fell onto my back, and I can see that the sand and pieces of sand were coming towards me, and they were clouding my vision. And I was trying to get out, but all I could see was all the sand was coming towards me." When asked what parts of his body were injured, Petitioner responded: "My back, my vertebrae, I started to feel pain from the top right here until all the way down my back into my legs, all the way down into the vertebra of my lower back." Petitioner pointed to his neck and the back of his head, adding "until all the way down." He stated he was able to move only his arms.

Petitioner further testified that he did not remember his initial treatment. He remembered being in a hospital in Indianapolis. He also remembered receiving treatment at Nova Medical Center. Around January of 2017, Petitioner went to Texas. Petitioner stated: "My boss sent me to Texas." However, Petitioner acknowledged having extended family there. In Texas, Petitioner received inpatient treatment at the PowerBack Rehabilitation Institute. He was then transferred to Pate Rehabilitation located in Anna, where he received inpatient treatment. Petitioner described his condition as follows: "[S]ince the time of the accident, I have been in the wheelchair since then. And when I was in the rehab in Anna, they would try to get me to walk and they would put me on a walker, but they would manipulate my legs so it would move. So they would tie this leg to something so that I wouldn't drag it. So they would try to get me to walk, but it seemed that I was getting weaker and weaker as time went by. So by the time I got to Anna and I was doing the outpatient, they didn't try to force me to walk anymore because the ataxia that I had was very severe by then." Petitioner added: "I can use the support handles like when I go to the bathroom to help myself and stabilize myself. But otherwise, I can't walk on my own and I am always dizzy. * * * I also had rectal bleeding from the day of the accident." Petitioner continued that he cannot see anything out of his right eye or hear out of his right ear. He has lost his senses of smell and taste. He has problems with urinary incontinence. Physical therapy made his chest pain unbearable.

Petitioner was unhappy with the condition of his wheelchair because it was worn out and too heavy. Petitioner stated the claims adjuster did not approve a new wheelchair or a wheelchair ramp to make Petitioner's brother's house wheelchair accessible. Petitioner further stated the adjuster wanted to take the wheelchair away, adding: "[H]e came in to my house, and he also took the hospital bed that they had given me and all of the other equipment that they had given me for my disability. And when he wanted to take my chair away from [me], I told him how can you take that away from me if this is the only way that I have to move around the house. And I finally convinced him to let me keep at least the wheelchair."

Petitioner was then asked about his visits to Parkland Hospital in May, August and September of 2017. Petitioner stated he sought treatment for pain in his back and chest. Petitioner also treated at Los Barrios Unidos Community Clinic in Texas and with Dr. Daniel Ivankovich in Illinois. At the time of the arbitration hearing, Petitioner was waiting to undergo further diagnostic studies. Petitioner stated the waiting list at the hospitals that take his disability insurance is very long. When asked about his current medications, Petitioner responded: "Yes, many medications and high doses."

At Respondent's request, Petitioner was examined by Dr. David Tasker with respect to his eye, Dr. Benzel MacMaster with respect to the physical problems, and Dr. Andrew Brylowski with respect to the mental health. Regarding Dr. Brylowski's examination, Petitioner stated: "[H]e didn't have an interpreter for me, so it was really difficult for me to tell him everything that I needed to tell him because my English is very limited. He did the whole thing in English. There is even a video of that appointment that I had with that doctor."[1] Petitioner continued: "[The doctor asked] like 500 awful questions in English. And yes, he would ask me the same questions over and over and over again. He would ask me the same question about three or four times, and it was really a bad experience, and I even had to lay down on the floor so I could continue." Petitioner believed he had suffered a seizure

---

[1] The video and other evidence show Petitioner is fluent in English. When asked about videotaping Dr. Brylowski's section 12 examination, Petitioner stated: "It was my right to be able to record that appointment."

during the examination. Petitioner further stated he needed to lie down on the floor because he was extremely tired and in a lot of pain.

Petitioner has not worked since December 2, 2016. Respondent paid benefits until July 12, 2017. In September of 2017, Petitioner was awarded Social Security disability benefits. Petitioner acknowledged traveling to Mexico to see his family in July of 2018, explaining that his wife had stage IV cancer.

Petitioner further testified that he lives in a small house on his brother's property behind the main house. His sister spends six hours a day cooking, cleaning and keeping him company. Petitioner is able to bathe, toilet and dress by himself, albeit slowly. Petitioner affirmed that he uses his wheelchair all the time and cannot walk. He continues to suffer from ataxia. "[E]very day it's getting worse, my extremities are getting worse and worse on a daily basis." Petitioner still cannot see out of his right eye, hear out of his right ear, or taste food. Petitioner described his pain as follows: "I have pain day and night, every day and every night. And I have to take large doses of medication, otherwise I can't deal with the pain." "I get pain with every movement I make. If you can see when I lift my arm like this, I get these like electric shocks and they feel like cramps." Such is the case with all his extremities. Petitioner receives psychological counseling and takes medication for his depression. He also suffers from flashbacks and relives the accident. At the close of his testimony, Petitioner made the following statement: "My life has changed quite a bit. Before the accident I was quite the athlete. I used to play sports, football, soccer. There is a mountain in my hometown that I used to enjoy going up there and climbing it, and I used to be able to climb it very well. I used to know very advanced math. I used to know algebra, trigonometry, geometry and analytical geometry, spatial geometry. Calculus, differentiation calculus. Liquid mechanics and solid mechanics. *** [A]nd now I can't even do a simple division, multiplication or addition. * * * I have completely lost all of the math that I knew. I have, since the accident, I have lost all control of my sphincter so I cannot urinate. And I am also now impotent. I cannot get an erection. I can't even enjoy a simple meal because I can't taste it or even enjoy the smell of it. My vision is very limited, and my hearing is also very limited. I am half the man of what I used to be." Petitioner stated he had studied at a university in Mexico.

On cross-examination, Petitioner testified that he worked for Respondent for two seasons before the accident. When asked whether he was in the hole alone, Petitioner responded: "[T]hat day I was to train a young man that was with me. He was new. And but when I was inside the hole, I was there by myself, and the young man was giving me the fittings I was to be using. He was outside of the hole giving me, handing me the fittings." The occurrence witness, who "should have seen everything," did not return to work after the accident. Petitioner maintained that his boss, Don Colclasure, sent him to Texas. "And he gave the order to the safety man. He gave the order to send me to Dallas with my siblings. * * * Since I didn't have anybody [in Illinois] to take care of me, my boss sent me to Texas so that my siblings could take care of me. And he also promised me that he was going to pay for all of the treatments that I incurred in Texas."

Petitioner denied having any surgery after the accident. Petitioner maintained he was "never taken to a specialist to see about [his] spine." "In Anna, none of the doctors ever explained anything to me." "In Anna, they told me that I was going to spend the rest of my life in a wheelchair." The doctor who said that was Dr. Ivankovich (whom Petitioner saw later in Illinois). Upon further questioning, Petitioner stated: "I only received recommendations from the therapists. The doctors didn't even talk to me. It was on the recommendations of the physical therapist that I followed." Petitioner maintained: "I

20IWCC0508
was constantly requesting the nurse case manager to send me to a specialist to see about my spine, to see about my back, specialist to see about my back, my eye, and my neck. *** [T]he therapist and my siblings can testify that I requested it. And the places, the doctors and specialists that I wanted to go see did not accept the Workmen's Comp insurance from Illinois." Petitioner maintained doctors told him that he cannot work. Petitioner was asked about medical records from Pate Rehabilitation stating he had begun working on a website for a business he wanted to start. Petitioner responded: "They did open up a Facebook page for me and they did setup an e-mail contact for me, but the problem is that I can't look at a computer for more than 20 minutes at a time because my good eye starts to get blurry and it gets very tired." At the arbitration hearing, Petitioner wore sunglasses, explaining he had sensitivity to light. Regarding his university education, Petitioner testified he "received [his] degree in *** military aeronomics" from Aeronomic Military University, but "I wasn't able to finish the college."

An individual identifying herself as Erin Connor, a speech and language pathologist at Pate Rehabilitation, testified on Petitioner's behalf. Ms. Connor stated she was also "a certified brain injury specialist" and "a primary therapist at the facility which means that I am responsible for overseeing the patient's full program, cognitive-wise and speech-wise. I set up programs for patients with brain injuries." She worked for Pate Rehabilitation for ten years and in her field for thirty years. Ms. Connor was one of Petitioner's medical providers and had daily interactions with him. When asked about her general observations of Petitioner, Ms. Connor responded: "I was witness to the difficulty that [Petitioner] had during therapy for focusing attention for periods of time. Concentration, memory, following directions. And also word finding during speech, during speaking. And I also witnessed the physical discomfort that I observed as far as the pain from what I can tell, a lot of pain during his physical therapy sessions. Extreme, as far as I can tell, because sometimes it would immobilize him; or the ataxia that he exhibits would become so profound that he couldn't move. ¶ He would have to take medication for nausea as well as for pain. He would have to take rest breaks. And I witnessed him being taken by ambulance from a physical therapy session because of the extreme pain that he was under. Exertional chest pain was the diagnosis. And he also had extremely high blood pressure. They had to stabilize him before he was taken from the facility. I witnessed that as well." Ms. Connor continued: "The therapy that he had to endure by instruction from the physician caused him extreme pain. And pretty much when he was done with his physical therapy in the morning, he had it from 9:00 to 10:00 every morning, it was very difficult for him to continue focusing and staying *** within the treatment day, which is a 9:00 to 3:30 day, *** five days a week. Sometimes he would have to go back to his room and sleep. Always had to take pain medication." Ms. Connor communicated with Petitioner in English because "[t]here was not an interpreter offered to [Petitioner]." Petitioner always understood Ms. Connor because she "made sure he did." Ms. Connor believed Petitioner's problem "was more a matter of the amount of information that he can *** process at one time." Ms. Connor therefore gave short instructions to Petitioner in English. Ms. Connor believed Petitioner had light and noise sensitivity "because of his brain injury."

The following colloquy took place:

"Q. [What did you observe] about [Petitioner's] ability to walk without the wheelchair?

A. Very, very difficult. I witnessed his—they would tie his foot up so that it wouldn't drag. They had him using a walker. But I witnessed him hopping, and I witnessed him extreme ataxia. I witnessed him falling. I witnessed *** the pain that he

was in. *** [T]he extreme amount of attention that he had to put into before he did every movement was very unusual in my eyes. [Petitioner's] case was very unusual to me. That's why I am here, because I have never seen a case present in such a way and not have the benefits that he needed to continue his treatment. I think it's horrible."

After Petitioner left Pate Rehabilitation, Ms. Connor stayed in touch with him and helped him complete paperwork for Social Security benefits. Once Petitioner was awarded the Social Security benefits, Ms. Connor helped him find clinics that took Medicaid and set up appointments. "He had a particular type of Medicaid called Molina, and I spent hours on the phone calling many different professionals that were listed in the directory, and I have copies of them. *** ¶ I would call every single person on that list and they would say, no, we no longer take [Molina]. I would say, so how am I going to get a specialist to see [Petitioner] if none of your providers accept the insurance that are in your directory." Ms. Connor continued: "And when I went with him to a doctor's appointment, if they were lengthy appointments it was very—it was apparent it was stressful for him because he would become—again, the pain would increase. He would have to take breaks."

Ms. Connor was present during Dr. Brylowski's section 12 examination "under [Petitioner's] insistence. He wanted a witness." "[I]n the beginning of the evaluation, long after it started, I witnessed [Petitioner] having neurological-type symptoms where he was not very—he was not present. He wasn't aware that his body was moving. And all different movements. His head was back. They called his name. He wasn't responsive. He vomited a little bit at the end. Dr. Brylowski would not allow anyone to attend to him. He said just observe. And after that was done, [Petitioner] wanted to go out and have a break and use the restroom because at that point it was probably about maybe two or three hours after we had started, and *** he needs a scheduled restroom break. ¶ And so he left the room. And then we came back and he continued. He wanted us to continue. He wanted him to continue with the evaluation, even though he had just suffered from what we can tell is some type of a neurological event." Ms. Connor maintained Petitioner "wasn't there" cognitively. "You call his name, he wasn't responding. His body was moving and shaking." At one point, Petitioner took a break in the waiting room and lied down on the floor. "And I have pictures of his laying on the floor." "And actually throughout the entire time that the MMPI, which is that long lengthy inventory was being—they were expecting [Petitioner] read it and respond, he was on the floor. And I had to read each question to him, several times might I say. Because the questions are not easy to process or understand especially in English."

Ms. Connor also "noted depression" and that Petitioner "would become absent from like in the middle of a conversation. And I would say something to him and he didn't respond. And he didn't respond. And then *** finally he would become awake, and I would say, did you realize that you just were—did you hear what I just said? And he said, no. And I said, well I don't know what's going on, but sounds to me like you need to get checked out neurologically. And so those are the things that I saw. Pain. He was always in pain. There is never a day that he is not in pain. And he told me. I mean, he tells me he's in pain." Petitioner "always uses the wheelchair."

Ms. Connor, at her own expense, traveled with Petitioner from Dallas to Chicago for the arbitration hearing because "[h]e needed assistance." When asked to characterize her relationship with Petitioner, Ms. Connor responded: "A friend, and kind of an assistant. *** I really felt ethically that justice had not been served to [Petitioner], and *** I felt in my heart that I needed to help him." Ms. Connor added: "As a matter of fact, my company doesn't even know I'm involved."

On cross-examination, Ms. Connor testified that she was the only person to accompany Petitioner from Dallas to Chicago for the arbitration hearing. None of Petitioner's family members came to Chicago. Ms. Connor admitted identifying herself to Dr. Brylowski as Karen Scott, a friend of Petitioner's sister. Ms. Connor used the alias Karen Scott "because honestly like I said, my company doesn't know that I am doing this." Ms. Connor acknowledged the speech pathologist identified in the medical records from Pate Rehabilitation is named Erin Hagag. Ms. Connor stated Hagag was her married name, but at the time of the arbitration hearing her legal last name was Connor.

Charles Ingram, a safety manager at Respondent's parent company, testified that Petitioner's accident was reported to him the afternoon of December 2, 2016. On December 3, 2016, Mr. Ingram traveled to Indianapolis and visited Petitioner in the hospital. Mr. Ingram did not have any difficulty communicating with Petitioner, who was "surprisingly fluent" in English. Petitioner complained of "[j]ust the normal soreness. His back was sore and the leg was sore is what I remember." On December 4, 2016, Mr. Ingram again visited Petitioner in the hospital and did not notice anything unusual. On December 5, 2016, Mr. Ingram traveled to the job site for an inspection. Mr. Ingram "interviewed all the employees who were on the work site at the time of the accident, with the exception of [Petitioner], and a young man who was actually the first one on the scene after the accident, who did not come back to work after. He just worked like one or two days and then never came back." Mr. Ingram summarized his findings as follows: "I learned and was disappointed that the excavation and hole had been filled back in already. Every employee who was on the site told the same story. * * * [Petitioner] had been down in the hole. A piece of dirt the size of a five-gallon bucket had hit him from the side. And he was laying in the dirt in the hole when the guy who went after the ten-inch tee that they needed to tie the lateral and the main together, is the one who discovered him. And then quickly the operator, David Martinez, was on site. David went down into the hole with [Petitioner], brushed some dirt off of him. And because they had concerns about more dirt coming down, they got him up. [Petitioner] stood up and walked up what they call the ramp. It's an end of the hole or the excavation that's made for the employees to go in and out of the hole. *** And [Petitioner] walked up. They laid him up on the ramp where he was safe and covered him with coats. " On December 25, 2016, Mr. Ingram again saw Petitioner, this time in a rehab center in Springfield, Illinois. Mr. Ingram and Petitioner spoke about their families and Christmas—"you know, just normal conversation." This time, Petitioner "seemed to have a slight tic, but there was not rhythm to it or anything. There was no frequency, *** just once in a while."

Daniel Arnsman, Respondent's safety representative at the time of the accident, testified that Petitioner's accident was reported to him the afternoon of December 2, 2016. Mr. Arnsman visited Petitioner in the hospital and then conducted a job site inspection and investigation on December 5, 2016. Mr. Arnsman spoke with Petitioner in the ICU. Petitioner recognized Mr. Arnsman and thanked him for coming. Mr. Arnsman visited Petitioner the following day, when Petitioner was being transferred out of the ICU to a regular hospital room. Mr. Arnsman had no difficulty communicating with Petitioner and did not notice anything unusual. On December 12, 2016, Petitioner was discharged from the hospital, and Mr. Arnsman drove him to a rehab facility in Springfield. Petitioner got into Mr. Arnsman's truck by getting out of the hospital's wheelchair, pulling and scooting. When they arrived at the rehab facility, the staff brought out a wheelchair for Petitioner. Petitioner did not do any walking, but appeared able to stand up on his own. Mr. Arnsman regularly visited Petitioner at the rehab facility and noticed, closer to Petitioner's discharge, that he was beginning to develop a tic. Petitioner said he was eager to return to work, and Mr. Arnsman told him that light duty was available when he was

20IWCC0508
ready. Mr. Arnsman last saw Petitioner right before "his brother came and picked him up and they went to Texas, to the rehab facility in Texas."

Turning to the exhibits, an employer's accident report summarizes the accounts of Petitioner's coworkers. "The employee (Juan) was found 1 to 1:30 minutes (estimated time by the track hoe operator) [after entering the excavation] by Installation trainee. Employee (Juan) was bent over on one knee, with a piece of dirt the size of a five-gallon bucket resting on him covering his left shoulder and part of his back. The dirt came out of the sidewall of the bench." The trainee who found Petitioner stated he responded, but not coherently. Another coworker helped Petitioner walk out of the excavation. A third coworker stated Petitioner "was conscious but not very responsive when being talked to." The coworker called 911.

The medical records from Indiana University Health show that on December 2, 2016, Petitioner was airlifted from Tipton Hospital with the diagnoses of bilateral lower extremity paralysis and T5 fracture.[2] Petitioner gave a history of working in a ditch when the trench collapsed around him. He complained of loss of sensation and movement in the lower extremities and minimal movement and sensation in the upper extremities. "The patient had movement of the lower extremities with insertion of a Foley catheter, however." The emergency room staff recorded the following history: "Patient was working in a ditch when the ditch collapsed on him. There is prolonged extrication time of 40 minutes. On evaluation of outside hospital patient is unable to feel from the waist down or move his lower extremities."[3] Subsequently, Petitioner would state he did not recall the accident and only remembered awakening in the ambulance. Imaging studies showed no acute findings, except a "[p]ossible subtle compression fracture of the anterior endplate of T5, without significant height loss. CT findings are equivocal." "No apparent injuries based on workup." There was no evidence of a neurologic deficit. Glasgow Coma Scale was 15 (normal). An MRI of the spine showed no compression fracture at T5 and nothing to account for Petitioner's complaints. Petitioner was admitted to the ICU.

On December 3, 2016, Petitioner complained of loss of sensation in the L1-L2 dermatomes. "[N]ot moving lower ext s/p accident." "[A]wake in bed, moving legs now. C/o neck pain." Petitioner also complained of eye floaters. No interventions or spine precautions were prescribed. On December 4, 2016, Petitioner complained of muscle spasms in the shoulders and neck, as well as diffuse paresthesias. Physical therapy was ordered. Surgery team was consulted and agreed with the recommendations.

On December 5, 2016, Petitioner was examined by Neurosurgery. He reported "he is doing better and his legs feel stronger. He c/o vision changes in his R eye & R leg pain." Neurologic exam was benign, with some giveaway weakness noted. There were no acute neurosurgical findings. An ophthalmology consult was recommended. Petitioner was assessed ready for discharge.

Resident physician notes discuss complaints of pain and some blood with defecation, incomplete emptying during urination,[4] episodes of dizziness, improving leg weakness, blurry vision in the right eye, hearing loss in the right ear, and symmetric ataxia of unclear etiology. An occupational

---

[2] The records from Tipton Hospital are not in evidence.

[3] Apparently, the history of ditch collapse and prolonged extrication came from Petitioner.

[4] A CT scan noted incidental findings of a prominent prostate gland and seminal vesicles.

therapy evaluation summary states: "Dysmetria noted bilaterally and horizontal nystagmus, noted Pt functionally limited this date by impaired activity tolerance, decreased LE strength (L>R), impaired gross/FM coordination, visual perceptual deficits, decreased functional cognition, and deficits in functional transfers impacting his independence with ADL tasks." However, a CT and an MRI of the spine showed no significant cord compression or narrowing. A CT of the head showed no intracranial abnormalities. An MRI of the brain was unremarkable. The staff recommended further workup of Petitioner's ataxia and further ophthalmology workup. A transfer to an acute rehabilitation facility was recommended.

On December 7, 2016, Petitioner was evaluated by an ophthalmologist, who noted the following complaints: "He states that 3-4 day hx of being able to see only straight ahead with right eye—unable to see from sides and what he does see is shadows. *** He states dirt hit his rt parietal head region but denies eye trauma. MRI head orbits did not demonstrate treatable disease or lesions." On examination, Petitioner stated "he sees light in mirror distance and squares on near card right eye." There was no nystagmus. Funduscopic exam was normal. The ophthalmologist was unable to explain Petitioner's presentation and recommended a neurology consult.

On December 8, 2016, Dr. Jason Mackey, a neurologist, evaluated Petitioner. Dr. Mackey noted the following history: "In discussion with the patient and his coworker, it sounds as though he was in an 8-foot deep hole when a portion of the ditch wall collapsed on him. As he was alone at that time, it is unclear exactly what happened. It sounds as though there was not that much dirt covering him, however. It is unclear at this point if something else in the hole may have fallen and hit him in the head." Dr. Mackey noted Petitioner "had multiple neurologic complaints during his stay. He has had trouble with his vision, upper extremity weakness on the left, nausea and vomiting along with vertigo." However, imaging studies were negative. On review of systems, Dr. Mackey noted: "He does complain of a lot of back pain and chest pain. His left arm and hand are weak. He complains of vertigo and nausea, no bowel or bladder incontinence." Petitioner was able to stand with a walker. Neurologic examination was notable for a "marked giveaway weakness in the left upper extremity." Regarding the eye complaints, Dr. Mackey found: "Pupils are equal, round, and reactive to light. Extraocular movements appear intact without nystagmus. Visual fields are grossly full." Dr. Mackey found the neurologic exam "reassuring," without a need for any additional workup. Dr. Mackey further found that Petitioner was ready to be discharged.

On December 9, 2016, transfer arrangements to Memorial Manor were finalized. Respondent agreed to transport Petitioner. On December 12, 2016, Petitioner was discharged. The discharge diagnosis was "[u]pper back pain is likely 2/2 whiplash. Imaging shows no injury to spinal cord and no ligamentous injury." The staff recommended outpatient physical therapy. A discharge notation states: "Patient would not sign report states he did not want to 'assume financial responsibility.' "

The medical records from Memorial Medical Center in Springfield, Illinois show Petitioner received inpatient rehabilitation from December 12 through December 28, 2016. The following history was recorded: "He is a 51-year-old construction worker who had a ditch collapse on him on December 2 causing paralysis from the waist down. He suffered a spinal cord contusion in the lower thoracic region with incomplete sensory and motor quadriparesis as a result. He did have some motor and sensory return but was unable to walk or perform his activities of daily living on his own and was admitted here for spinal cord injury rehabilitation therapy." Of significance is a physician progress note dated December 23, 2016. Dr. David Gelber stated: "Patient improving. He still has some

abnormal motor movements but his tests are normal and I am not entirely convinced that these are organic. They [come] and go and have an unusual appearance." Petitioner's inpatient stay was summarized as follows: "There were no major medical complications during patient's rehabilitation stay. Patient did have some dyskinesias during his rehabilitation stay but ultimately was felt either to be a medication reaction or perhaps movements of a psychiatric nature. Patient's tramadol and acid reflux medications were discontinued and patient's movements did not improve somewhat during his stay. A brain MRI was normal and laboratory studies were normal." It was further noted that Petitioner "showed significant improvement in his functional abilities. At the time of discharge patient could walk 20 feet with a walker and could perform his daily cares and transfers with standby assistance." Because it was felt Petitioner could not live independently, he "will be going to live with a brother in Texas and continuing his therapies there as an outpatient." Petitioner's discharge diagnosis was "[t]horacic myelopathy of a traumatic nature with incomplete sensory and motor quadriparesis at a lower thoracic level." Petitioner was discharged to his family. At the time of discharge, Petitioner was provided with a wheelchair and a wheeled walker. Other equipment and supplies were ordered to be delivered once Petitioner arrived in Texas.

The medical records from Nova Medical Centers in Texas show that on December 30, 2016, Petitioner saw Dr. Peter Marsh, who noted the following history and complaints: "Pt sts was working on a hole and the wall collapsed on him. He has partial paralysis at lower thoracic level. He has just been released from a rehab facility out of state, to be cared for by his brother. We have realized today that it is not reasonable for him to live with his brother, because he can not negotiate in the home. He also needs intensive physical therapy which is only available in a rehab residence facility." "Pt sts feeling pain upper back 7/10, middle back 4/10, lower back 4/10, arms 7/10, neck 7/10, head 7/10, r eye is blurry, l leg is numb and feels sharp pain, r leg 4/10 with sharp pain and cramps, headaches, pulsing, sharp pain, cramps, loses coordination (ataxia)." Dr. Marsh diagnosed an incomplete spinal cord lesion at T11-T12 and ordered inpatient rehab and home health care in the interim.

The medical records from PowerBack Rehabilitation show Petitioner received inpatient therapy from January 5 through January 17, 2017, under the care of Dr. Karishma Khan, an internist who adopted Dr. Marsh's diagnosis. Upon admission, Petitioner complained of "severe left sided weakness and involuntary movements of all extremities." However, repeat examinations of the extremities were unremarkable, and there was no muscle wasting. During the course of treatment, Petitioner's main complaints to Dr. Khan related to constipation and anal fissure. The hospitalist, Dr. Myrna Hsiao, was under the impression Petitioner sustained a traumatic brain injury, a fracture at T5 and incomplete spinal cord injury at T11-T12. "[A]t this time, he continues to have involuntary movement in his extremities. He has significant ataxia. Patient has difficulty controlling his finger movement, the left arm more than the right arm. He states that he has shooting pain down in the extremities that can move around. His right eye is blind, except to see light. He has constant static noise in his right ear. He says that food really has not much taste. His left leg has no voluntary movement at this time but the right leg he does have voluntary movement. Patient states that he has been having difficulty with memory, especially short term memory, he is having word-finding difficulties. He is incontinent of bowel and bladder." Dr. Hsiao, however, noted that outside imaging studies showed no spinal cord injury. On January 17, 2017, Petitioner was transferred to Pate Rehabilitation with the diagnoses of "incomplete lesion at T11-T12 level of thoracic spinal cord, *** paralytic syndrome, unspecified, ataxic gait, paralytic gait, muscle weakness (generalized), other lack of coordination, cognitive communication deficit, headache, dizziness and giddiness, unspecified visual disturbance, slow transit constipation,

attention-deficit hyperactivity disorder, unspecified type, gastro-esophageal reflux disease without esophagitis."

The medical records from Pate Rehabilitation show Petitioner reported a traumatic brain injury due to being buried in a collapsed ditch for 30 to 40 minutes. At Pate Rehabilitation, Petitioner underwent inpatient treatment from January 17 through June 16, 2017, under the care of Dr. Benjamin Nguyen and Dr. John Thottakara, physical medicine and rehabilitation specialists. At the time of admission, Dr. Nguyen assessed "multiple traumatic injuries," "a diagnosis of paraplegia" and "concerns for possible traumatic brain injury." On January 18, 2017, Dr. Nguyen examined Petitioner, noting the imaging studies performed at Indiana University Health were unremarkable. "Due to problem with short-term memory, mental slowing, inability to void consistently, he was subsequently admitted to Pate post-acute rehab to address his probable brain injury as well as possible incomplete spinal cord injury." Dr. Nguyen noted the following work history: "Currently, working in construction. He used to work in Mexico as a math teacher teaching high school algebra and calculus." Petitioner complained of poor memory, poor sleep, constipation and problems with urination and incontinence. "Also has excessive tremor in his left upper and lower extremity, especially to evaluation." "He did not have any tremor until his left side was assessed." Examination of the extremities was as follows: "No edema, clubbing or cyanosis." Neurologic examination was as follows: "He was alert and appropriate in Spanish per interpreter. Face symmetrical. Tongue midline. Manual muscle exam 4+ to 5/5 right upper and lower extremity with giveaway weakness. Left upper extremity antigravity plus; however, when I assessed him, it became markedly dyskinetic, problem with dyskinesia. Left lower extremity 0/5, unable to lift his leg. No clonus was evident. Sensation grossly intact to light touch." Dr. Nguyen assessed "[q]uestionable history of traumatic brain injury from a ditch collapsing on him with rocks and dirt and loss of consciousness, now with possible cognitive deficit," "[m]ultiple lesions, bony fracture on his spinal column," inability to void and overflow incontinence, "[d]izziness and hard of hearing," neuropathic pain, muscle spasm, gastroesophageal reflux disease and neurogenic bowel. Dr. Nguyen ordered MRI studies, neuropsychiatric testing, urodynamic study and an audiogram.

On January 24, 2017, Dr. Carlos Marquez de la Plata, PhD, performed a neurobehavioral intake, concluding: "Pt is a 51 yo male who suffered an hypoxic injury after walls of a trench he was working in collapsed on him causing LOC for at least 1 hr. He also suffered an incomplete spinal cord injury, is experiencing myoclonus and quadriparesis which is causing functional impairments in basic ADLs and ambulation. Cognitively, he experiences symptoms consistent with his injury (distractibility, forgetfulness, mental fatigue, visual field disturbance, and slowed processing speed). These Sx may be influenced by a combo of injury, meds, and possible sleep apnea."

On February 7, 2017, Dr. Thottakara noted the imaging studies and neurological workup performed at Indiana University Health showed no abnormality that would explain Petitioner's "perceived weakness in his lower extremities." "The patient self-reports that his right lower extremity improved; however, he has been having dysfunction in the bilateral upper extremities and no improvement in the left lower extremity. He reports he has abnormal sensation throughout his arms and legs, a feeling of roughness. He reports dysfunction with voiding, sexual dysfunction in his inability to maintain erection and difficulty with defecation. He reports with his bladder he has to apply suprapubic pressure to evacuate his bladder fully. *** He does report that he has had issues with memory, attention. He reports he feels sleepy. He thinks it is because of the medications. Denies any seizures. Reports that his mood is fine. He does feel anxious at times, however. He reports that his vision is impaired in his right eye and he has decreased hearing in his right ear." Dr. Thottakara noted Petitioner

closed his eyes throughout much of the conversation. "His affect ranges from somber to laughing at a situation. He is able to follow commands and attempts to participate with the examination." Neurologic examination was as follows: "Reveals him to have fluent, nondysarthric speech. In observation when called to do activities, he has some abnormal movements, some dystonic in nature, some best described as choreoathetotic, but again, these are inconsistent and not present at all times. His motor exam is remarkable for poor effort with giveway weakness throughout the bilateral upper and right lower extremity with more so giveway weakness in the left upper extremity. He has no active movement throughout the hip flexors, knee extensors, plantar flexors, dorsiflexors to command. He has 4+/5 strength in right lower extremity, at least 4+/5 strength in the bilateral upper extremities. He has significant abnormal movements when trying to do finger-to-nose bilaterally. He has impaired fine motor coordination in the right on command. When asked to tap his fingers, he is unable to do so smoothly. More dysfunction on the left than the right. Reflexes are 2+ and symmetric at the biceps, triceps, brachioradialis, patella and Achilles. Again, it is symmetric bilaterally in the lower extremities. No clonus bilateral ankles. Negative Hoffman sign bilaterally. Normal muscle bulk and tone throughout. There is no spasticity noted in the bilateral upper or lower extremities. He has decreased sensation to pinprick throughout his face and bilateral upper and lower extremities. He can best discriminate sharp, dull in his right lower extremity although he reports he cannot discriminate in his bilateral upper or left lower extremity. I attempted to stand him from the wheelchair. He is able to put his arms on the armrest and support himself with his right lower extremity. When asked to take pressure off his right foot, he reports he is unable to do so." Dr. Thottakara diagnosed incomplete tetraparesis, impaired cognition, impaired vision, impaired hearing, bowel and bladder dysfunction, and anxiety, qualifying: "With regard to patient's incomplete tetraparesis, unclear what lesion would be responsible for all his deficits. Again, there is giveaway weakness and inconsistencies with the examination. He reportedly had imaging studies of his spine that were unremarkable or could explain his deficits. Do agree that should look into MRI brain one last time given his deficits are more consistent with movement disorder in the bilateral upper extremities and right lower extremity; however, I think the yield is quite low here." Further, Dr. Thottakara recommended neuropsychiatric testing, urodynamic studies, neuro optometry assessment, audiology assessment, and "psychiatry referral for evaluation of mood issues and to be involved as his condition (pending completion of other workup) appears to be psychosomatic in nature."

On February 10, 2017, Petitioner saw Dr. Rena Malik at the Urology Clinic of the University of Texas Southwestern Medical Center. No abnormality was found on examination. Petitioner declined urodynamic testing "due to bad experience with catheters previously." Dr. Malik prescribed Viagra for erectile dysfunction.

On March 16, 2017, Petitioner underwent repeat MRI studies. An MRI of the cervical spine showed "[v]ery mild multilevel cervical spondylosis without evidence of neural impingement at any level. No acute injury is identified." An MRI of the thoracic spine showed "1. Small right paracentral disc protrusions at T6-7 and T7-8 which contact the ventral margin of the cord but do not narrow the AP dural diameter at midline. 2. Marrow signal is within normal limits and there is no evidence of acute fracture or stress injury." An MRI of the lumbar spine showed "1. Disc space narrowing, disc desiccation, and left paracentral disc protrusion superimposed on a disc bulge at L5-S1 without evidence of neural impingement. 2. No lumbar vertebral body compression fractures." An MRI of the head and brain showed abnormalities "more likely related to chronic ischemic changes rather than a history of traumatic axonal injury." There was no acute intracranial abnormality.

On March 29, 2017, Dr. Nguyen reviewed the repeat MRIs, also noting unremarkable imaging studies from Indiana University Health. Dr. Nguyen stated: "[The patient] [c]omplains of constant pain, appears anxious, and is seen by Cathy Parker of Psychiatry. Neuropsyche testing reveals minimal cognitive deficits, suggestive of conversion disorder if other medical causes are ruled out. Able to ambulate 237 ft with PT, although L leg was flaccid to my exam today." "Complained of poor memory. Complained of poor sleep. Complained of constipation requiring stool softener as well as problem with urination and incontinence. Also unable to move LLE." Additionally, Petitioner complained of pain in the low back and numbness/tingling in the fingers. Dr. Nguyen confirmed that Petitioner was prescribed Viagra, among his other medications. Examination of the extremities was as follows: "No edema, clubbing or cyanosis." Neurologic examination was as follows: "He was alert and appropriate in Spanish per interpreter. Face symmetrical. Tongue midline. Manual muscle exam 4+ to 5/5 right upper and lower extremity with giveaway weakness. Left upper extremity antigravity plus. Left lower extremity 0/5, unable to lift his leg. No clonus was evident. Decreased sensation to light touch." Dr. Nguyen assessed: "1. Questionable history of traumatic brain injury from a ditch collapsing on him with rocks and dirt and loss of consciousness, now with possible cognitive deficit. Initial imaging in Indiana was negative. Has minimal cognitive deficits per recent neuropsyche testing. ? Conversion disorder. MRI brain/C/T/L spine does not explain for his neurological deficits. *** 2. Multiple lesions, bony fracture on his spinal column. Again, MRI of the cervical, thoracic and lumbar spine does not explain for current motor deficits. He requests to be seen by a spine specialist. I will set him up with Dr. Ankit Patel of Spine service for further evaluation, including an EMG nerve conduction study to evaluate why his left leg is so weak. 3. Inability to void. He complained of inability to void. He did require intermittent straight catheterization when he was in Indiana. Now, he also has overflow incontinence. 4. Dizziness and hard of hearing. No complaints today. 5. Neuropathic pain. Continues to complain of pain in the arms and legs. We will increase Neurontin *** for pain control. 6. Muscle spasm. See above. If needed, will add Robaxin. 7. Gastroesophageal reflux disease. We will continue Prilosec ***. 8. Neurogenic bowel. He is able to move his bowel with Colace and senna as well as suppositories b.i.d."

On April 10, 2017, Dr. Thottakara and Emily Harstad, Petitioner's rehabilitation program manager, issued a letter to Petitioner's attorney stating: "[The patient] presents with motor changes including ataxia, paralysis, weakness, dystonia, significant pain, vision loss, and vertigo. He has undergone various imaging and testing to help determine the etiology of his deficits. The most recent images do not reveal any injuries that would be causing him to have these deficits however additional testing is recommended. ¶ [The patient] participated in neuropsychological testing on 3/2/17 and 3/3/17. While the assessment does state the possibility of Conversion Disorder, this diagnosis could only be considered if no organic etiology is found for his physical symptoms. Conversion Disorder diagnosis is rare and many cases are later found to have an organic etiology. Therefore additional assessments are recommended to rule out any possibility of a medical pathology that would explain his physical symptoms. The recommended assessments should include but are not limited to an EEG, EMG, nerve conduction study, and blood tests to rule out vitamin deficiencies and other reversible cause of motor dysfunction and cognitive decline. It has also been recommended that [the patient] be evaluated by a neuro-optometrist to assess the vision loss in his right eye to help rule out oculomotor dysfunction, visual-spatial dysfunction, visual perceptual deficits, and traumatic visual acuity loss. An otology/neurotology consultation has also been recommended to help determine any structural changes within the ear and/or ear canal that could be contributing to his chronic vertigo."

On May 2, 2017, Petitioner complained of chest pain during physical therapy and was sent to the emergency room of Medical City McKinney. Cardiac workup was unremarkable, and Petitioner returned to Pate Rehabilitation the following day.

On June 6, 2017, Petitioner saw Dr. Thottakara after a physical therapist reported no improvement in the memory impairments. Petitioner reported "difficulty with tolerating light and often prefers to be in a dark room. *** He continues to complain of pain in nerves." He also reported depression and anxiety. Examination of the extremities was as follows: "No pedal edema, no calf tenderness. It should be noted that in the left lower extremity there are no skin changes, no asymmetric changes in terms of edema. Muscle bulk is symmetric." Neurologic examination was as follows: "Reveals him to have full functional range of motion of the shoulders. When attempting to do pronator drift he does some abnormal twitching, but is able to maintain without drift. His strength appears to be full in the bilateral upper extremities and right lower extremity. On command he does not move his left lower extremity in terms of hip flexion, knee extension, knee flexion, plantar flexion, and dorsiflexion. He has reflex in the patella as well as Achilles. No clonus in the ankle. It should be noted that he is somewhat argumentative during today's session insisting upon seeing a spine specialist before he completes more treatment." Dr. Thottakara diagnosed spine dysfunction/back pain, neuropathic pain, hypertension and depression, qualifying: "With regard to the patient's spine and back dysfunction, he presents with left lower extremity flaccid paresis; however, he does have symmetric reflexes compared to the contralateral right side and no upper motor neuron signs. I cannot explain this lesion by imaging studies." Dr. Thottakara instructed Petitioner to follow up as needed.

Petitioner underwent physical, occupational and speech/language therapy at Pate Rehabilitation. One of the physical therapists noted Petitioner "will be able to return to computer work including plans to do online business," further noting: "He travels frequently between the United States and Mexico and owns several businesses." Another provider noted: "He used to work in Mexico as a math teacher for HS Algebra and Calculus." One of Petitioner's providers was Erin Hagag, a speech and language therapist. She was not one of his main providers.

A discharge record states, among other things, "[The patient] sought treatment at the Parkland Emergency Department for complaints of severe back pain. From that ED visit, he has been referred to see various specialists (internist, neurologist, spine specialist). He has not shared the dates/times of these appointments with Case Manager at Pate." Petitioner did not meet most of his treatment goals. However, he was looking into starting an online business and had recently set up a Facebook account.

The medical records from NeuroHispanos show that on March 2, March 3, March 13 and March 22, 2017, Dr. Katrina Belen, Psy.D., performed a neuropsychological evaluation of Petitioner, noting the following occupation/work status: "Seasonal construction worker in U.S. Seasonal gem miner in MX. Mexican Airforce – Selective Service by history." Dr. Belen noted the following educational history: "14 years in MX Pilot – MX Air Force and commercial. Advanced learner by report." Dr. Belen noted the following complaints: "He reports that vision in his right eye is foggy and that his left eye is normal. He reports that his eyes burn currently and he believes his eyes are infected;" "He reports that he hears well with his left ear. He experiences buzzing in his right ear that is bothersome and was not present before injury;" "He reports vertigo since the day of injury;" "He reports that he cannot smell. Food has no flavor and he does not have an appetite;" "He reports that his hands feel like they are asleep. His face has reduced sensation and feels as if there is a piece of paper over it;" "He reports pain in his neck that is currently between a 4 and 5 on a 10-point pain rating scale

that can escalate to an 8 or 9 on a 10-point scale. *** He experiences cramping in his hands bilaterally. He reports radiating pain in his legs. He reports spasms causing his head to jerk back. He reports that pain seems to start in his upper back and runs throughout his body. When he steps he has cramping and radiating pain. He reports that his entire body hurts. He has strong headaches about twice per week that last about 24 hours;" "He reports heightened sensitivity to light when experiencing headaches;" "Since injury he is weak and he fatigues more easily;" "He reports tremor throughout his entire body and legs. He reports that his hands move involuntarily and he reports non-purposeful movements. He reports that his jaw dislocates on the right and he has problems chewing;" "He reports that he can't move his left leg, his right leg is strong but has poor coordination;" "He reports he is not able to write because of problems with tremor and coordination. He can type slowly;" "He reports he is able to maneuver and navigate his wheelchair well and anticipates being able to return to driving;" and "He has problems with short term memory on occasion and this seems to be improving." On neuropsychological testing, Petitioner "endorse[d] an unusually large amount of atypical neurological complaints that was consistent with his observed behavior." Petitioner's "most notable concerns are related to motor changes including ataxia, paralysis, weakness, and dystonia that do not seem to correlate with imaging and other objective measures, according to his physicians and therapists. If there is no organic etiology to his physical symptoms, a diagnosis of Conversion Disorder (DC) may be considered. True CD is rare, with an incidence rate of 14-22 cases per 100,000 population. In as many as 25-50% of patients diagnosed as CD, an organic medical diagnosis is eventually found. The diagnosis is always temporary and conditional, due to the time factor involved until the appearance of organic evidence. ¶ A complete medical assessment is essential in order to rule out any possibility of an organic etiology and might include imaging (MRI), electrophysiological studies *** and blood tests to rule out vitamin deficiency and other reversible cause of motor dysfunction." Dr. Belen also recommended neuro-optometry and audiology/otology evaluations. Dr. Belen felt that "[t]reatment should be directed towards the symptoms. Whether his symptoms are organic in nature, or psychological, [it] is recommended that he be hospitalized according to his physical symptoms and not placed, for example, in a psychiatric unit."

The medical records from Parkland Health and Hospital System show that on May 31, 2017, Petitioner was seen in the emergency room with complaints of chronic, gradually worsening back pain. He was administered dilaudid and valium, and discharged. On August 30, 2017, Petitioner presented "to establish care." "He has brought a brief discharge summary from his rehab but no other records." The staff were under the impression Petitioner had just moved to Texas from Illinois. Petitioner was seen by a nurse practitioner.

The medical records from the University of Texas Southwestern Medical Center, which contain duplicate medical records from Drs. Nguyen, Thottakara and Malik, are also significant for a chart note dated October 16, 2017, stating "[s]pouse, Erin"[5] requested an appointment for Petitioner for back pain. On October 17, 2017, Petitioner was a no show, no call for his appointment with an orthopedic surgeon. On October 24, 2017, Dr. Kavita Trivedi, a physical medicine and rehabilitation specialist, performed an "initial assessment" of Petitioner, who was "self referred." Dr. Trivedi reviewed the imaging studies from March of 2017, but apparently not the notes from Drs. Nguyen and Thottakara. Dr. Trivedi ordered X-rays and electrodiagnostic studies.

The medical records from Los Barrios Unidos Community Clinic, which are summary, span the time period from November of 2017 through November of 2018. There is also a record from Lone Star

[5]Petitioner repeatedly stated his wife lived in Mexico and was unable to visit him in the US.

Neurology dated November 30, 2017, noting the following complaints: "He has numbness and tingling in bilateral upper extremities, right sided numbness in his right toes and his left lower extremity from the hip down. He also has numbness and tingling on both sides of his face but worse on the right side. He has pain radiating from his back and down bilateral lower extremities. He also states that he has neck pain that is worse with movement of his arms and neck. He has episodes of dizziness when he does any physical activities, when he stands up, and occasionally upon walking. He does not have vision in his right eye and he is sensitive to light. He has dystonia, incontinence, erectile dysfunction, has no sensation of taste or smell. He also has headaches every day that last a few hours that are located in the frontal region and move backwards that are associated with nausea. He has some problems with memory – has trouble following a conversation and problems doing calculation. He has ataxia and is unable to walk without a walker and someone helping him." Neurological examination was normal, however. An EEG was also normal, showing no epileptiform abnormalities or seizures. A colonoscopy performed August 8, 2018, found polyps and hemorrhoids. Another EEG was performed October 23, 2018, after Petitioner complained of daily seizures. "During this routine EEG, the patient had an event *** during which he made a loud gasp and then had Left leg extended/elevated, and then had Left arm arrhythmic shaking in variable directions with start/stop features; he was unresponsive to the technician testing during this episode, which lasted about 45 secs. Afterwards, he reported nausea and malaise. There was no associated EEG correlate, aside from the associated movement artifact." The EEG did show "background slowing *** in a nonspecific finding but does suggest a mild degree of encephalopathy."

The medical records from Chicago Musculoskeletal Institute show one visit, on May 3, 2018. Petitioner saw Dr. Ivankovich, who noted Petitioner presented "due to pain in his back and paralysis of his left leg after a workplace accident that occurred in December of 2016 in which debris fell upon him." "Patient notes pain in his upper back that radiates to his arms and chest and lower back pain that radiates to his legs. He also experiences numbness in his hands bilaterally." Petitioner additionally reported difficulty with urination. Physical examination was notable for spasticity of the hands and diminished sensation over the face and left leg. "Patient has ataxia, which is more pronounced when attempting to stand. Unable to assess gait as patient is wheelchair bound." Dr. Ivankovich referred to imaging studies that showed a disc herniation at T6-T7 and disc protrusion and spondylosis at L5-S1. He recommended electrodiagnostic studies and a urology consult.

Respondent had Petitioner examined by Dr. Tasker, an ophthalmologist, Dr. MacMaster, an orthopedic surgeon, and Dr. Brylowski, a psychiatrist and neurologist. In his section 12 report dated June 20, 2017, Dr. Tasker noted the following history and complaints: "52-year old with history of being in an eight-foot hole when the ditch they were building collapsed on him and he was trapped. *** Extraction by co-workers took 30-40 minutes. He apparently had loss of consciousness and only remembers the collapse. He was noted to have inability to move lower extremities post-injury when seen at the emergency room. This was diagnosed as incomplete paraplegia. Patient also had vision deficits, right ear hearing loss and continued dizziness." Dr. Tasker evaluated Petitioner for a complaint of vision loss in the right eye. Dr. Tasker reviewed the medical records, noting various complaints of vision loss in the right eye, limited vision in the right eye, blurry vision in the right eye, and a shadowy appearance in the vision field of the right eye. Petitioner reported prior eye surgery ten years earlier. On examination, Petitioner claimed he was unable to see out of the right eye. Dr. Tasker found Petitioner uncooperative during a portion of the examination. The examination showed no physical defect in the right eye. Subjective examination was inconsistent. Dr. Tasker stated: "There was no documented injury to the visual system, no MRI or CAT scan damage to the visual system in

the brain, and nothing but symptoms has been documented in review of the medical records without consistent findings of nystagmus, foggy vision, total loss of vision in the right eye, or anything on the examination to produce a visual field defect. Important documentation is missing in the documents reviewed to understand what eye surgery was performed ten years ago on the eyes. Incomplete medical records leave gaps in the true diagnoses of pre-existing ocular conditions." Dr. Tasker concluded Petitioner sustained no ocular damage as a result of the accident.

In his section 12 report dated June 26, 2017, Dr. MacMaster noted the following history and complaints: "The patient *** presents with complaints of pain in the thoracic, lumbar region and cervical regions. He also complains of bilateral leg pain and numbness. He says he is unable to walk because of weakness in his legs, left greater than right. The onset was sudden with an on-the-job injury that occurred on 12/2/2016. [The patient] explained that he was in a 10 foot-deep ditch, cutting a pipe when the sides of the ditch suddenly caved in on top of him. He said that it was raining at the time. He says he doesn't really remember much about the accident but has been told that it took a long time to free him." Petitioner rated his current pain a 3/10. Dr. MacMaster reviewed the medical records, noting no diagnostic evidence to substantiate Petitioner's complaints of paraplegia. Physical examination was notable for reports of decreased sensation in a non-dermatomal distribution. There was no noticeable atrophy in the cervical, thoracic or lumbar musculature or the extremities. Overall, the examination was "inconsistent with any known physical injury to the neurological or musculoskeletal systems." "[T]he objective findings and observations on examination do not support [the patient's] subjective complaints. Specifically, he has no objective evidence of any incomplete spinal cord injury, no objective evidence of a fracture involving the thoracic spine, and no objective evidence of urinary retention. Additionally, on observations made during my examination, [the patient] demonstrated muscle activity in his left lower extremity that he did not show during my motor examination of that extremity." Dr. MacMaster "found no evidence of a specific ongoing physical injury," excluding any psychiatric or psychological condition, and no aggravation of any preexisting condition. Dr. MacMaster therefore opined Petitioner required no further treatment from the orthopedic standpoint. Rather, Dr. MacMaster found symptom magnification, stating: "[The patient] was quite histrionic during the interview conducted while I performed his physical examination. He insists that he has severe physical injuries that preclude many activities but demonstrates mobility of the extremities that is completely inconsistent with his claimed degree of impairment." Dr. MacMaster suspected a neuropsychiatric injury. Regarding Petitioner's work status, Dr. MacMaster opined he "could return to Modified Duty at the position he was performing prior to the accident of December 2, 2016. His limitations would include no lifting of greater than 35 lbs., no climbing of ladders or scaffolding, and no kneeling/stooping/bending/crawling." Lastly, Dr. MacMaster opined Petitioner had reached maximum medical improvement on or about March 16, 2017.

In his section 12 report dated January 28, 2018, Dr. Brylowski began by noting Petitioner did not complete a registration form. The examination, which lasted approximately three hours, was videotaped. Petitioner presented with "his friend, Karen Scott." Petitioner stated he did not remember his date of birth. "The claimant was talking about needing a translator, but he was discussing that in English. He had good command of English language." Dr. Brylowski further stated:

> "The claimant is in a wheelchair and sometimes he propels himself and sometimes Karen Scott propels it. *** He reports that sometimes he has accidents in his pants, and at night he uses Pampers. He reports that he does not remember getting any type of registration packet despite at least two being sent out to him. The claimant is

wearing sunglasses indoors. He then goes into very dramatic behavior. His pupils were equal round reactive to light and accommodation. He acts bizarre and almost becomes combative in the examination when it gets close to examining him. The examiner observed this for approximately 20-30 minutes. Eventually the claimant began to be more interactive and had [to] go to bathroom. He was given his urine drug screen to do, came back and interacted for the examination process. He responded to questions about why he was here, apparently not understanding. But in the context of the examination, he describes not getting any treatment from the insurance company, listed about 14 different things that they are not doing for him and made a comment about other than these types of examination, where he does not get prescribed any medications or get any treatment which was the explanation that was provided to him, so he understood why he was here.

The claimant reports to get some treatment for depression. He does not remember who prescribes medication, but he takes one pill for it. Ms. Scott is unable to provide any information even who the psychiatrist is. She does volunteer information that brother and sister help, that he lives in a small house on the property of his brother. She reports that she has never seen anything like the behavior that she is seeing in this examination with him in a wheelchair. She reports that she has seen absence seizures. When asked what those are, she reports that he will get a blank stare for a couple seconds, like he is not there. ***

Karen Scott *** is a friend of his sisters and describes him living in a small house in the back of his brother's house. Karen Scott is angry that the insurance company would not pay $3000 for concrete driveway which they needed so that he could use his wheelchair. She reports that they did pay for remodeling his house in order to accommodate his various alleged deficits. She reports that PATE Rehabilitation had sent out an onsite person to inspect and provide the recommendations. She reported that the claimant was at PATE for about 6 ½ months. Karen Scott had never observed the claimant urinating and defecating on himself but knows that he urinates on himself because he is incontinent. She reports she knows that because she read it in the medical record. She reports that the current incident was brought on by stress. When asked what she meant by that, she reported that she was just making that assumption.

The claimant eventually came around after about 20-30 minutes. He reports he has most of the pain in his neck and it radiates to both arms. He reports he has pain in all his nerves. He reports he will shake. He reports he cannot do anything he used to do. He reports that his goal is to recover and still work. He reports his work in the past has included cooking. *** He reports he worked as a farmer in the field in California with his father. He would pick fruits and vegetables. He reports he has done construction and that he was doing construction at the time of the injury. *** He reports that he does not work for them anymore because he cannot do heavy work. He reports he cannot do heavy work because he had an accident. The claimant reports it was wet and rainy and they were in a hole about 10 feet deep. He reports he was trying to connect something related to the pipe and the trench collapsed on him. He reports he felt pain and could not breathe, and then he felt pain in his back and his heart but he does [not] remember anything and the next thing he remembers is being in the hospital.

Examinee reports that his friends explained to him that there was an accident. He reports that friends told him that he was not breathing and turned very white. They thought he was dead. He reports they put a sheet over him. He reports that his friends and paramedics arrived and others from his best understanding, dug him out. He reports a helicopter took him to a nearby hospital. He reports that he had broken C5 and C6 vertebrae; but he had no surgery and no need for halo. The claimant described being angry at the insurance company for not fixing his broken bone in his neck. He reports he was told he had several discs. He reports he was eventually sent to Dallas and that Workers' Comp never sent him to see a spine specialist or neurologist. He reports when his blood pressure went up when he was at PATE Rehabilitation, he had to go to the hospital and he had a heart attack. He reports he has never received proper treatment for his spine. He reports they cut his benefits. He reports he is getting Social Security and Medicare."

Petitioner's complaints included "[r]ight eye," loss of sense of smell, loss of sense of taste, loss of hearing in the right ear, impotence, needing to urinate every three hours, anal bleeding, stomach problems, insomnia/sleep apnea, flashbacks, expressive aphasia, dizziness, nausea and headaches. Dr. Brylowski noted significant alcohol consumption. Petitioner reported to Dr. Brylowski he had only a primary education. "He has worked in the cooking, farming, construction and concrete work."

Petitioner stated he did not remember his height or weight and became combative when Dr. Brylowski attempted a physical examination. Dr. Brylowski made the following notes of appearance and behavior: "The examinee is in a wheelchair. He behaves in very bizarre nonphysiologic spastic-like behavior. Karen reports he fell in the shower today. However, she did not see him do that." "Behavior is bizarre, dramatic, and he postured in nonphysiologic fashion. He looked like he was going to vomit, and Karen wanted to go get a bucket and I asked everybody just to observe. He ended up spitting a little bit on the floor or letting spit drip from his mouth. I wanted to examine him at that point. However, he was postured in a violent fashion towards the examiner. However, in the course of formal psychiatric examination, he reports he never gets upset and is never violent with people." "Affect is flat. However, when making comments about age and then asking him about wanting to kill himself or anybody else, he is able to laugh robustly." "The claimant says he cannot understand English, but he speaks and understands English very well. He has a poor grasp of Spanish. For the Spanish proverb he could not even translate it." "Thought processes are excellent. He is able to consistently be of poor cooperation and obstruct trying to get answers. He frequently says, 'I do not remember,' or 'I do not know.' " "The examinee denied auditory or visual hallucinations and laughs when I asked him about that." "The examinee was alert and oriented to person, place, time and date." "Memory for remote events is good. He is able to relay the accident. Immediate recalls appeared to be poor. Short-term memory appears to be poor. He is able to recall 3 of 3 objects with prompting of 2 after about 5 minutes." "Concentration is excellent. He is able to maintain his disability posture. He cannot spell the word VERDE. He cannot spell his first name. He cannot do simple arithmetic. However, he is able to do 1+1 and 5+1. For 10+5 he reports, 'I do not know.' He is able to subtract 1 from 5 and then 1 from 4 and then 1 from 3 and so on, but when asked what 1-1 was he reported 'no more.' " "Insight and Judgment are poor. The claimant is acquiesced to disability lifestyle." Test of Memory Malingering showed Petitioner's memory was "excellent." MMPI-2 showed good concentration and "selective responding for unknown motivation." MMPI-2 was positive for anxiety and depression, but also "consistent with some concern about overreporting psychiatric issues," "consistent with extreme over

reporting of somatic, cognitive, and memory complaints," and consistent with somatic symptom disorder or conversion disorder. Urine test was negative for illicit drugs.

Dr. Brylowski diagnosed: a conversion disorder or factitious disorder, preexisting alcohol use disorder, general personality disorder, and possible ADHD—all unrelated to the work accident. Dr. Brylowski further diagnosed extreme symptom magnification. Lastly, Dr. Brylowski opined Petitioner could return to work full duty.

The Commission, having carefully considered the entire voluminous record, including the video of Dr. Brylowski's examination, modifies the Decision of the Arbitrator with respect to permanent disability. The Commission considers the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act): "(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." 820 ILCS 305/8.1b(b).

Regarding factor (i), the Commission notes no impairment rating has been submitted into evidence. The Commission therefore gives no weight to this factor.

Regarding factors (ii), (iii) and (iv), Petitioner's occupation at the time of the accident was a laborer. The record indicates Petitioner was an itinerant worker, who suffered from preexisting mental disorders. The Commission finds no objective evidence that the work accident caused a loss of trade. Rather, Petitioner's age (currently 55) would make it difficult to work as a laborer. The video of Dr. Brylowski's examination confirms Petitioner's fluent command of English. The Commission finds the work accident caused a decompensation of Petitioner's mental condition. Given Petitioner's extreme symptom magnification, the Commission declines to find the work accident caused an impairment of earning capacity.

Regarding factor (v), the objective findings do not corroborate significant physical injury. Rather, the work accident caused a decompensation of Petitioner's mental condition. The Commission gives substantial weight to this factor, while being mindful of Petitioner's extreme symptom magnification.

The Commission finds the proper measure of disability is 20 percent of the person as a whole.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2019 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $693.19 per week for a period of 15 weeks, from December 2, 2016 through March 16, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $623.87 per week for a further period of 100 weeks, as provided in §8(d)2 of the Act, for the

reason that the injuries sustained caused the permanent partial disability to the extent of 20 percent of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 1 2020
o-08/05/2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0508

HERRERA, JUAN Case# **17WC008945**
Employee/Petitioner

AG DRAINAGE INC
Employer/Respondent

On 2/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

5578 FRANCESCA D LARSEN LAW OFFICE
150 N MARTINGALE RD
SUITE 225
SCHAUMBURG, IL 60173

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

Juan Herrera
Employee/Petitioner

v.

AG Drainage, Inc.
Employer/Respondent

Case # **17** WC **008945**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **November 16, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 2, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**54,068.56**; the average weekly wage was $**1039.78**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**22,083.91** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,083.91**.

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

ORDER

Temporary Total Disability

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $693.19 PER WEEK COMMENCING DECEMBER 2, 2016 THROUGH MARCH 16, 2017, AS PROVIDED IN SECTION 8(B) OF THE ACT. RESPONDENT SHALL BE GIVEN A CREDIT OF $22,083.91 FOR TEMPORARY TOTAL DISABILITY BENEFITS THAT HAVE BEEN PAID.

PERMANENT PARTIAL DISABILITY

BASED ON THE FACTORS IN SECTION 8.1B(B) OF THE ACT, AND THE RECORD AS A WHOLE THIS ARBITRATOR FINDS THAT PETITIONER SUSTAINED PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 45% LOSS OF A PERSON AS A WHOLE, AT A RATE OF $623.87 FOR 225 WEEKS, PURSUANT TO 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]
Signature of Arbitrator

February 19, 2019
Date

FEB 19 2019

Juan Herrera v. AG Drainage, Inc., No. 17 WC 008945

Preface

The parties proceeded to hearing November 16, 2018, on a Request for Hearing indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to the injury; whether Respondent is liable for unpaid medical bills or expenses incurred after June 26, 2017; whether Petitioner is entitled to temporary total disability from December 3, 2016, through November 16, 2018; and what is the nature and extent of the injury. Arbitrator's Exhibit 1. Although a transcript of proceedings was ordered, it was never provided to this Arbitrator. Therefore, references to testimony taken at the hearing are done in reliance on the contemporaneous notes taken by this Arbitrator. The parties submitted 11 joint exhibits of approximately 4,000 pages of various medical records. Most were unpaginated, many were out of order or not sequenced. The records were fairly duplicative and cumulative, with a fair number in Spanish, which could not be read by this Arbitrator. Respondent submitted seven exhibits and Petitioner, two. Except for those in Spanish, all records were thoroughly reviewed.

Findings of Fact

On December 2, 2016, Juan Herrera (Petitioner), a 51 year old male, was working for A.G. Drainage (Respondent) as an installation laborer making lateral pipe connections in an agricultural field near Kempton, Indiana. Petitioner was in an excavation hooking up a lateral pipe to a main pipe. He had been warned not to enter the excavation until someone was watching him. He ignored that warning. Petitioner testified as to what happened in the excavation. His version cannot be deemed reliable, given the lack of corroborative evidence, his documented and observed cognitive impairment, and his repeated statements throughout the medical records that he did not remember the incident. Joint Exhibit 6 (unpaginated); Joint Exhibit 2 at 175. There were no eyewitnesses to the event.

An analysis of the event by Respondent, which is the only credible version of events, revealed Petitioner was crouched on one knee making the connection, and found by a coworker one to one and a half minutes later still on his knee with a piece of dirt, the size of a five gallon bucket, resting against his left shoulder and small portion of his back. The coworker entered the excavation and moved the dirt off Petitioner. The coworker called others to help, as he had a hard time understanding Petitioner. Petitioner stood up with very little help and walked under his own power 10 to 12 feet up an elevated ramp before lying down. Petitioner was conscious, and never lost consciousness the entire time his coworkers, and later police, were with him. Respondent's Exhibit 7; Joint Exhibit 5 (unpaginated) (1-23-17). However, on December 5, 2016, A Registered Nurse, Savannah Mason, memorialized an event in her notes stating that a coworker of Petitioner stopped her to tell her he found Petitioner face down with his knees

buckled under him and nothing had collapsed on him. The coworker showed her pictures of the excavation and the walls did not look like they had collapsed. Mason recorded the encounter because she was worried there might be something medically wrong with Petitioner deeper than what they are observing but Petitioner does not want to confront it because he wants to get back to work to send money back to Mexico. Joint Exhibit 1 at 772-773.

There are no reliable records or testimony about the depth of the excavation, about Petitioner's ever being trapped in the excavation, or any type of extended period of extraction. There was no extraction, Petitioner walked out of the excavation. There are no records at all of any emergency services taking Petitioner to initial medical care. There are virtually none to indicate his initial medical care. These would have been of great value in showing Petitioner's initial medical condition.

The first somewhat reliable medical records regarding Petitioner are from Indiana University Health. Petitioner was admitted December 2, 2016. His admitting diagnosis was, simply, trauma. A CT scan of his thoracic spine indicated a possible subtle compression fracture of anterior endplate of T5 without significant height loss. CT findings are equivocal. This fracture was never verified. A CT scan of Petitioner's lumbar spine showed no apparent injuries. Joint Exhibit 1 at 20, 2, 31.

The records note a language barrier with Petitioner not speaking English. At the same time, they also note Petitioner speaks fluent English. Joint Exhibit 1 at 57, 62, 322, 610. This is a glaring inconsistency that appears throughout the records and testimony. As many reflections of a language barrier [Joint Exhibit 8 (seen with interpreter); Joint Exhibit 9 (Spanish interpreter); Respondent's Exhibit 3 (modest grasp of spoken English)], there are many more notations of Petitioner's fluency in English [Joint Exhibit 2 at 69-72 (declines interpreter); Joint Exhibit 4 (declines offer of interpreter); Joint Exhibit 5 (speaks English well, patient spoke English), Joint Exhibit 6 at 1-16 (confident in English proficiency), Joint Exhibit 7 (language is English), Respondent's Exhibit 4 at 2 (good command of English language), 10 (English very good), 11 (understands English very well), Joint Exhibit 10 (language is English)] Two witnesses at trial, Charles Ingram and Daniel Arnsman, both testified they had no language issues with Petitioner and no language barriers.

Early, on December 8, 2016, Dr. Jason Mackey noted it was unclear exactly what had happened in the hole. The records note a brain MRI was unremarkable, and from a neurological perspective, Petitioner could be discharged. The discharge notes, from December 2, 2016, through December 12, 2016, note Petitioner was unable to feel or move his lower extremities and complained of back pain. No operative intervention was recommended. Petitioner complained of decreased vision in his right eye, but an exam was normal, and the etiology was of uncertain origin. Petitioner's pain was well controlled, he was ambulating. An MRI of his spine showed nothing to account for lower extremity weakness. Petitioner was discharged to an acute rehabilitation facility in stable condition. Joint Exhibit 1 at 510, 591, 543, 592.

Charles Ingram, the safety manager for Respondent, testified he saw Petitioner at the Indiana hospital. He had no issues with communication. He said they talked about their kids, work, and Petitioner's life. Ingram was there two days and saw no unusual behavior.

Daniel Arnsman, a safety representative for Respondent, testified he picked up Petitioner at the Indiana hospital and drove Petitioner to Memorial Medical Center in Springfield, Illinois. Petitioner got in Arnsman's truck by himself. He had no wheelchair.

The records of Memorial Medical Center in Springfield, Illinois, indicate Petitioner was there from December 12, 2016, to December 28, 2016. A history and physical were done December 13, 2016. Those records indicate Petitioner was admitted for speech, physical, and occupational therapy. His prognosis for significant and practical improvement within a reasonable time period was thought to be good. Those records reflect, without explanation, Petitioner had suffered a spinal cord contusion with incomplete sensory and motor paraparesis and was not able to walk or perform independently. Joint Exhibit 2 at 1, 24-27.

The progress notes at Memorial, over the period of time Petitioner was there, indicate Petitioner complained of pain in his neck and spine and had ataxia and apraxia. Severe involuntary muscle convulsions of his lower extremities, trunk, and neck were noted, as were increased giggling during rehabilitation sessions. Petitioner's abnormal motor movements were not organic, his tests were normal. A wheelchair and walker were delivered to Petitioner, and it was noted he was going to be discharged to 1704 Western Park Drive, Dallas, Texas. Petitioner's discharge summary of December 28, 2016, indicates he was discharged to his brother's care. He was admitted for rehabilitation, thoracic myelopathy of a traumatic nature with incomplete sensory and motor quadriparesis at a lower thoracic level. It was noted Petitioner had some motor and sensory return but was unable to walk or perform activities of daily living. He was continent of bowel and bladder. Petitioner had a normal brain MRI and lab studies. The summary noted no major medical complications during his stay, with some uncontrolled muscle movement attributed to either a reaction to medication or psychiatric in nature. Joint Exhibit 2 at 155, 79-155, 45-66, 69-72, 9-24. Charles Ingram testified he visited Petitioner at Memorial Medical Center, he had no problem speaking, Petitioner was laughing and joking. Daniel Arnsman also visited and called Petitioner. Petitioner had no pain complaints or trouble communicating. Arnsman told Petitioner light duty was available for him. Arnsman describe the job Petitioner would have.

Petitioner testified that his boss at Respondent sent him to Texas. However, Ingram testified when he told the owner of Respondent, that Petitioner was going to Texas, he was unaware of that.

Once in Texas, Petitioner was seen at Nova Medical Center, Duncanville, Texas, on December 30, 2016. Those records note it was not reasonable for Petitioner to live with his brother because he could not negotiate in the home. His diagnosis at Nova was: other incomplete lesion at T11-T12 level of thoracic spinal cord, sprain of ligaments of lumbar spine, sprain of ligaments of cervical spine, headache, other visual disturbances. Inpatient

rehabilitation was recommended. Joint Exhibit 3 (unpaginated). There appears to be nothing to substantiate the diagnosis.

Petitioner testified at hearing in an emotional and often histrionic fashion, and disjointed manner. He was very compelling. However, most of his testimony is contradicted by the records submitted in evidence or, it seems, irrelevant. He testified about his previous abilities and occupation in Mexico, but his work history and credibility cast doubt on that testimony. In many instances, his testimony was flat wrong. As one example, Petitioner denied he did not have surgery or that none was ever recommended. The records belie his testimony.

About a week after having been seen at Nova, Petitioner was admitted to Powerback Rehabilitation in Richardson, Texas. He was there for less than three weeks. Powerback's records indicate Petitioner was admitted from a private home. The information Powerback received came from Petitioner's family. Those records indicate Petitioner was declining pain medications and denied being in pain. He was walking independently with a stable gait. Of the limited medical records provided Powerback, they noted no spinal cord damage or injury was seen. Petitioner claimed he suffered from at least ten medical conditions. The occupational therapy and physical therapy notes suggest no real progress was made with Petitioner and no value to the admission. Joint Exhibit 4 (unpaginated).

We do not know precisely why, but Petitioner upon discharge from Powerback was admitted to Pate Rehabilitation. Petitioner remained at Pate for about five months, interspersing treatment with UT Southwestern Medical Center in Dallas and Neurohispanos. At Pate, the records indicate the etiology of Petitioner's motor and visual deficits were unclear, and noted Petitioner frequently traveled between the United States and Mexico, owning several businesses. An MRI of the cervical spine, on March 16, 2017, showed no evidence of neural impingement at any level and no acute injury. An MRI of the thoracic spine, on March 16, 2017, showed no evidence of acute fracture or stress injury. An MRI of the lumbar spine, on March 16, 2017, showed no evidence of neural impingement and no evidence of lumbar vertebral body compression fracture. An MRI of the head and brain, on March 16, 2017, showed no acute intercranial abnormality. Joint Exhibit 5 (unpaginated); Joint Exhibit 8 (unpaginated); Joint Exhibit 6.

Physical therapy evaluation notes at Pate note Petitioner had extreme extraneous nonpurposeful movements of his upper extremities, head and neck. Speech and language evaluation notes indicate ataxia and impairment to orientation, attention, memory, information processing and problem solving. Joint Exhibit 5.

Erin Connor testified on behalf of Petitioner. She represented herself as a speech therapist who had daily interaction with Petitioner at Pate. She accompanied him to an IME. On cross examination, she admitted she was also known as Karen Scott, and was friend of the family. Connor is depicted in the video recorded IME of January 18, 2018, and identified herself as Karen Scott, who attended for personal attendance reasons. I discount the testimony of Connor for several reasons. First, a review of the voluminous records of Pate fails to reference Connor or any of her aliases, in any treatment of Petitioner. Second, she misrepresented herself

at the IME as simply a friend who sometimes transports Petitioner. She was, as can be gleaned by the video of the IME, there to influence the IME. Third, she was an obvious advocate, extremely upset with purported denials of payment to Petitioner for vague benefits. Joint Exhibit 5; Respondent's Exhibit 4 at 2; Respondent's Exhibit 5 at 28:23.

The notes of Dr. Benjamin Nguyen of UT Southwestern Medical Center indicate he believed Petitioner had a questionable history of traumatic brain injury and thought maybe Petitioner had a stroke. Nguyen said neuropsyche testing revealed minimal cognitive deficits and suggested Petitioner had conversion disorder if other medical causes had been ruled out. He said diagnostics do not explain Petitioner's neurological deficits or his current motor defects. Joint Exhibit 8 (unpaginated)

The notes of Dr. John Thottakara noted inconsistencies in Petitioner's examination and could not identify what was responsible for Petitioner's deficits. In a letter dated April 10, 2017, to Richard Victor of Briskman and Briskman, Thottakara said the most recent images of Petitioner do not reveal any injuries that would be causing him to have motor changes, ataxia, paralysis, weakness, dystonia, significant pain, vision loss, or vertigo. He noted that Petitioner participated in neuropsychological testing, and conversion disorder could be considered if no organic etiology was found for Petitioner's physical symptoms. He thought Petitioner could return to some level of employment. Joint Exhibit 8 (unpaginated).

Notes in a Physical Medicine and Rehabilitation Spine Initial Assessment by Dr. Kavita Trivedi found Petitioner's pain unexplained by diagnostics; paresthesis and weakness unexplained by diagnostics; and no evidence of a T5 compression. Joint Exhibit 8 (unpaginated).

While in treatment at Pate, with clinical impressions noted of uncontrollable movements of his upper extremities, being dizzy, and blurred vision, Petitioner somehow was able to secure Viagra by a Dr. Malik on February 10, 2017. How this relates to his treatment is unexplained. Joint Exhibit 5 (unpaginated).

Petitioner was discharged from Pate June 16, 2017, with no upcoming medical appointments scheduled, and plans to do an online business. Pate recommended Petitioner continue outpatient physical therapy. Joint Exhibit 5 (unpaginated).

With that, six months after the incident, Petitioner's medical and physical condition remained unexplained. No organic or diagnostic explanations existed, and the only theories expounded were stroke and conversion disorder. Petitioner had no treatment plan.

Petitioner submitted to an Independent Medical Examination by Dr. David Tasker on June 20, 2017. Petitioner said he had vision deficits and could not see out of his right eye. Tasker found no documented injury to Petitioner's visual system or damage to his visual system in his brain. He found no ocular damage from the injury of December 2, 2016. Respondent's Exhibit 2.

Petitioner then submitted to an Independent Medical Examination by Dr. Benzel MacMaster, an orthopedic surgeon, on June 26, 2017. MacMaster examined Petitioner, who

complained of pain in his spine, bilateral leg pain and numbness, being unable to walk because of weakness in his legs. MacMaster found his examination inconsistent with any known physical injury to Petitioner's neurological or musculoskeletal systems. There was no evidence of ongoing physical injury; no medical justification for Petitioner to wear a cervical collar; and no required further treatment for any spine condition. MacMaster noted that Petitioner demonstrated mobility of his extremities completely inconsistent with his complained degree of impairment. MacMaster believed the injury suffered December 2, 2016, was neuropsychiatric in origin and did not involve the musculoskeletal system or represent an organic brain or spinal cord injury. He thought his objective findings did not support Petitioner's complaints. He found no evidence of a T5 fracture, or an aggravation of a preexisting injury. MacMaster found Petitioner could return to modified duty with limitations on lifting, climbing, kneeling, stooping, bending, or crawling; and had reached MMI March 16, 2017. Respondent's Exhibit 3 at 1, 9, 10.

Petitioner submitted to a third Independent Medical Examination by Dr. Andrew Brylowski on January 18, 2018. It was video recorded. Petitioner testified he wanted the IME videotaped. There are several examples in the records and testimony of Petitioner attempting to dictate the course of his treatment, from refusing diagnostic tests, to refusing to participate in rehabilitation and threatening to go back to Mexico for treatment, to feeling Respondent should pay for Viagra, to demanding to see various specialists. Joint Exhibit 8; Joint Exhibit 5; Respondent's Exhibit 4; Respondent's Exhibit 5.

Dr. Brylowski, in the IME report, noted Petitioner's dramatic behavior and acting bizarre, almost combative. This is dramatically visible in the video of the examination. Brylowski stated Petitioner's imaging studies were unremarkable for a significant injury, and he had no documented spinal cord injury. Brylowski diagnosed Petitioner with conversion disorder, alcohol use disorder, general personality disorder, hypertension, obesity, and tachycardia. He found none were related to the December 2, 2016, injury. Brylowski noted a significant volitional element to the diagnosis, and extreme symptom magnification. He said Petitioner, relative to psychiatric, mental, and behavioral issues, could return to work without restrictions. It is apparent, from the video, Petitioner was attempting to affect, if not sabotage, the examination. Respondent's Exhibit 4 at 2, 19-22; Respondent's Exhibit 5 at 5:36-32:55.

Inexplicably, Petitioner sought treatment from Chicago Musculoskeletal Institute in Chicago, May 3, 2018. He complained of back pain. The notes of Dr. Daniel Ivankovich indicate Petitioner was anticipating legal advice regarding pain. Ivankovich diagnosed Petitioner with muscle wasting and atrophy of the left thigh and left lower leg; spondylosis in the lumbar region, and invertebral disc displacement in the thoracic lumbar region. He recommended an EMG. There is no indication Ivankovich had any access to or knowledge of the extensive records and treatment of Petitioner. His records are of no real value.

Daniel Arnsman testified at hearing he told Petitioner as far back as December 2016, that light duty was available for him.

Thus, the evidence in this case shows no objective, diagnostic, or any explanation at all for any of the Petitioner's claimed physical conditions. There are wildly conflicting,

inexplicable diagnoses from the various treatment facilities. There is no current treatment plan or medical care ongoing. There is no neurological explanation for Petitioner's conditions. There was no medical testimony offered at hearing.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill being causally related to the injury.

An injured employee bears the burden of proof to establish the elements of his right to compensation, including the existence of a causal connection between his condition of ill being and his employment. Navistar International Transportation Corporation v. Industrial Commission (Diaz) 315 Ill. App. 3d 1197, 1202-1205 (2000). A claimant must prove that some act or phase of his employment was a causative factor in the ensuing injury. It need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill being. Whether a causal connection exists is a question of fact. Vogel v. Illinois Worker's Compensation Commission, 354 Ill. App. 3d 780, 786 (2005).

What, exactly, is Petitioner's current condition of ill being? There is not an easy, clear cut answer. The last medical records of Petitioner from the Chicago Musculoskeletal Institute by Dr. David Ivankovich of May 13, 2018, indicate complaints of, and signs of: back pain; muscle weakness; upper extremity paresthesis; upper extremity edema; spasticity of the hands; and ataxia. At hearing, Petitioner testified to pain with every movement; the inability to think clearly; the loss of control of his sphincter; impotence; the loss of sense of taste; limited vision; and not being able to walk. Joint Exhibit 10 (unpaginated). One of the very first doctors to treat Petitioner, at Indiana University Health, Dr. Jason Machey, noted six days after the accident that it was unclear exactly what happened in the hole. Joint Exhibit 1 at 510. There is no medical testimony that clearly establishes, or even suggests, that Petitioner's employment was a causative factor. The medical records offer no support whatsoever to suggest any phase of Petitioner's employment was a causative factor in his current condition. Joint Exhibit 1 at 507 (no evidence of neurologic deficit), 31 (no injury of lumbar spine), 543 (uncertain etiology of eye complaints), 592 (no bowel problems), 605-06 (nothing to account for lower extremity weakness; Joint Exhibit 2 at 9-24 (continent of bowel and bladder . . . psychiatric nature of dykinesias), 45-66 (non-organic nature of abnormal motor movements); Joint Exhibit 4 at January 9, 2017 (ambulates independently with stable gait), January 17, 2017 (no spinal cord damage); Joint Exhibit 6 at 1-16 (questionable history of traumatic brain injury . . . unusual nature of immobility . . . motor changes do not correlate with imaging and objective measures . . . if no organic etiology, conversion disorder); Joint Exhibit 8 (possible stroke . . . unclear what is responsible for deficits . . . suggestive of conversion disorder . . . diagnostics do not explain neurological deficits, motor deficits . . . physical presentation not explained by diagnostics . . . no evidence of T5 compression fracture . . . no injuries caused deficits . . . conversion disorder); Joint Exhibit 5 (unclear etiology of motor and visual deficits . . . no evidence of injury to spine or brain in diagnostics . . . no record of brain injury).

The independent medical examinations of Dr. Tasker and Dr. MacMaster find no causative factor. Respondent's Exhibit 2 at 6 (no documented injury or damage to Petitioner's visual system . . . no ocular damage from the injury of December 2, 2016); Respondent's Exhibit 3 (no evidence of T5 fracture . . . no evidence of ongoing physical injury . . . no requirement for further treatment for spine conditions . . . mobility of inconsistent with claims of impairment . . . injury of December 2, 2016, was neuropsychiatric in origin, not organic).

Finally, Dr. Brylowski on January 18, 2018, diagnosed Petitioner with conversion disorder and said it was not related to the December 2, 2016, injury. His is the only medical opinion in the record on causation. Conversion reaction, also known as conversion hysteria, is defined as a form of hysteria or psychoneurosis in which physical signs and symptoms are substituted for anxiety. Smith v. Industrial Commission, 161 Ill. App. 3d 383, 387 (1987). A conversion reaction disorder is manifested by physical symptoms but lacks an organic cause. Psychological causation is likely, and the onset of the disorder can usually be traced to the occurrence of a traumatic event. See Mtengule v. City of Chicago, 257 Ill. App. 3d 323, 325 (1993). But relying on Dr. Brylowski, not here. Moreover, not one of Petitioner's treating physicians indicated it was. They had no observations on causal connection. The history in the records of Petitioner's treating physicians was, for the most part, incomplete or flat incorrect. I find as a conclusion of law, Petitioner has failed to prove his current condition of ill being is causally related to the injury.

Disputed issue **J** is, has Respondent paid all appropriate charges for reasonable and necessary medical services.

Petitioner requests the payment of $5,446.63 to Parkland Hospital. The records of Parkland Hospital show a visit to the emergency room May 30, 2017, with Petitioner complaining of back pain from a motor vehicle accident a year ago, and a fracture of T5. Joint Exhibit 8 (unpaginated). Petitioner had not been involved in a motor vehicle accident. Petitioner did not have a fracture of T5. Joint Exhibit 8 (unpaginated); Respondent's Exhibit 3. Petitioner did not testify as to why he went to Parkland. I reject the charges from Parkland as speculative and irrelevant based on the content of those records.

Disputed Issue **K** is whether Petitioner is entitled to temporary total disability benefits from December 3, 2016, through November 16, 2018.

To be entitled to a temporary total disability award under the Act, an injured worker must prove not only he did not work, but that he was unable to work. Ingalls Memorial Hospital v. Industrial Commission, 241 Ill. App. 3d 710 (1993). Such award exists from the time the injury incapacitates him from work until such time as he is recovered or restored as the permanent character of the injury will permit. Mount Olive Coal Company v. Industrial Commission, 295 Ill. 429 (1920).

An award of temporary total disability is predicated on an employment related injury. Although the evidence as to whether Petitioner was injured on the job is sketchy, the parties have stipulated to Petitioner's sustaining an accident that arose out of and in the course of employment. Arbitrator's Exhibit 1. The first notation in the records of Petitioner being placed

off work was December 30, 2016, at Nova Medical Center. Joint Exhibit 3. It is likely previous records ignored the issue due to belief in Petitioner's claims of loss of sensation and movement in his lower extremities. Dr. Benzel MacMaster placed Petitioner at MMI as of March 16, 2017, and stated he could do modified duty. Respondent's Exhibit 3 at 10. The availability of such duty was confirmed by Daniel Arnsman and offered as early as Petitioner's stay at Memorial Medical Center. That testimony is unrebutted. Petitioner was required to take the light duty provided. He did not.

I find as a conclusion of law, Petitioner is entitled to temporary total disability benefits of $693.19 per week beginning December 2, 2016, to March 16, 2017.

Disputed Issue **L** is, what is the nature and extent of this injury. I find, based on the records submitted into evidence as well as the examination of Dr. MacMaster, Petitioner sustained a neuropsychiatric injury not involving his musculoskeletal system or brain or spinal cord, and no physical injury. Respondent's Exhibit 3 at 9.

Here, Petitioner only claims permanent and total disability. To be entitled to a temporary total disability award under the Act, an injured employee must prove not only that he did not work, but that he could not work. Lukasik v. Industrial Commission of Illinois, 124 Ill. App. 3d 609 (1984). In this case, Petitioner offered no testimony and points to no specific evidence in the record indicating Petitioner could not work. I rely on the examinations of Petitioner by Dr. MacMaster and Dr. Brylowski that Petitioner could work. Respondent's Exhibit 3 at 10; Respondent's Exhibit 4 at 22. Petitioner offered no evidence on wage differential or earning capacity.

Thus, any permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Because of the lack of such report or opinion, I give this factor no weight in determining the level of disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the employee, I note Petitioner was essentially a laborer working in water drainage. Petitioner did not go back to work. He can work, with restrictions, and has been offered work within the restrictions with Respondent. I give this factor some weight in determining the level of disability.

With regard to subsection (iii) of Section 8.1b(b), this Arbitrator notes Petitioner was 51 years old at the time of the accident. Because of that age, I give it some weight in determining the level of disability.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings, this Arbitrator notes the restrictions on Petitioner's employment will impact on his future earnings. I give this factor weight in determining the level of disability.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, this Arbitrator notes the comments of Dr. Brylowski of Petitioner's

extreme symptom magnification; as well as comments of Dr. MacMaster that Petitioner's demonstrated mobility was completely inconsistent with Petitioner's claimed degree of impairment, and the lack of support for Petitioner's subjective complaints. Petitioner's complaints are uncorroborated. I give this factor a minor amount of weight in determining the level of disability.

Based on the above factors and my reading and consideration of the record as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 45% (225 weeks) loss of a person as whole pursuant to Section 8(d)2 of the Act.

[signature] 2-14-19

Arbitrator Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DENNIS KELM,

Petitioner,

20 IWCC0510

vs. NO: 17 WC 33988

D-B CARTAGE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner was employed by Respondent as a semi-truck driver for 20 years until his termination on November 2, 2017. He first alleges a repetitive trauma injury to his right hip that manifested on November 2, 2017 as a result of getting up and down from his truck's cab an average of 20 times per day over the course of his 20-year career. Petitioner utilized two steps to get in and out of the truck's cab, and when exiting on these steps, he normally came down on his right leg after dropping a couple feet to the ground. Petitioner testified that he had a progressive onset of his right hip problems with the pain worsening the more he climbed in and out of his truck.

Petitioner initially presented to Dr. John Lombardi on July 18, 2017 with complaints of right hip pain. Petitioner reported that the pain had begun three years prior but worsened over the last six months. Right hip X-rays were obtained and showed moderate joint space narrowing. Dr. Lombardi diagnosed Petitioner with right hip osteoarthritis, prescribed naproxen, and

recommended an injection. Petitioner voiced no left hip complaints at that time.

On August 18, 2017, Petitioner presented to Dr. Paul Manganelli, a pain management doctor, for an injection upon referral from Dr. Lombardi. Petitioner told Dr. Manganelli that his right hip pain began atraumatically a few years prior. He reported that initially, the pain was low grade and intermittent, but over time, it had increased in intensity and frequency. Lumbar X-rays were suggestive of femoral acetabular impingement syndrome as well as moderate osteoarthritic changes in the bilateral hips, right greater than left. Dr. Manganelli diagnosed Petitioner with right hip pain and osteoarthritis. He then administered the right hip injection.

When Petitioner returned to Dr. Lombardi on October 24, 2017, he exhibited decreased range of motion in the right hip with pain, especially with internal rotation. Dr. Lombardi's diagnosis remained right hip osteoarthritis. He reported that Petitioner wanted to hold off on surgical treatment but understood that it was the only definite way to treat his problem. In the interim, Dr. Lombardi recommended meloxicam and physical therapy. Petitioner testified that at that time, his symptoms were all in his right hip with no left hip symptoms.

At the request of Petitioner's attorney, Dr. Jeffrey Coe thereafter examined Petitioner on May 15, 2018 and authored a report of the same date. Dr. Coe opined that Petitioner had suffered repetitive impact strains to his right hip through his customary work practices. He explained that the repetitive impact strains contributed to Petitioner's right hip joint breakdown and accelerated the degenerative arthritis in his right hip, causing both acute and chronic pain. As a result, Dr. Coe opined that the right hip replacement surgery recommended by Dr. Lombardi was medically indicated.

Although Dr. Coe found a causal relationship between Petitioner's right hip condition and work activities, he offered no such causal opinion regarding Petitioner's current left hip condition, as Petitioner had denied any left hip symptoms at that time. When Dr. Coe was subsequently deposed, he testified that his examination of Petitioner's left side had found no tenderness with full range of motion and strength in the left leg. Dr. Coe testified that there were no symptoms or clinical findings to suggest any need for a left hip replacement.

Following his examination by Dr. Coe, Petitioner was sent to Dr. Matthew Jimenez for a §12 examination at Respondent's request on August 23, 2018. In his report of the same date and subsequent deposition, Dr. Jimenez found that Petitioner had bilateral end-stage hip osteoarthritis, right worse than left. However, he opined that Petitioner's osteoarthritis was not causally related to his work duties. Instead, Dr. Jimenez believed that Petitioner had preexisting, longstanding bilateral hip osteoarthritis that likely had a genetic component and occurred over many years.

The §12 examination was the first instance where Petitioner complained of left hip symptoms in addition to his right hip symptoms. Petitioner testified that he was not having any left hip problems at the time he saw Dr. Coe; however, sometime thereafter, he began overcompensating for his right hip pain by putting all of his weight onto his left leg. Petitioner testified that because of his right leg injury, he started using his left leg more, and as a result, his left hip was worse than his right hip at the time of the arbitration hearing.

Petitioner did not mention any left hip symptoms to his treating doctors until he returned to Dr. Lombardi on March 19, 2019. At that time, Petitioner complained of bilateral hip pain with the left hip progressively worsening over the last three months. Petitioner reported no known injury, but he stated that the pain came from compensating for his right hip problem. Bilateral hip X-rays revealed severe joint space narrowing superiorly and severe degeneration. Dr. Lombardi diagnosed Petitioner with pain and osteoarthritis of both the right and left hip. He prescribed meloxicam and indicated that they would continue to plan for a total hip arthroplasty.

Following a careful review of the entire record, the Commission finds that Petitioner failed to meet his burden of proving that the current condition of his left hip is causally related to his alleged work accident. Petitioner did not report any left hip symptoms or concerns to his treating doctors until his March 19, 2019 visit with Dr. Lombardi. Dr. Lombardi did not discuss any of Petitioner's work activities at that visit, nor did he relate Petitioner's newly onset left hip pain back to a work-related activity. Petitioner did not thereafter receive any further medical treatment for his left hip in between his March 19, 2019 visit with Dr. Lombardi and the arbitration hearing. Additionally, Petitioner had stopped working for Respondent on November 2, 2017, and as such, he was no longer climbing in and out of his truck cab at the time he developed his left hip symptoms.

Although Dr. Coe related Petitioner's right hip condition to his repetitive work activities, no medical provider offered any such causal opinion regarding Petitioner's current left hip condition. At the time of his examination, Petitioner did not have any left hip symptoms for Dr. Coe to evaluate. Instead, Dr. Coe determined that there were no clinical findings to suggest any need for a left hip replacement surgery.

To recover under the Illinois Workers' Compensation Act, a claimant bears the burden of proving all elements of his case by a preponderance of the evidence. *Arbuckle v. Industrial Comm'n*, 32 Ill. 2d 581, 585 (1965). Liability cannot rest upon imagination, speculation, or conjecture. *Id.* In the present matter, Petitioner's treating doctors failed to render a causal opinion regarding his left hip, and Petitioner did not have any left hip symptoms at the time of his examination by Dr. Coe. As Petitioner's left hip complaints developed only after he saw Dr. Coe, any opinion Dr. Coe may have projected regarding the future condition of Petitioner's left hip would be speculative. For this reason, the Commission modifies the Decision of the Arbitrator to find that Petitioner failed to prove by a preponderance of the evidence that his current left hip condition represents an overcompensation injury that is causally related to his repetitive work duties. 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 July 1, 2019 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that Respondent is not liable for any prospective medical care for Petitioner's left hip, as Petitioner has failed to prove by a preponderance of the evidence that the current condition of his left hip is causally related to the November 2, 2017 accident. Respondent remains liable for the prospective medical care for Petitioner's right hip, including the recommended right hip replacement surgery.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. 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: SEP 1 1 2020

Deborah L. Simpson

Barbara N. Flores

DLS/met
O- 7/23/20
46

DISSENT IN PART, CONCURRENCE IN PART

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Majority affirmed and adopted the Decision of the Arbitrator finding that Petitioner's right hip condition was causally related to his employment with Respondent. It reversed the Arbitrator's finding that Petitioner's left hip condition was also causally related to his employment. I would have affirmed and adopted the Decision of the Arbitrator in its entirety. Therefore, I concur as to the finding regarding Petitioner's right hip condition and dissent as to the finding that Petitioner failed to prove that his left hip condition was related to his work accident.

Petitioner's left hip condition became symptomatic only after his right hip deteriorated to the point he was required to overcompensate for the right hip. Petitioner was observed by Dr. Coe, Dr. Lombardi and Respondent's Section 12 examiner, Dr. Jimenez, favoring his right hip. Dr. Coe opined that Petitioner's favoring of his right hip could accelerate and lead to the breakdown of the left hip. Petitioner reported to Dr. Lombardi in March of 2019 that his left hip had worsened over the last three months because of "overcompensating for the right hip." I believe Petitioner met his burden and proved that his left hip condition was causally related to his work accident. Therefore,

I respectfully concur in part and dissent in part with the Decision of the Majority.

O-7/23/20
MP/dak
68

Marc Parker

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

20IWCC0510

KELM, DENNIS
Employee/Petitioner

Case# **17WC033988**

D-B CARTAGE INC
Employer/Respondent

On 7/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

5122 PORRO NIERMANN LAW GROUP LLC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

5647 ACCIDENT FUND HOLDINGS INC
PERRY GENTILE
PO BOX 40790
LANSING, MI 48901

20IWCC0510

20IWCC0510

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DENNIS KELM
Employee/Petitioner

v.

D-B CARTAGE, INC
Employer/Respondent

Case # **17** WC **33988**

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Wheaton IL**, on **4/30/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. X What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

L. ☐ 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, **11-2-17**, 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 $**56,829.03**; the average weekly wage was $**1,092.87**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

ORDER

Respondent shall pay Petitioner for the treatment provided by DuPage Medical Group, on March 19, 2019, subject to Sections 8 and 8.2 of the Act, subject to the fee schedule, as provided in the attached Conclusions of Law;

Respondent shall authorize and pay for Petitioner's right hip replacement surgery and related care. Respondent shall also approve any pay for the NSAID proscription recommend by Dr. Lombardi for the left hip. The Arbitrator does not make any finding regarding left hip replacement surgery, as provided in the attached Conclusions of Law.

Petitioner's petitioner for penalties and attorney fees is hereby denied.

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

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

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

Signature of Arbitrator

6/25/2019
Date

ICArbDec19(b)

JUL 1 - 2019

Procedural History

This matter was tried on April 30, 2019 pursuant to Sections 19(b) and 8(a) of the Act. The disputed issues were whether Petitioner sustained an accidental injury that arose out of and in the course of his employment, whether Respondent was given notice of the accident within the time limits stated in the Act, whether Petitioner's current condition of ill-being is causally connected to his injury, whether Respondent is liable for unpaid medical bills, whether Petitioner is entitled to prospective medical care and whether Petitioner is entitled to penalties and attorney's fees pursuant to Sections 16(k), 19(l), and 16 of the Act.

Findings of Fact

Dennis Kelm (hereinafter referred to as "Petitioner") testified that he worked for D-B Cartage, Inc., (hereafter referred to as "Respondent") as a truck driver for over 20 years. (T. 10-11). Petitioner drove a semi-tractor requiring him to climb two steps to enter and exit the cab of the tractor. (T.11) Petitioner testified that when exiting the cab, he would turn around, face the truck, and place his left foot on the highest step before stepping down to the ground on his right foot. (T.11-12). Petitioner testified that when stepping down to the ground, he would drop a couple of feet before his right foot reached the ground. (T.16) Petitioner testified that the truck steps were about 2 feet apart. (T.16) During the 20 years, Petitioner worked for Respondent he drove a truck five days a week for 52 weeks each year. (T.13) Petitioner was 6'1'' tall and he weighed 225 pounds. Petitioner testified that his weight did not vary much over the past 20 years. (T.14) Petitioner testified that he also would climbed up onto to the trailer of the truck to sweep the deck. (T.15) Petitioner testified that he did not suffer a specific injury to his hips before November 2017. (T.16-17)

Petitioner testified that while performing his work, he felt the onset of pain in his right hip. (T.17) In June of 2017, Petitioner sought treatment for the right hip. (T.18) Petitioner continued working but the right hip pain progressively worsened. (T.18-19) Petitioner testified that his pain worsened when he would climb in and out of the truck. (T.19) In October 2017, right hip replacement surgery was recommended. (T.20)

Petitioner testified that, on November 2, 2017, he informed the safety director, Jim Collins, that he needed surgery. (T.20-21) At that time, Petitioner did not file a worker's compensation claim. (T.21) On November 2, 2017, Petitioner's employment with Respondent was terminated for reasons unrelated to his alleged work injury. Thereafter, Petitioner found

similar work and is current working as a truck driver. Petitioner testified that after consulting with an attorney, he filed a worker's compensation claim. (T.22)

Medical History

On July 18, 2017, Petitioner sought medical treatment for his right hip at DuPage Medical Group. Petitioner received right hip treatment on July 18, 2017 and August 1, 2017. Petitioner was examined by Dr. Lombardi on August 1, 2017. At that visit, Petitioner reported right hip pain that began a few years ago. Petitioner described the pain as low grade and intermittent but over time the pain increased in intensity and frequency. Petitioner was diagnosed with osteoarthritis and given a right hip injection which provided some relief. Petitioner returned to Dr. Lombardi on October 24, 2017. At that time, surgery was discussed but Petitioner was proscribed meloxicam and physical therapy. Petitioner returned to DuPage Medical Group after October 24, 2017 but he did not make any right hip complaints. Petitioner returned to DuPage Medical Group, on March 19, 2019, for additional right hip treatment. (PX 2).

On May 15, 2018, Petitioner was examined by Dr. Jeffrey Coe. At that visit, Petitioner reported that he started to experience pain in his right groin, proximal thigh and lateral hip. Petitioner indicated that his pain was initially intermittent and improved with rest, but his right pain continued to increase, becoming more severe and persistent with his work activities. Petitioner reported that he continues to treat with Dr. Lombardi, on an as-needed basis, and that he contracted Dr. Lombardi regarding a repeat right hip steroid injection and was told it was unlikely to be helpful. During the examination, Petitioner complained of an intense deep and sharp pain in the right groin extending into the proximal thigh and lateral right hip region. The pain is made worse by standing, walking and he is unable to sleep on his right side due to the pain. Petitioner walks with a limp, favoring his right leg, and used a cane to walk more than one block. Petitioner reported that his right hip felt "unstable" and that he has stumbled on several occasions due to the pain. The examination showed that Petitioner walked with a limp, with limited right leg weightbearing, tenderness about the right hip, groin and proximal thigh, with decreased range of motion in the right hip with forward flection, abduction and adduction. Petitioner also had muscular weakness and mild atrophy of the right thigh. Dr. Coe indicated that Petitioner suffered a repetitive impact train to his right hip in his customary work practice as a truck driver which was a factor contributing to the right hip joint breakdown and accelerating

the degenerative arthritis necessitating the need for right hip replacement surgery. Dr. Coe opined that there was a causal relationship between the repetitive right leg strain injury and his current right hip symptoms. (PX1, EX# 2).

Respondent Witness: Paul Busse

Paul Busse, who is the president and owner of Respondent, testified that he learned of Petitioner's work injury was after receiving documents from Petitioner's attorney. (T.43) Mr. Busse testified that Petitioner did not completed an accident or injury report, nor did Petitioner tell him about the right hip injury. (T.44) Mr. Busse testified that part of the safety director's job was to inform him of any work-related injuries and the safety director did not inform him of Petitioner's right hip injury. (T.45) Mr. Busse admitted that he received Petitioner's Application For Adjustment Of Claim prior to November 15, 2017 and that he turned the application over to the insurance carrier. (T.46) Mr. Busse testified that he would have received some type of notice of the claim before he notified his insurance carrier of the claim. (T.46)

Testimony of Dr. Jeffrey Coe

Petitioner was examined by Dr. Jeffrey Coe for a second opinion. Dr. Coe testified that he is board-certified in occupational medicine specialist, which is a specialty involving work place injuries. (PX1 p.5) Dr. Coe testified that a third of his practice is devoted to clinical examinations for workers and employers, a third of the practice is devoted to working as an advisor and consultant for employers, insurers, 3rd party administrators, labor unions and some governmental agencies and a third of his practice is devoted to IME work, 50% of which are for respondents. (PX1 pgs.6-7). Dr. Coe testified that he also teaches occupational medicine at the University of Illinois Medical Center. (PX1 p.7-8) Dr. Coe testified to his specialized knowledge and background of causal mechanisms of injuries that occurred to truck drivers. (PX1 p.9) In his 30 years as an occupational medicine specialist he had had an opportunity to examine a large number of truck drivers for various injuries including injuries to the lower extremities. (PX1 p.9) He also worked as the regional medical director and medical advisor for loss prevention at Liberty Mutual insurance in the 1980s. (PX1 p.9) This carrier was particularly interested in injuries to truck drivers as Liberty Mutual insured many cartage companies. (PX1 p.9) During that period, Liberty Mutual carried out a variety of research studies about the hazards of truck driving including impact and climbing hazards and other hazards such as deep vein thrombosis of the lower extremities. (PX1 p.9-10) Dr. Coe testified that the health of truck

drivers was also a significant area of concern at the annual meetings of the American College of Occupational and Environmental Medicine, so he was familiar with injuries to the lower extremities of truck drivers. (PX1 p.10)

Dr. Coe testified that Petitioner worked for more than 20 years as a truck driver and he had to climb in and out of his cab and onto the bed of the truck. Petitioner had to climb in and out the cab of his truck approximately 20 times a day. (PX1 p.12). Petitioner also had to climb onto and down from the truck bed between 3 or 4 times a day. (PX1 p.13) When exiting his truck cab, Petitioner would twist and pivot descending facing inward, to the truck, landing on the ground with his right leg and pivoting on his right leg. (PX1 p.13)

Petitioner reported that he required frequent rest breaks because of the right leg symptoms and that his right hip was unstable that causes him to stumble because of sharp pains in the right groin and hip region. (PX1 p.16) Dr. Coe testified that Petitioner developed pain and characteristic symptoms arising from his right hip. Dr. Coe also testified that Petitioner underwent diagnostic tests, therapeutic injections into the right hip joint, with only limited improvement, before receiving a recommendation for surgery. (PX1 pgs. 14-15).

Dr. Coe performed an examination. Petitioner described the pain as an intense deep and sharp pain in the right groin region extending into the proximal right thigh and lateral right hip. (PX1 p.16) The pain was worse with standing and walking and improved with less activity or by sitting and elevating the right leg. (PX1 p.16) Dr. Coe noted that Petitioner had an antalgic gait, right leg and foot eversion, and atrophy in the right thigh caused by not putting full weight on his right leg. Dr. Coe noted tenderness along the lateral of the right hip, tenderness to deep palpation in the proximal thigh, marked stiffness in the right hip, decreased abduction, stiffness in the right hip associated with sharp and severe right groin and lateral hip pain. (PX1 pgs. 19-20).

Dr. Coe noted that Petitioner had some arthritis in the left hip based on x-rays, but Petitioner did not complain of left hip at that time. Based upon his review of Petitioner's medical records, work history and the physical examination, Dr. Coe diagnosed degenerative arthritis of the right hip with significant symptoms of right hip arthritis and he recommended right hip replacement surgery. (PX1 p.22) Dr. Coe also recommended work restrictions consisting of no repetitive bending at the hip, kneeling, squatting, and no climbing where Petitioner could fall and potentially injure himself. (PX1 p.23)

Dr. Coe opined that there was a causal relationship between the diagnosed condition and Petitioner's work activity. (PX1 p.24) Dr. Coe opined that the repetitive climbing into and out of the cab, onto and off the back of his truck, leading with his right leg with his right leg twisting and impact aggravated Petitioner's pre-existing degenerative arthritis in his right hip and cause the right hip breakdown which developed into acute and chronic right hip pain. (PX1 p.25) Dr. Coe also opined that Petitioner's work activities were a factor causing the need for the right hip replacement surgery. (PX1 p.25)

Dr. Coe testified that Petitioner was loading his right hip far more than his left hip, with the work activities, in that exiting the cab 20 times per day loaded his right hip 20 times more than the left hip. Dr. Coe also testified that the same concept was true when Petitioner would climb in and out of the trailer. (PX1 p.26) Dr. Coe testified that over a five-day week, Petitioner loaded the right hip 120 times more than the left hip and extending that over a 48-weeks of work, Petitioner loaded his right hip 5,760 times more frequently than his left hip. (PX1 p.26-27) Dr. Coe also testified that a force multiplier applies involving the individual's weight coming down or stepping down stairs or down the ground on a single leg. A single impact could be between 2 to 8 times a person's body weight of the force on a joint such as the hip. Dr. Coe testified that Petitioner weighed 225 pounds. (PX1 p.28). On cross-examination, Dr. Coe acknowledged that the cab's grab bars could reduce the impact on the hip but if used by the driver when exiting the cab of the truck. Dr. Coe testified that a Liberty Mutual research study showed that a driver would still be exposed to at least a twofold multiplier of his body weight across the right hip while descending the cab and the impact would be higher if the driver jumped down or twisted. (PX1 p.41) Dr. Coe testified that he was aware that Petitioner reported complaints in the right hip three years before treatment and that Petitioner's condition worsened in 2017 causing him to seek treatment. (PX1 p.35) Dr. Coe also recognized that none of the treating physicians addressed causation or Petitioner's job duties. (PX1 p.39)

Testimony of Dr. Matthew Jimenez, the Section 12 physician

Petitioner was examined by Dr. Matthew Jimenez pursuant to Section 12 of the Act. Dr. Jimenez is a board-certified orthopedic surgeon. (RX1 p.4) He treats patients with lower extremity and hip pain and does IMEs. (RX1 p.4-5) Dr. Jimenez testified that Petitioner reported that his hips became symptomatic as he moved in and out of a vehicle over several decades and that he feels it is the reason why he has hip problems. (RX1 p.6). Dr. Jiminez

examined Petitioner and noted limp and reduced range of motion of both hips, with the right being worse than the left. (RX1 p.7) X-rays from the visit revealed end-stage arthritis in both hips. (RX1 p.8)

Dr. Jimenez diagnosed hip end-stage arthritis, longstanding, with the right worse than the left. (RX1 p.9-10) Dr. Jimenez opined that Petitioner's end-staged osteoarthritis is not causally related to his work exposure because there is no evidence in literature showing any causal link between repetitive flexion/extension of a joint or hip and arthritis and because of his 25 years of practice performing hip replacements. Dr. Jimenez also opined that the hip surgery was necessary but not caused by his work. (RX 1 p. 10).

On cross, Dr. Jimenez testified that he did not know who hired him or how much he is paid for examinations or depositions. (RX1 p.12) Dr. Jimenez acknowledged that he had never performed research on causal mechanisms for the development of osteoarthritis in any joint or repetitive load studies for the hip joint. (RX1 p.15) Dr. Jimenez attributed Petitioner's hip condition to genes, but he could not identify the gene or genes involved in development of arthritis or how any of genes would express themselves to contribute to the condition. (RX1 p.15) Dr. Jimenez thought that Petitioner's condition was multifactorial with a primary genetic component and common genetic linkage through families but after explaining that it was very common for families to have a genetic lineage of joint arthritis, he admitted he had not surveyed Petitioner's family for osteoarthritis. (RX1 p.16-17)

Regarding the issue of causation, Dr. Jimenez was asked whether he knew what specifically the Petitioner was doing when he is getting out and into his vehicle each day. Dr. Jimenez responded, "*I can't tell you what he specifically was doing because I wasn't a witness to his activity, nor were you, with respect, sir. And the way that I understand the term knowing or the term specificity, you would have to actually be that individual or witness his every activity every day and no one did that, other than him...So neither you or I know, the way I describe knowing and knowledge, with specificity what he was doing. It doesn't mean I don't understand what it takes to go in and out of a truck.*" (RX 1 p. 22). During re-cross examination, Dr. Jimenez was asked in the medical literature and orthopedic literature, whether the term causation was different than the way he was using it. Dr. Jimenez responded, "*...There's not a report that I'm aware of anywhere in the literature where arthritis is determined to be caused solely by*

movement of a hip, that is, repetitive motion or loading of a hip or a knee or an ankle..." (RX 1 p. 35).

Petitioner's Current Condition

Regarding his current condition, Petitioner testified that some days his hip gives out and he stumbles while walking. Petitioner would like the recommended surgery. Petitioner also testified that his employment with Respondent terminated in November of 2017 and he found similar work and that he is still working.

The Arbitrator finds the testimony of Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as 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).

In support of the Arbitrator's decision relating to issues "C, D & F", the Arbitrator concludes as follows:

When a worker's physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *Sisbro v. Indust. Com'n*, 207 Ill.2d 193, 205 (2003). Workers need only prove that some act or phase of employment was a causative factor in her ensuing injuries. *Land and Lakes Co. v. Indust. Com'n*, 359 Ill.App.3d 582, 592 (2005). The work-related task need not even be the sole or principal causative factor of the injury, as long the work is a causative factor. See *Sisbro*, 207 Ill.2d at 205. Even if the claimant has a preexisting degenerative condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as she can show that her employment was also a causative factor. *Id.* At 205. Employers are to take their employees as they find them. *A.C.&S v. Industrial Commission*, 710 N.E.2d 8347 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (1982). There is also no legal requirement that a certain percentage of claimant's workday be spent on repetitive tasks to establish the repetitive nature of a claimant's job duties. *Edward Hines Precision Components v. Indust. Com'n*, 356 Ill.App.3d 186, 193-194 (2005). As these principles apply to our case: 1) accidents include bodily breakdown from usual work tasks; and 2) causation is established when the tasks contribute to an injury.

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 credible evidence that he sustained an injury to his right hip arising out of and in the course of his work with respondent and that his date of accident was November 2, 2017. Petitioner testified that his pain came on gradually and worsened as he came down out of his cab onto his right leg until November 2, 2017. Petitioner's pain worsened causing him to seek medical attention. The Arbitrator finds the date of accident of November 2, 2017 given the nature of the injury and progression of the symptoms to be reasonable. Petitioner worked for only one employer over the past 20 years and the symptoms developed during the period Petitioner worked for Respondent. Because repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. *Oscar Mayer & Co. v. Industrial Comm'n*, 176 App.3rd 607, 531 N.E.2d 174. Respondent offered no dispute regarding the details of Petitioner's work, the repetitive nature of Petitioner's job duties nor the onset of Petitioner's right hip complaints. Petitioner's testimony was unrebutted.

As such, the dispute is based upon whether Petitioner's work activity could give rise to a breakdown of the hip joint or aggravation of a preexisting condition. Dr. Coe is an occupational medicine specialist who focuses on causation issues between injuries and work activities. Workers, employers, carriers, 3rd party administrators and government agencies hire him for this work. Dr. Coe also testified about his specialized knowledge regarding the nature and mechanism of injuries to truck drivers through the research conducted on that issue while he served as regional medical director for Liberty Mutual. Research that had shown that truck drivers experienced a body weight multiplier on the leg the driver lands when stepping down from a truck cab. Dr. Coe also testified that he reviewed Petitioner's work duties, in detail, and found that Petitioner loaded his right hip far more than his left hip because of his work activities for Respondent. (PX1 p.26, T.24) Each day, for the past twenty years, Petitioner exited the cab of his truck 20 times per day and, as a result, loaded this right hip 20 times more than his left hip. (PX1 p.26) The same loading occurred each time he got up and down on the trailer. (PX1 p.26) Petitioner loaded the right hip more than the left hip 120 times over a five-day week, 52 weeks a year for the past 20 years. (PX1 p.26) Dr. Coe testified that research showed that Petitioner was

putting between 2 to 8 times his body weight onto his right hip joint when stepping to the ground. (PX1 p.28) The Arbitrator finds that the Petitioner's history was consistent with the history, examinations and findings. Petitioner's right hip was significantly worse than his left hip. The Arbitrator also finds that the mechanism of the injury, impact on the right hip and the development and progression of right hip symptoms, supports Dr. Coe's causation opinions.

The Arbitrator finds the opinions of Dr. Coe to be more persuasive than the opinions of Dr. Jimenez. The Arbitrator further finds that Dr. Coe had a better familiarity of Petitioner's work activities than Dr. Jimenez. The Arbitrator further finds that Dr. Jimenez's responses during the evidence deposition to be evasive and, often, nonresponsive. Dr. Jimenez was asked whether he knew what specifically the Petitioner was doing as he is getting in and out of his vehicle each day and Dr. Jimenez responded, *"I can't tell you what he specifically was doing because I wasn't a witness to his activity, nor were you, with respect, sir. And the way that I understand the term knowing or the term specificity, you would have to actually be that individual or witness his every activity every day and no one did that, other than him...So neither you or I know, the way I describe knowing and knowledge, with specificity what he was doing. It doesn't mean I don't understand what it takes to go in and out of a truck."* (RX 1 p. 22). The Arbitrator finds that Dr. Jimenez did not sufficiently elicited information, during his examination, regarding the mechanism of Petitioner's injury and the repetitive nature of Petitioner's work activities to give his opinions as much weight as the opinions of Dr. Coe. Based upon Dr. Jimenez's lack of understanding of the mechanisms of Petitioner's injury including the repetitiveness involving climbing in and out of the truck, the Arbitrator does not give much weight to Dr. Jimenez's opinions. It is axiomatic that the weight accorded an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-15 (First Dist. 2000).

For the reasons stated above, the Arbitrator find that Petitioner has proven by the preponderance of the credible evidence that his current right hip condition is causally connected to his injury of November 2, 2017.

The Arbitrator also finds that Petitioner has proven by the preponderance of the credible evidence that his current left hip condition is causally related to his work accident of November 2, 2017. Petitioner testified that his left hip pain was caused because he was overcompensating

due to the worsening right hip pain. X-rays revealed some degeneration in both of hips, but Petitioner did not make any left hip complaints during his treatment in 2017 or when examined with Dr. Coe in May of 2018. Dr. Coe noted that Petitioner's left leg physical examination was within normal limits. (PX1 p.17) At that time, Dr. Coe indicated that trying to accommodate for the right hip injury could accelerate a breakdown of his left hip if Petitioner overloads the left hip. (PX1 p.30) During the examination, Dr. Coe noted that Petitioner was limping favoring his right leg. (PX1 p.18) Dr. Coe also indicated that Petitioner was standing with his weight primarily on the left leg to avoid putting weight on the right leg. (PX1 p.18) When Petitioner saw Dr. Lombardi in March of 2019, he reported a worsening of his left hip condition because he was overusing the left hip accommodating his right hip. At trial, Petitioner explained that because he was having so much pain in the right hip, he overcompensated by putting all the pressure on the left hip and the left hip was worse than the right one by the time of the trial. (T.25) Dr. Lombardi noted that Petitioner's left hip had worsened over the last three months because he was overcompensating for the right hip. (T.27) Employers are relieved of liability only if an intervening cause completely breaks the causal chain between the original work-related injury and the ensuring condition of ill-being. *Global Products v. IWCC*, 392 Ill.App.3d 408, 411 (2009). That the subsequent employment may have aggravated the condition is irrelevant. See Par *Electric v. IWCC*, 2018 IL App (3d) 170656WC, p.12 (2019).

Based upon the Petitioner's undisputed testimony, Dr. Coe's testimony and Dr. Lombardi's records involving overcompensating for the right hip symptoms and lack of prior hip complaints, the Arbitrator finds that Petitioner has proven that his current left hip condition is causally related to the right hip injury and work accident of November 2, 2017.

In support of the Arbitrator's decision relating to issue "E", the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner had proven that he provided timely notice of the injury to his right hip to Respondent within 45 days of the accident date. Respondent stipulated that it received constructive notice of the work injury on or about November 15, 2017. (T.9) Mr. Busse confirmed that he would have received notice of Petitioner's injury prior to informing his carrier of the work injury. (T.46) Petitioner testified that he notified the safety director that he needed right hip replacement surgery on November 2, 2017. (T.21) Petitioner also testified that he had to explain to the safety director and company owner why he was taking time off to go

to the doctor for his hip. (T.39) Respondent did not proffer the testimony from the safety director to dispute Petitioner's testimony.

In support of the Arbitrator's decision relating to issue "J" the Arbitrator finds as follows:

Given the Arbitrator's findings regarding accident and causation, the Arbitrator further finds that the medical treatment provided by DuPage Medical Group, on March 19, 2019, to be reasonable and necessary to treat Petitioner from the effects of his injury. The Arbitrator notes that Dr. Jimenez did not proffer any opinions that the treatment received by Petitioner was not reasonable or necessary. As such, Respondent shall pay Petitioner for the treatment provided by DuPage Medical Group, on March 19, 2019, subject to Sections 8 and 8.2 of the Act, subject to the fee schedule.

In support of the Arbitrator's decision relating to issue "K", the Arbitrator finds as follows:

Dr. Lombardi recommended right hip replacement surgery. Dr. Coe agreed with the need for right hip replacement surgery. Dr. Jimenez agreed that the surgery was reasonable and necessary but not related to Petitioner's work accident. Based upon the findings on accident and causation, as stated above, the Arbitrator finds that Respondent shall authorize and pay for Petitioner's right hip replacement surgery and related care. The Arbitrator does not make any finding regarding left hip replacement surgery. As stated above, the Arbitrator found that Petitioner's current left hip condition is causally related to his work accident of November 2, 2017. However, Dr. Coe did not proffer an opinion regarding the need for left hip surgery and Dr. Lombardi did not indicate that surgery was being proscribed. On March 19, 2019, Dr. Lombardi only proscribed NSAID: meloxicam. As such, the Arbitrator also finds that Respondent shall approve any pay for the NSAID proscription.

In support of the Arbitrator's decision related to issue "M", the Arbitrator finds as follows:

Petitioner is seeking penalties and attorney fees pursuant to Sections 19(k), 19(l) and 16 of the Act. Petitioner's petition for penalties and attorney fees is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrea Griffin,
Petitioner,

20IWCC0509

vs.

NO: 16 WC 30129

J W Marriott,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent and being advised of the facts and law, 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 26, 2020, 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 $12,00.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 1 2020
o8/6/20
BNF/rm
046

Barbara N. Flores

Marc Parker

DISSENT

I respectfully dissent from the Decision of the Majority. The Majority affirmed and adopted the Corrected Decision of the Arbitrator who awarded Petitioner a total award of 32.25

weeks of PPD representing loss of the use of 30% of left leg less credit of 15% of the left leg previously awarded in 14 WC 14849. I would have modified the Decision of the Arbitrator to reduce the PPD award to 25% of the left leg less the prior credit of 15% of the leg for a new award of loss of the use of 10% of the left leg. The nature and extent of Petitioner's permanent disability was the only issue before the Commission on review.

Petitioner was working as a room attendant for Respondent when she injured her left knee bumping her left knee on a bathtub. Petitioner had left-knee chondroplasty surgery for severe chondromalacia after the accident that was subject to her previous claim, in 14 WC 14849. On the other hand, after the instant accident Petitioner was only treated conservatively with physical therapy, medications, and injections. After the instant accident, Petitioner was off work for 24&1/7 weeks (awarded as TTD) and returned to her prior job as room attendant. In his decision, the Arbitrator gave weight to the statutory factor of potential loss of income. However, the record is clear that Petitioner returned to her previous job as room attendant and Petitioner did not submit any evidence suggesting any loss of current income or potential loss of future earning potential. In my opinion, the Arbitrator's consideration of potential loss of earning potential was based on nothing other than speculation and therefore was inappropriate. In addition, it does not seem reasonable that Petitioner should receive the same PPD award (15% of the left leg) for an injury requiring surgery, as in 14 WC 148349, and an injury requiring only conservative treatment, such as after the instant injury

For the reasons stated above I would have modified the Decision of the Arbitrator to reduce the PPD award to 25% of the left leg less the prior credit of 15% of the leg for a new award of loss of the use of 10% of the left leg. Therefore, I respectfully dissent from the Decision of the Majority.

O-8/6/20
DLS/dw
46

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

20 IWCC0509

GRIFFIN, ANDREA
Employee/Petitioner

Case# **16WC030129**

J W MARRIOTT
Employer/Respondent

On 2/26/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0491 SOSTRIN AND SOSTRIN PC
NEAL WISHNICK
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

20 I W CC0509

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Andrea Griffin,
Employee/Petitioner
v.
J.W. Marriott,
Employer/Respondent

Case # **16** WC **30129**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **December 20, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 7, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**32,815.64**; the average weekly wage was $**631.07**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**10,157.16** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,157.16**.

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 $420.71/week for 24-1/7 weeks, commencing September 12, 2016 through November 30, 2016, February 28, 2017 through May 8, 2017, and May 22, 2017 through June 9, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,157.16 for temporary total disability benefits that have been paid. Respondent stipulated to this period of temporary total disability (Arb. X. 1)

Respondent has paid all reasonable and necessary medical, pursuant to the stipulation of the parties, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $378.64/week for 32.25 weeks, **after credits,** because the injuries sustained caused the **30%** loss of use of the left leg, as provided in Section 8(e)12 of the Act. After statutory credit for the prior settlement in case 14WC 14849 of 15% loss of use of the left leg, Petitioner is entitled to a current award of additional permanent partial disability of 15% loss of use of the left leg, or 32.25 weeks of compensation.

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.

20 IWCC0509

Robert M. Harris

Signature of Arbitrator Robert M. Harris

February 21, 2020
Date

FEB 2 6 2020

MEMORANDUM OF DECISION OF ARBITRATOR
FINDINGS OF FACTS

At trial Petitioner testified she was employed by Respondent for 8 years as a Room Attendant. As a room attendant she is required to clean 15 rooms per day. She reported to work at 8:00 a.m., a meeting was held at which time she would get her room assignments.

On the morning of September 7, 2016, she reported to work at 8:00 a.m. She got her room assignment. While cleaning a room at approximately 8:30 a.m. she bumped her left knee on a bathtub. A co-worker, Valerie, came into the room. The accident was reported to her supervisor Jamie and Petitioner was referred to Physicians Immediate Care (PX 1) by her employer.

The records of Physicians Immediate Care (dated 9/7/2016) state Petitioner hit bathtub with left knee. X-rays were taken. It was noted Petitioner had prior surgery to her left knee. On September 8, 2016 an MRI was prescribed. The September 7, 2016 diagnosis was a sprain to the lateral collateral ligament.

On September 11, 2016 Petitioner was seen by Physicians Immediate Care at that time she was restricted to sit down work only. The diagnosis was a sprain of the lateral collateral ligament.

An MRI was performed on September 4, 2016. The MRI's impression was:

1. Vastus medialis myotendinous strain with partial tearing along the peripheral margin of the medial retinaculum as well as high grade partial tear along the proximal medial collateral ligament. No evidence of full thickness tear or ligamentous retraction.
2. No evidence of meniscal tear.
3. Patellofemoral joint space narrowing, osteophyte formation and high grade chondromalacia.
4. Medial and lateral tibiofemoral joint space narrowing, osteophyte formation, and Grade III chondromalacia.

On September 15, 2016 Petitioner again was seen at Physicians Immediate Care. A diagnosis was made of a sprain of the lateral ligament of the left knee. Petitioner was again restricted to sit down work. It was noted Petitioner does not need to return to the clinic once her care is transferred to a specialist.

Petitioner then was seen by Dr. Sompalli Chandrasekhar, an orthopedic surgeon, (PX 2) on September 23, 2016. Dr. Chandrasekhar on his January 24, 2017 visit stated if Petitioner's pain did not improve she will need left knee arthroscopy and a chondroplasty of the patella. Petitioner was prescribed a knee brace and returned to work full duty. Dr. Chandrasekhar continued seeing Petitioner with exams on February 28, 2017; March 24, 2017; April 21, 2017; May 23, 2017; and June 6, 2017.

At the request of Respondent, Petitioner was examined by Dr. Brian Cole (PX 3) on May 22, 2017. Dr. Cole diagnosed left knee patellofemoral chondrosis and aggravation of a pre-existing condition sustained at work. Dr. Cole prescribed more treatment in the form of hyaluronic acid injections and a combination injection of platelet-rich plasma.

Petition was then referred to Dr. Nikhil Verma. Petitioner first saw (PX 4) Dr. Verma on January 29, 2018. Dr. Verma agreed with Dr. Cole. Dr. Verma performed three injections on Petitioner: March 5, 2018, March 19, 2018 and March 26, 2018. Petitioner continued to work full duty. On his last visit Dr. Verma noted Petitioner received a minimal benefit from the injections. Dr. Verma told Petitioner to modify her activities. Petitioner returned to full duty and continues to work full duty.

Petitioner testified she continues to work in pain. Petitioner testified she notices she cannot work as she did before this accident. Petitioner testified she has pain and swelling in her left knee and has to rest after cleaning a room.

Conclusions of Law as to disputed issue (F) causal connection and (L) Nature and Extent. The Arbitrator finds and concludes as follows:

Causal Connection:

The Arbitrator finds and concludes Petitioner's has proven by a preponderance of the credible evidence that her current condition of ill-being is causally connected to accident of September 7, 2016.

The expert medical opinions of Respondent's Section 12 examiner Dr. Brian Cole (PX 3) clearly support this conclusion. Dr. Cole opined in his report dated May 22, 2017 that Petitioner sustained an aggravation of a pre-existing condition of left knee patellofemoral chondrosis. Dr. Cole wrote in his report, "Yes, the fact pattern provided supports this notion that she incurred an aggravation of a preexisting condition. This is one that [h[as not been temporized a of yet and remains ongoing, thus warranting care related to the injury."

Dr. Cole further wrote, "Yes, I do believe she incurred an aggravation of a preexisting condition. This has not been rendered temporary with successful treatment as of yet, unfortunately, thus, the recommendation for surgery to quiesce her symptoms and hopefully bring her condition to a stable endpoint of care. She almost certainly has a moderately high level of patellofemoral chondrosis ingoing to the injury in September 2016 and aggravated the condition with her blunt contusion-like trauma on September 7, 2016, thus rendering the knee symptomatic and warranting care now."

The Arbitrator notes that while Respondent disputed causal connection at trial, it had Dr. Cole's report, and in Respondent's post-trial submission to the Arbitrator, it agreed to causation based on this same report.

Nature and Extent:

The Arbitrator notes Petitioner received a prior award of 15% loss of use of her left leg pursuant to a settlement approved on May 7, 2015. An employer receives a credit for a prior award when there is a subsequent injury and award to the same member. *See, Lusietto v. Industrial Commission,* 174 Ill.App.3d 121, 129, 123 Ill.Dec. 634, 639 (3rd Dist. 1988). The prior loss is taken into consideration and deducted from any award for the subsequent injury. *Id.* Accordingly, Respondent's credit of 15% loss of use of the leg will be deducted from the award of 30% permanent partial disability in this case pursuant to Section 8(e)17.

Because Petitioner's injury occurred after September 1, 2011, the Arbitrator addresses the five Section 8(1)(b) factors as follow: The nature and extent of injury requires an analysis of the five factors of Section 8.1(b). The factors are: (1) the reported level of impairment; (2) the occupation of the employee; (3) the employee's age at the time of injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records.

1. No impairment rating was submitted by either party (nor are they required to do so). Therefore, the Arbitrator gives that factor no weight;

2. Petitioner was a room attendant at the time of the injury. The Arbitrator gives this factor some weight regarding permanency;

3. The Petitioner was only 33 years of age at the time of this injury. Both Dr. Cole and Dr. Verma noted Petitioner has arthritis in her left knee which was aggravated due to this injury. Petitioner has a long life expectancy and she will therefore have to live with the effects of the work injurie, which may increase over time. The Arbitrator gives this factor greater weight towards increased permanency;

4. Neither party offered evidence of the effects of this injury on Petitioner's earning capacity. Petitioner did not allege or testify that she has been working less hours or that her ability to perform the full scope of her job duties has been reduced due to the effects of this injury. The evidence shows Petitioner's wages increased between 2013 and 2016, and at the time of her 2013 injury her average weekly wage was $590.52. At the time of her September 7, 2016 injury her wages had increased to $631.07. However, Petitioner's future earning capacity may be limited or reduced due to her injury causing her the pain that impacts her ability to work without having to rest in between cleaning rooms. The Arbitrator gives this some weight regarding permanency;

5. Petitioner has met her burden of proof as to her disability to her left leg through her testimony and corroborating medical records including Respondent's Section 12 exam. Dr. Brian Cole noted in his examination of May 22, 2017 that "if she does not garner enough relief then I think a left knee

arthroscopy and debridement with evaluation of the patellofemoral cartilage is reasonable." Dr. Verma notes on his last exam on June 11, 2018 (PX 4), "she received a viscosupplementation series with minimal benefit. Her Pain is activity related with weather changes." Petitioner last saw any physician for the injury on June 11, 2018. Dr. Verma documented a normal gait, no effusion and preserved range of motion. Dr. Verma opined any residual complaints of pain could be managed with activity modification but did not officially or permanently restrict Petitioner's work or other activities. At trial, Petitioner complained of continued pain and swelling with activity and moving slower but Petitioner has not sought treatment since 2018. The Arbitrator gives greater weight to these factors.

Petitioner further refers to the prior Commission Decision of *Victor Roa v. City of Chicago*,15 IWCC 434, with a similar leg injury. The Arbitrator notes the similar medical and disability factors.

Based on the above factors, the Arbitrators finds the Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left leg pursuant to Section 8(e)12 of the Act. Petitioner has a prior settlement of 15% for which Respondent is entitled to a credit. Petitioner is therefore entitled to additional permanent partial disability of 15% loss of use of the left leg (32.25 weeks) after credit is applied.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: February 21, 2020

STATE OF ILLINOIS	)
	) SS.
COUNTY OF WILL	)

[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

Aquilla Williams,
Petitioner,

vs. NO: 06 WC 6563

K Five Construction,
Respondent.

20 I W C C 0 5 1 1

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, medical expenses, 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 20, 2019, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 5 2020
o08/20/20
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

WILLIAMS, AQUILLA Case# **06WC006563**
Employee/Petitioner

K FIVE CONSTRUCTION
Employer/Respondent

20IWCC0511

On 2/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

5122 PORRO NIERMANN LAW GROUP LLC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

2097 KRAKER FANNING & OLSEN
DANIEL K SWANSON
300 S RIVERSIDE PLZ SUITE 2050
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
CORRECTED ARBITRATION DECISION

Aquilla Williams
Employee/Petitioner

Case # **06** WC **6563**

v.

K Five Construction
Employer/Respondent

20IWCC0511

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 5, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 11, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**94,440.84**; the average weekly wage was $**1,816.17**.

On the date of accident, Petitioner was **39** 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 $**8,650.75** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**5,917.70** for other benefits, for a total credit of $**14,568.45**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,078.31**/week for **190 2/7** weeks, commencing **December 12, 2005** through **August 4, 2009**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**8,650.75** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**591.77**/week for **225** weeks, because the injuries sustained caused the **45**% 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.

Arbitrator Anthony C. Erbacci

February 15, 2019
Date

FEB 20 2019

FACTS:

201WCC0511

On December 11, 2005 the Petitioner sustained and undisputed accidental injury arising out of and in the course of her employment with the Respondent. The Petitioner testified that she was employed by the Respondent as a flagger, and that she had been so employed for nine months prior to her injury. The Petitioner testified that prior to her injury, she had no neck, back or shoulder pain or problems, no psychological issues, no depression, no hallucinations and no sleep problems. The Petitioner testified that her injury occurred while she was walking to her flagging assignment, carrying a pail and some equipment, and her right foot "went into a hole" and she fell forward. The Petitioner testified that she immediately experienced pain in her upper extremities and her low back.

On December 12, 2005, the Petitioner presented at the emergency department of Central DuPage Hospital where she gave a history of having fallen onto her left upper extremity and she complained of pain in her neck, back and leg. Cervical x-rays and x-rays of the left wrist were performed and revealed no acute fractures. The Petitioner was diagnosed with a left wrist contusion and a cervical strain. She was prescribed medications and released to light duty work.

On December 15, 2005, the Petitioner was seen by Dr. David Trotter at The Center for Sports Orthopaedics. Complaints of neck pain, back pain, and shoulder pain were noted, and the impression was "Shoulder contusion and lumbosacral strain; rule out rotator cuff tear of the left shoulder." The Petitioner was taken off work and therapy was prescribed. On January 5, 2006, Dr. Trotter noted that the Petitioner's condition that could be reasonably attributable to the work place injury "had resolved essentially in its entirety." Dr. Trotter released the Petitioner to return to work in four to five days and indicated that the Petitioner would be at maximum medical improvement from her injuries on January 9, 2006. Dr. Trotter indicated that a second opinion might be appropriate.

The Petitioner testified that she then chose to treat with Dr. Slusarenko, a chiropracter, at Affiliated Health Care Associates. The records of Affiliated Health Care Associates indicate that the Petitioner was first seen there on January 6, 2006 with complaints of severe headaches, neck pain that radiated into her left shoulder and hand, and lower back pain that radiated into her left leg and caused numbness in her right leg. The Petitioner began a course of chiropractic therapy and A Cervical MRI and a Cervical EMG were conducted.

On January 11, 2006, a cervical MRI was performed at Lincoln Park Open MRI Center and was reported to be unremarkable, revealing no focal abnormality. On January 16, 2006, EMG/NCV was conducted and was reported to be suggestive of left sided radiculopathy at C5-6 with mild sensory polyneuropathy.

On January 27, 2006 Dr. Slusarenko diagnosed Petitioner with a left cervical strain with left C5 C6 cervical radiculopathy, posttraumatic sprain of the thoracolumbosacral spine, posttraumatic bilateral lumbar radiculopathy, and myofascial pain. Dr. Slusarenko recommended that the Petitioner limit her physical activities and engage in therapies through his office. Dr. Slusarenko also referred the Petitioner to Dr. Diesfelt.

The Petitioner saw Dr. Diesfelt on January 30, 2006 for pain management consultation. Dr. Diesfelt noted decreased range of motion of the cervical spine and myofascial trigger points in the posterior paracervical muscles. His diagnosis included left cervical radiculopathy/brachial plexopathy with a secondary myofascial musculoskeletal pain syndrome with trigger points. Dr. Diesfelt offered

an epidural steroid sympathetic block with trigger point injections and he also prescribed amitriptyline and Tramadol.

On February 6, 2006 the Petitioner was seen and examined by Dr. Mark Levin at the request of the Respondent. Dr. Levin noted that during the examination, the Petitioner exhibited a number of inconsistent responses and exaggerated responses to testing. He concluded the physical examination showed that her subjective complaints were out of proportion to objective findings. Dr. Levin opined that the findings were consistent with "potential" manipulation by the patient and he indicated that there was "some symptom magnification" present. Dr. Levin noted that from an orthopedic standpoint, the Petitioner did not need any additional orthopedic care or have evidence of orthopedic injury. He opined that her current restrictions were self-imposed based on marked subjective findings which are not substantiated objective findings. He did not believe any physical therapy or chiropractic treatment would help.

An MRI of the Petitioner's Lumbar spine was performed on February 8, 2006. The history noted on the MRI report is "MVA w/back pain" and it was reported that the MRI revealed small disc herniations at L4-5 and L5-S1 with mild generalized neuroforaminal narrowing at L5-S1. On February 13, 2006 a repeat EMG/NCV was performed by Dr. Osman and reported to demonstrate bilateral (right greater than left) L4-S1 radiculopathy, most notable at L5-S1. On cross-examination, the Petitioner testified that she did not recall being involved in a motor vehicle accident as is reflected in the MRI report.

On March 6, 2006, the Petitioner was seen by Dr. Robert Fink who noted complaints of pain in the low back radiating into the right leg that began with the fall at work on December 11, 2005. Dr. Fink noted the L4–S1 disc herniations shown on the MRI and prescribed medication, a TENS unit, and lumbar epidural steroid injections. Dr. Fink continued the Petitioner off work.

The Petitioner returned to Dr. Fink on April 5, 2006 and he continued to recommend lumbar epidural steroid injections. On June 7, 2006, Dr. Fink again noted complaints of pain in the low back radiating into the right leg with decreased sensation in the right leg. Dr. Fink again diagnosed L4–S1 disc herniations and he continued to recommend lumbar epidural steroid injections. In his report of June 14, 2006, Dr. Fink indicated his diagnosis was herniated discs at L4/L5 and L5/S1. Dr. Fink opined that the Petitioner's lumbar spine condition was causally related to the December 11, 2005 work accident.

On June 12, 2006, Dr. Osman wrote that the EMG/NCV's that he had Performed were consistent with left cervical radiculopathy and bilateral lumbar radiculopathy. He stated that the lumbar findings were consistent with the lumbar MRI scan revealing disc herniations at L4-S1. On the same date, Dr. Diesfeld wrote that the Petitioner's ongoing symptoms were directly related to her work accident of December 11, 2005.

On June 26, 2006, the Petitioner returned to Dr. Fink with complaints of ongoing upper and lower back and extremity pain. The Petitioner also reported pain in her right knee. A right knee MRI was prescribed and was performed on July 10, 2006. The scan was reported to reveal minimal joint effusion at the right knee without bony abnormality. The right knee MR1 scan was reviewed by Dr. Fink on July 12, 2006.

On August 23, 2006, the Petitioner was examined by Dr. Alexander Ghanayem at the request of the Respondent. Dr. Ghanayem noted the history of the Petitioner's accident on December 11,

2005, with continuing symptoms. Examination revealed decreased right leg weightbearing, cervical and lumbar tenderness and lumbar stiffness. Dr. Ghanayem reviewed the cervical and lumbar MRI scans noting mild degenerative change in the lower back. Dr. Ghanayem noted that his findings did not show anything objective that required additional care and treatment, and he opined that the accident of December 11, 2005, represented a cervical and lumbar strain, He did not recommend additional treatments and opined that the Petitioner had reached maximum medical improvement.

The Petitioner continued to treat with Dr. Fink with follow-up on August 9, 2006, and September 13, 2006. During this time, she also continued to treat with Dr. Slusarenko.

On November 15, 2006, the Petitioner sought treatment at the emergency room of Northwestern Memorial Hospital with complaints of back pain. She was given analgesic medication and referred to the Rehabilitation Institute of Chicago for evaluation and pain management therapies.

Petitioner received a lumbar epidural steroid injection on December 1, 2006 from Vikash Dugar MD and Khalid Malik MD. Their assessment was that the Petitioner had low back pain and right L5 radiculopathy along with a possible component of sacroiliac joint dysfunction from her work accident. The doctors gave her a script for hydrocodone. A second lumbar MRI was done on January 12, 2007 and was reported to reveal a minimal disc bulge at L5-S1. An unremarkable discogram and CT scan of the lumbar spine were done on February 1, 2007, and Dr. Malik included myofascial pain as a diagnosis after the discogram. The Petitioner was prescribed narcotics and therapy and the Petitioner was referred fur further care to the Rehabilitation Institute of Chicago Chronic Pain Management Program.

The Petitioner was evaluated at the Rehabilitation Institute of Chicago Chronic Pain Management Center where she came under the care of Dr. Lynn Rader. The Petitioner came under the care of Dr. Rader on January 13, 2007 and she continued to treat with Dr. Rader through August 29, 2011. The Petitioner treated for low back pain, neck pain and left upper arm pain and decreased sleep. Petitioner participated in group counseling, individual counseling, physical and occupational therapy, and behavioral health treatment, and she received narcotics and other medications. The Petitioner's condition reportedly remained unchanged with the RIC. Dr. Rader indicated that the Petitioner's ongoing disability was related to her work related injury and opined that the Petitioner could no longer do heavy construction work and that she needed to see a psychologist. Dr. Rader diagnosed the Petitioner's condition as including lumbar degenerative disc disease, lumbar radiculopathy, myofascial pain, depression, sleep disturbance and sacroiliac joint dysfunction.

On March 20, 2007 the Petitioner was evaluated by Dr. Dunagan for the Bureau of Disability Determination Services. Dr. Dunagan's diagnoses included severe chronic major depressive disorder with psychotic features and severe chronic panic disorder with agoraphobia. Petitioner testified that she had none of these problems before her accident and that she did not seek treatment with Dr. Dunagan until everything started to fall apart after her work injury and the insurance companies stopping of benefits and treatment.

On May 8, 2007 the Petitioner was examined by Dr. Roopa Karri at the request of the Social Security adjudicator. Dr. Karri noted the Petitioner still had decreased range of motion in the neck and back tenderness in the areas as well as patchy loss of sensation. Dr. Karri concluded that the Petitioner had neck pain and lower back pain secondary to her work injury.

In 2007, the Petitioner was awarded Social Security Disability benefits. The Notice of Award indicates that the Social Security Administration determined that the Petitioner had become disabled, according to their rules, on December 11, 2005.

On May 25, 2007, Dr. Rader reexamined the Petitioner and noted that she had a history of lumbar disc disease, myofascial pain and radicular pain. He noted that her complaints at this time were primarily arising from her lower back. Examination revealed lumbar tenderness and stiffness. Dr. Rader diagnosed chronic pain due to lumbar disc degeneration with radicular pain, sleep disturbance and depression. Additional medications were prescribed including antidepressant medication, analgesic medication and muscle relaxant medication for chronic pain. Ms. Williams was also treated by a psychologist for control of stress arising from chronic pain and disability.

On July 18, 2007, Dr. Rader again examined the Petitioner for a "flare" of lower back pain. Dr. Rader noted that the Petitioner continued to experience radiating pain into the right leg with right foot numbness. Her pain was described as constant, aching and burning with right leg tingling. Following examination, Dr. Rader prescribed a sacroiliac joint block and additional oral medication.

On November 5, 2007, Dr. Rader again examined the Petitioner in a follow-up visit for chronic pain. Decreased pain was noted on that date. Treatment was begun with Neurontin. Additional follow-up was recommended.

On April 1, 2008 the Petitioner returned to Dr. Rader reporting a flare of pain in her lower back with right leg radiating pain. Dr. Rader performed a right sacroiliac joint block and also prescribed physical therapy with additional oral medications, Lumbar injections. An epidural steroid injection and sacroiliac blocks were performed at Northwestern Memorial Hospital. Water therapy was also prescribed and carried out.

The Petitioner returned to Dr. Rader on May 19, 2008. Some improvement was noted in pain arising from her lower back, Significant ongoing depression was noted and additional medications were prescribed including Cymbalta.

On June 27, 2008, Dr. Rader's reexamination revealed a further flare of pain when the Petitioner ran out of medication. The pain was described as constant, sharp and burning and made worse by exertion. Additional medications were prescribed. Dr. Rader diagnosed degenerative disc disease at L4-SI with stenosis, sacroiliac joint pain, insomnia and depression. Referral was made to a spinal specialist for further evaluation of the lumbar disc herniations and additional treatment recommendations,

On October 6, 2008, Dr. Rader found worsening of the Petitioner's back symptoms. She was given additional medication. A repeat lumbar MRI scan was prescribed.

On November 3, 2008, the Petitioner underwent a repeat lumbar MRI scan, which was interpreted as showing a small left-sided foraminal disc herniation at L4-1,5 as noted on the prior MRI scan, No right-sided herniations were observed. The Petitioner was seen that same day by Dr. Ihm, who reviewed the lumbar MRI scan and commented that he did not notice any significant central disk herniation or right sided herniation that could explain the Petitioner's right lower limb pain. Dr. Ihm diagnosed chronic right lumbosacral radiculopathy and chronic left cervical radiculopathy. A repeat EMG/NCV was prescribed with pain management therapies.

Dr. Rader reexamined the Petitioner on November 6, 2008. On that date, Dr. Rader noted complaints of pain in the Petitioner's back radiating into her right leg, Additional medications were prescribed.

On January 22, 2009, the Petitioner was seen again by Dr. Levin, at the request of the Respondent. Dr. Levin noted that the Petitioner was treating in a chronic pain center and was complaining of constant low back pain at a level of 8 to 10 out of 10 which was worse with increased activities. She complained of shooting pain in her right leg to her toes with numbness and tingling in her right foot, at times with the feeling of right foot drop. The Petitioner was noted to have had crying spells throughout Levin's second evaluation. Dr. Levin indicated that he was not surprised that treatment had provided no ongoing relief for her pain, and he again noted that the Petitioner presented with inconsistent exam results. Dr. Levin had no recommendations for orthopedic treatment, as he indicated there was nothing to treat from an orthopedic standpoint.

On August 4, 2009, the Petitioner was examined by Dr. Jeffrey E. Coe at the request of her attorney. Dr. Coe noted the history of the Petitioner's accident and subsequent medical treatment, as well as her continuing treatment with Dr. Rader. Dr. Coe indicated that the Petitioner suffered multiple contusions and strains in her work accident and that those injuries aggravated degenerative disc disease and degenerative arthritis in her cervical and lumbar spine causing symptomatic disc herniations at L4-L5 and L5-S1 with chronic cervical and lumbar discogenic and myofascial pain as well as lumbar facet joint mediated pain. Dr. Coe further indicated that the accident and associated disc injuries was also a cause of left cervical and right lumbar radiculopathy symptoms. Dr. Coe opined that there was a causal relationship between the injuries suffered by the Petitioner in her work accident and her current cervical and lumbar symptoms and state of impairment. Dr. Coe further opined that the Petitioner continued to be in need of treatment by the pain management specialist and that she required "sedentary" work restrictions. Dr. Coe opined that the Petitioner could not return to work as a construction laborer. Dr. Coe further opined that the Petitioner had reached maximum medical improvement with regard to her upper and lower back conditions by early 2008 and that limited duty work would have been appropriate for the Petitioner by mid-2008.

The Petitioner testified that she moved to Rockford and then developed drug and alcohol addictions. The records of Crusader Clinic, where the Petitioner treated, indicate that the Petitioner admitted that she was addicted to hydrocodone pain medication and that she was using more than 250 tablets per month and more if she could get it. The Petitioner also reported she was having hallucinations and requested the name of a psychiatrist. Physical therapy was recommended to address the ongoing lumbar pain complaints and a psychiatric workup was done. The psychiatrist assessed the Petitioner as having major depression with psychotic features.

In January 2011, the Petitioner was seen at Janet Wattles Center for psychological issues. A mental health assessment was performed, with Petitioner reporting she had chronic pain since 2005 when she fell on the job, ever since then she'd been dealing with a lot of back and neck pain which triggered her depression. The counselor thought the Petitioner's chronic pain was a barrier to her recovery, and that Petitioner needed psychiatric services and psychotropic medication monitoring. The Petitioner testified that she was treated at Janet Wattles Center for pain, depression, schizophrenia, bi-polar disorder, and hallucinations. The mental health treatment lasted from January 13, 2011 through July 25, 2011, and the treatment notes document depression, anxiety, and lack of sleep.

On July 5, 2012, the Petitioner was examined again by Dr. Ghanayem. Dr. Ghanayem testified that his opinions regarding the Petitioner's condition were the same as the opinions he expressed after his previous examination of the Petitioner in August of 2006.

In October of 2010, the Petitioner underwent an assessment at Remedies Renewing Lives, apparently upon referral from the Crusader Clinic. The presenting history was that Petitioner had been abusing pain medication by using a minimum of 20 pills of Norco daily over the last six years. Petitioner underwent group and individual counseling and participated regularly in group sessions and began to attend Narcotics Anonymous meetings on a weekly basis.

In April of 2014, the Petitioner was directed Rosecrance for crisis intervention. A plan was devised to provide short term crisis specific individual therapy to address her severe depression. The therapy was going to address her cognitive, emotional and behavioral dysregulation. Petitioner was discharged from Rosecrance on December 18, 2014 and told to follow up with her primary care physician.

In October of 2015 the Petitioner began treatment at Mercy Hospital for her chronic pain complaints. She also mentioned a motor vehicle accident. She complained of pain in her back and neck areas and she reported that she had run out of medications. She was noted to be taking an antipsychotic medication, Gabapentin, an NSAID, and a selective serotonin reuptake inhibitor for depression and anxiety. The impression included chronic pain after a work accident and vehicle accident, and the attending physician felt that she needed a referral to a pain clinic. She also had depression and required a follow up with a psychiatrist.

On January 12, 2016, the Petitioner was seen by Dr. Nancy Landre, a licensed clinical Psychologist, at the request of the Respondent. Dr. Landre noted the Petitioner's history of injury and medical treatment, including treatment for depression and bipolar disorder following the injury. Dr. Landre also reviewed some of the Petitioner's medical records, noting that the orthopedic physicians who evaluated the Petitioner found nothing to operate on. Dr. Landre administered a battery of psychometric tests to petitioner as part of the examination. Dr. Landre opined that the psychometric tests results were invalid because the Petitioner failed multiple symptom and performance validity measures. Dr. Landre concluded the Petitioner was malingering and that she did not show compelling evidence of an injury-related decline in cognitive or emotional functioning.

On January 19, 2016, the Petitioner saw the psychologist, Dr. Galligan. She reported she had become addicted to pain medication, that she was homeless for a time, and that her sleep was poor. At the time, she was not having active suicide thoughts but had passive thoughts about being better off dead. The substance abuse inventory noted that her addiction to hydrocodone had lasted more than 5 years. The mental status examination revealed a slow and tearful speech pattern, a dysphoric mood, tearful forlorn affect, and fears. The diagnosis consisted of bipolar disorder with recurrent depression, chronic pain, and psychosocial stressors, and Dr. Galligan recommended a psychiatric evaluation and individual therapy.

The Petitioner saw the psychiatrist, Dr. Channon, on February 26, 2016, presenting with depression and chronic disabling pain. She reported that she had been at the pain management program at RIC and that she had become addicted to pain medication for years, although she had been off the medications for the last couple of years. She had mood swings, experienced auditory and olfactory hallucinations which began 10 years earlier with a sudden onset. Dr. Channon's assessment was that she was suffering from major severe recurrent depression with psychosis. Dr.

Channon recommended individual therapy and medication management. Therapy was thereafter carried out by Dr. Galligan.

On July 5, 2017, the Petitioner was evaluated by Dr. Patricia Andrise, a clinical psychologist at the request of her attorney. Petitioner consulted with Dr. Andrise on three occasions. Dr. Andrise reviewed the Petitioner's medical records and reviewed Dr. Landre's testing and report. Dr. Andrise also administered additional testing including pain inventories which Landre had not performed. Dr. Andrise did not believe that the Petitioner would be a good surgical candidate, and Dr. Andrise's formal psychological and physiological diagnosis was chronic pain syndrome. Dr. Andrise opined that the chronic pain syndrome was caused by the work accident, because the Petitioner was normal before the accident and she became depressed and unable to work after the accident. Dr. Andrise further opined that the Petitioner's depression was also related to the work accident, as she had no hint of depression prior to the accident. She opined that the psychotic component was also related to the depression which led back to the accident. Dr. Andrise opined that the Petitioner was not capable of working with her condition and that the Petitioner was permanently and totally disabled.

In May of 2018, the Petitioner began treating at John Stroger Hospital in Chicago for pain with psychotic features, major depressive disorder with psychotic features. During the mental status examination, the Petitioner reported auditory and visual hallucinations at times, as well as suicidal ideation without plan or intent. The records of the Petitioner's treatment at Stroger Hospital continue through August 29, 2018. As of that date, the treatment had included motivational interviewing and behavioral activation and the Petitioner was also attending concurrent pain treatment and accupuncture. Medications included Gabapentin, Ondanestrone and duloxetine. The Petitioner testified that she was still treating at John Stroger Hospital at the time of the hearing.

The Petitioner testified that she currently continues to experience pain in her low back which radiates down into her buttocks and down into her right leg and knee, as well as pain in her neck which radiates down into her arm. She testified that she continues to have psychological issues, as well as difficulty sleeping, extreme fatigue, lack of energy, and feelings of sadness and loneliness. The Petitioner testified that she also continues to experience visual, auditory and olfactory hallucinations. The Petitioner testified that she spends 90% of her time laying in bed in her room and that she continues to require physical therapy and mental health treatment.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Petitioner slipped and fell on December 11, 2005 sustaining a sprain/strain to her lumbar and cervical spine. Petitioner's back, neck and shoulder pain developed immediately following the accident and the Petitioner continued to report continuing pain in these areas of her body throughout the course of her medical treatment. The Petitioner treated with many different physicians, clinics and hospitals and her complaints are documented throughout the duration of her treatment. The Petitioner's testimony, her medical records, and the testimony of several physicians demonstrate that the pain from her December 11, 2005 work accident developed into a chronic pain condition. Dr. Coe, who examined the Petitioner on August 4, 2009, reviewed the voluminous records of the Petitioner's medical treatment up to that date and opined that the Petitioner suffered from chronic discogenic and myofascial pain. Dr. Coe causally related the Petitioner's continuing back and neck

pain to the December 11, 2005 work accident. Dr. Lorenz agreed that the Petitioner suffered from chronic pain, as did each of the medical providers who saw the Petitioner after Dr. Trotter. Both of the clinical psychologists that saw the Petitioner also agreed that she suffered from chronic pain.

While the Arbitrator notes the records of Dr. Trotter, and the opinions of Dr. Levin and Dr. Ghanayem, the Arbitrator finds the testimony and opinions of Dr. Coe to be credible, reliable, and persuasive in the instant matter. The Arbitrator finds, therefore, that the Petitioner's current lumbar and cervical pain complaints are causally related to the Petitioner's December 11, 2005 work accident.

With regard to the Petitioner's psychological condition(s), the Arbitrator finds that the Petitioner failed to meet her burden of proving that those conditions are causally related to the December 11, 2005 work accident. In so finding, the Arbitrator notes the testimony and opinions of Dr. Landre and Dr. Andrise and finds the opinions of Dr. Landre to be credible and persuasive. The Arbitrator notes that Dr. Andrise's opinions appear to be primarily based on the mere fact that the Petitioner didn't have any psychological issues prior to the accident and that all of the Petitioner's psychological issues, including a bi-polar disorder, developed after the accident. While the Arbitrator notes that, in some cases, the temporal sequence of events can itself support a finding of causation, the Arbitrator cannot make that leap in the instant matter.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (O.), Prospective Medical Treatment, the Arbitrator finds and concludes as follows:

While Dr. Coe opined that the Petitioner had reached maximum medical improvement by early 2008, he also indicated that she was in need of additional pain management treatment, the Respondent's responsibility for treatment does not run beyond her two choices of physicians. The Respondent initially sent the Petitioner to an industrial clinic which does not qualify as Petitioner's choice. The Petitioner then chose to treat with Dr. David Trotter which qualifies as her first choice of physicians. The Petitioner then chose to treat with Dr. Slusarenko who ultimately sent her to Drs. Osman, Disefeld, Fink and Lorenz. Dr. Slusarenko is the Petitioner's second choice of physicians. Drs. Osman, Disefeld, Fink and Lorenz are within the chain of referrals from Dr. Slusarenko. The Respondent is responsible for paying for treatment provided at each of those locations and for the therapy and tests ordered by those physicians. Unfortunately, while the Petitioner may be in need of additional pain management treatment, treatment beyond those initial choices are not the responsibility of respondent under the two-physician rule.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

Following her injury on December 11, 2005, the Petitioner was continued off work by her treating physicians. The Petitioner has not returned to any type of work since that time.

On August 4, 2009, the Petitioner was examined by Dr. Jeffrey E. Coe at the request of her attorney. Dr. Coe's testimony was admitted into the record as Respondent's Exhibit 1, and the Arbitrator has found the testimony and opinions of Dr. Coe to be credible, reliable, and persuasive in

the instant matter. Dr. Coe indicated that the Petitioner suffered multiple contusions and strains in her work accident and that those injuries aggravated degenerative disc disease and degenerative arthritis in her cervical and lumbar spine causing symptomatic disc herniations at L4-L5 and L5-S1 with chronic cervical and lumbar discogenic and myofascial pain as well as lumbar facet joint mediated pain. Dr. Coe further indicated that the accident and associated disc injuries was also a cause of left cervical and right lumbar radiculopathy symptoms. Dr. Coe opined that there was a causal relationship between the injuries suffered by the Petitioner in her work accident and her current cervical and lumbar symptoms and state of impairment. Dr. Coe further opined that the Petitioner continued to be in need of treatment by the pain management specialist and that she required "sedentary" work restrictions. Dr. Coe opined that the Petitioner could not return to work as a construction laborer. Dr. Coe opined that the Petitioner had reached maximum medical improvement with regard to her upper and lower back conditions by early 2008 and that limited duty work would have been appropriate for the Petitioner by mid-2008.

Based upon the testimony of Dr. Coe, the Arbitrator finds that the Petitioner failed to prove that she was entitled to Temporary Total Disability benefits after August 4, 2009.

The Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from December 11, 2005 through August 4, 2009, a period of 190 2/7 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

In the instant case, the Petitioner suffered multiple contusions and strains in her work accident and those injuries aggravated degenerative disc disease and degenerative arthritis in her cervical and lumbar spine causing symptomatic disc herniations at L4-L5 and L5-S1 with chronic cervical and lumbar discogenic and myofascial pain as well as lumbar facet joint mediated pain. The Petitioner testified that he currently continues to experience pain in her low back which radiates down into her buttocks and down into her right leg and knee, as well as pain in her neck which radiates down into her arm. Dr. Jeffrey Coe, who examined the Petitioner on August 4, 2009, opined that the Petitioner could not return to her employment as a construction laborer and that she would be restricted to sedentary work.

Because the Petitioner's work accident occurred before September 1, 2011, consideration of the criteria required by Section 8.1(b) of the Act is not required in determining the level of the Petitioner's permanent partial disability, if any. The Arbitrator, having considered the testimony and opinions of Dr. Coe, the testimony of the other examining physicians, the testimony of the Petitioner, and the voluminous medical records admitted into the record, finds that as a result of the work injury of December 11, 2005, the Petitioner suffered a "loss of career" injury which resulted in 45% permanent disability to the Petitioner's whole person.

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
		[X] Modify [Up]	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Enrique A. Robles,

Petitioner,

vs. NO: 17 WC 130

Southwest Airlines Co.,

Respondent.

20 IWCC0512

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, permanent disability, and penalties and fees, 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.

Regarding the issue of permanent partial disability (PPD) benefits, subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of PPD benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2014). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

In this case, the Arbitrator placed weight on factors (i), (ii), and (iii), and no weight on factors (iv) and (v). The Commission is in general agreement with the Arbitrator's consideration of the statutory factors, with the exception of factors (iii) and (v). The Arbitrator assigned weight to Petitioner's age, 28 at the time of the accident, but the Commission concludes that this factor should be given significant weight as Petitioner will have to manage the effects of the injury in this case for an anticipated work life continuing over the next several decades. Moreover, Petitioner's testimony regarding his current condition of ill-being matches the pain he reported to Dr. Maday in June 2017. Accordingly, the Commission places some weight on the

evidence of disability corroborated by the treating medical records. Accordingly, the Commission modifies the award of PPD benefits upward to reflect the loss of eight percent of the person as a whole.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Respondent has paid Petitioner's reasonable and necessary medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claim for the unpaid medical bills regarding Dr. Maday's prescription of the Flurbiprofen 10%/ Cyclobenzaprine HCL 10% topical cream is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties and fees is denied, based on the Commission's finding regarding the medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $535.37 per week for a period of 40 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused an 8% 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.

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $21,500. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 5 2020
o: 8/20/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBLES, ENRIQUE A
Employee/Petitioner

Case# **17WC000130**

SOUTHWEST AIRLINES CO
Employer/Respondent

20IWCC0512

On 5/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment, however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4084 TIMOTHY J DEFFET LAW OFFICE
5875 N LINCOLN AVE
SUITE 231
CHICAGO, IL 60659

0766 HENNESSY & ROACH PC
QUINN M BRENNAN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Enrique A. Robles
Employee/Petitioner
v.
Southwest Airlines, Co.
Employer/Respondent

Case # **17** WC **000130**

Consolidated cases: ____

20IWCC0512

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **March 6, 2019**. After reviewing all the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 9, 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 $**46,399.08**; the average weekly wage was $**892.28**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**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

Permanent Partial Disability

BASED ON THE FACTORS IN 820 ILCS 305/8.1B AND THE RECORD TAKEN AS A WHOLE, THIS ARBITRATOR FINDS PETITIONER SUSTAINED PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 5% (25 WEEKS) OF A PERSON AS A WHOLE PURSUANT TO SECTION 8(D)2 OF THE ACT.

PENALTIES

NO PENALTIES OR FEES ARE AWARDED PETITIONER.

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

5-6-19
Date

MAY 6 - 2019

Enrique A. Robles v. Southwest Airlines, Co., No. 17WC000130

Preface

The parties proceeded to hearing March 6, 2019, on a Request for Hearing indicating the following disputed issues: whether Respondent is liable for unpaid medical bills; what is the nature and extent of the injury; and whether Petitioner is entitled to penalties and/or attorney's fees. Two witnesses testified, Petitioner and, via evidence deposition, Dr. Peter Hoepfner. Enrique A. Robles v. Southwest Airlines, No. 17WC000130 Transcript of Proceedings on Arbitration at 5; Arbitrator's Exhibit 1; Respondent's Exhibit 1.

Findings of Fact

Enrique Robles (Petitioner), a 28 year old male, testified he is a ramp agent for Southwest Airlines (Respondent) at Midway Airport, loading and unloading cargo. On November 9, 2016, he was working gate B-12 and while loading cargo, felt a throbbing in his shoulder. He said he was not able to continue working and went to Clearing Clinic as required by his employer. Robles at 11, 13-15.

The records of Clearing Clinic indicate Petitioner was seen nearly two months later, January 3, 2017. He complained of right shoulder pain. Petitioner was assessed with cervical radiculopathy and right shoulder pain. It is unclear whether he had restrictions or what treatment was given him. Petitioner's Exhibit 3. Clearly there are medical records missing regarding his visits and treatment.

Petitioner testified he saw Dr. Michael Maday in February 2017. The records of Dr. Maday indicate Petitioner first saw him three months after the incident, February 17, 2017, for a second opinion, complaining of shoulder, trapezius and neck pain. Those records indicate a history of therapy, MRI's of neck and shoulder, injections without improvement, purported visits to a sports medicine specialist, and a referral to a neurologist. Petitioner failed to introduce any records about this or testify to that history. Maday recommended an EMG and MRI of the shoulder. He said Petitioner was unable to return to his duties. Robles at 17; Petitioner's Exhibit 7 (unpaginated).

The records indicate Petitioner saw Maday five more times, the last being June 9, 2017. Maday assessed Petitioner with a labral injury to the shoulder with suprascapular nerve injury. He did not feel Petitioner was a surgical candidate but recommended physical therapy. Petitioner's symptoms improved and he progressed to a work conditioning program. By June 9, 2017, Maday allowed Petitioner full unrestricted duties. Petitioner's Exhibit 7 (unpaginated).

Petitioner submitted to an independent medical examination April 12, 2018, by Dr. Peter Hoepfner, a board certified orthopedic surgeon. After taking a history from Petitioner, reviewing his medical records and diagnostics, and conducting a physical examination of Petitioner, Hoepfner diagnosed Petitioner with a small posterior labral tear in addition to suprascapular

nerve neuritis, and related that to the November 2016 accident. He also did an impairment rating of Petitioner, finding the impairment rating at 0%. Respondent's Exhibit 1 at 10, 15, 16, 19, 23, 25-26, 32, 36; Respondent's Exhibit 2.

Petitioner testified that since he returned to work, his pain is occasional, he has no problems working with his right shoulder, and is working full time. He has no stiffness or pain in his right shoulder. Robles at 23, 25.

Conclusions of Law

Disputed issue **J** is whether Respondent is liable for unpaid medical bills. Petitioner merely states "See attached Petitioner Exhibit List." Despite that vague direction to the list by the parties, preliminarily and then on the record, the sole disputed amount is $3,224.98 to Midland Orthopedic Associates. The circumstances concerning that amount are murky at best. Apparently, Dr. Maday prescribed Flurbiprofen 10%/Cyclobenaprine HCL 10% cream for Petitioner. I say apparently because his records, supposedly from the date of prescription, May 30, 2017, concern a follow up while Petitioner was work conditioning. Dr. Maday wanted him to finish and follow up in a week with an anticipated return to work. There is no indication any medication was prescribed. It seems a $3,224.98 bill for this cream was denied during a utilization review, which simply indicated the service was not authorized. In a request for "retro-authorization", Maday indicated Petitioner had pain and inflammation that was inadequately controlled with other therapies or oral medications. He said it was medically necessary to avoid the "drastic side effects and complications of chronic oral NSAID therapy. ." A close review of the records of Midland Orthopedic Associates indicates no other therapies (besides physical therapy) or any medications were prescribed Petitioner at all. Any pain reported by Petitioner from February 2017 through June 2017 was either resolved by April 18, 2017, or mild by May 30, 2017, or only occasional by June 9, 2017. There are no notes of side effects from NSAID therapy, no use of NSAIDs at all. Maday's justification is simply made up. Petitioner's Exhibit 7 (unpaginated). Petitioner offered no testimony regarding being prescribed medication or the failure of other medications to control any pain and inflammation, nor did he testify as to any side effects or complications of any medication he was taking. His only testimony regarding the cream was that it provided minimal relief—he realized it was not doing much. Robles at 24, 28.

Dr. Hoepfner testified he does not use topical creams because they are placed too far away from the pathology to be effective. He called it a spurious use of a modality without recognized documented peer review literature to support its use for Petitioner's indication. He said use of the cream was not reasonable and necessary, it would not be effective for Petitioner's shoulder. His opinion is based from a medical standpoint, not a utilization review reasoning. Respondent's Exhibit 1 at 26, 29, 30, 48, 55-56, 70.

I find as a conclusion of law, based on a lack of justification or documentation, and the testimony of Dr. Hoepfner, Respondent is not liable for unpaid medical bills for Florbiprofen cream.

Disputed issue **L** is, what is the nature and extent of the injury. The injury suffered by Petitioner was a small posterior labral tear in addition to suprascapular nerve neuritis. Here permanent partial disability is established using criterial found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

With regard to subsection (i) of Section 8.1b(b), Dr. Hoepfner testified, extensively, he prepared an AMA impairment rating and concluded Petitioner suffered 0% impairment for the shoulder and the person. I therefore give weight to this factor in determining the level of partial disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the employee, I note at the time of injury Petitioner was a ramp agent for Respondent, loading and unloading cargo of up to 100 pounds and cargo manifests of up to 250 pounds. He returned to that work. He testified his shoulder bothers him after constant use of loading a heavy flight. I give weight to this factor in determining the level of partial disability.

Regarding subsection (iii) of Section 8.1b(b), this Arbitrator notes Petitioner was 28 years old at the time of the accident, he has many working years ahead of him, and I give this factor weight in determining the level of disability.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings, no evidence was offered on any effect to Petitioner's future earnings. I give no weight to this factor in determining the level of disability.

With regards to subsection (v) of Section 8.1b(b), evidence of disability corroborated by treating medical records, there really is none. I give this factor no weight in determining the level of disability.

Based on the above factors, the testimony offered, and my reading and consideration of the record as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of five (5) % (25 weeks) loss of a person as a whole pursuant to Section 8(d)2 of the Act.

Disputed issue **M** is, should penalties and fees be imposed upon Respondent. Here, although the Petition for Penalties and Fees is not entirely clear, it appears based on the nonpayment of Dr. Maday for Flurbiprofen cream. Based on finding Respondent is not liable for payment of that cream, such Petition is denied. This is not a case, by any stretch of the imagination, that warrants the imposition of fees or penalties.

[signature] 5-6-19

Arbitrator Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ulises Garcia,

Petitioner,

vs. NO: 15 WC 39378

Southwest Airlines Co.,

Respondent.

20 I W C C 0 5 1 3

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, permanent disability, and penalties and fees, 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.

Regarding the issue of permanent partial disability (PPD) benefits, subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of PPD benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2014). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

In this case, the Arbitrator placed significant weight on factors (i) and (ii), and little weight on factors (iii), (iv), and (v). The Commission is in general agreement with the Arbitrator's consideration of the statutory factors, with the exception of factor (iii). The Arbitrator placed little weight on Petitioner's age, 29 at the time of the accident, finding there was no evidence that the injury would significantly affect Petitioner's work-life expectancy. The Commission concludes that this factor should be given significant weight, as Petitioner will have to manage the effects of the injury in this case for an anticipated work life continuing over the

20 I W CC0513

next several decades. Accordingly, the Commission modifies the award of PPD benefits upward to reflect the loss of 20 percent of the person as a whole.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Respondent has paid Petitioner's reasonable and necessary medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claims for unpaid medical bills from ADCO (compound topical pain cream) and MK Orthopedics (work hardening) are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for penalties and fees is denied, based on the Commission's finding regarding the medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $557.45 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 20% 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.

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $55,800. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 15 2020
o: 8/20/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, ULISES
Employee/Petitioner

Case# **15WC039378**

SOUTHWEST AIRLINES
Employer/Respondent

20IWCC0513

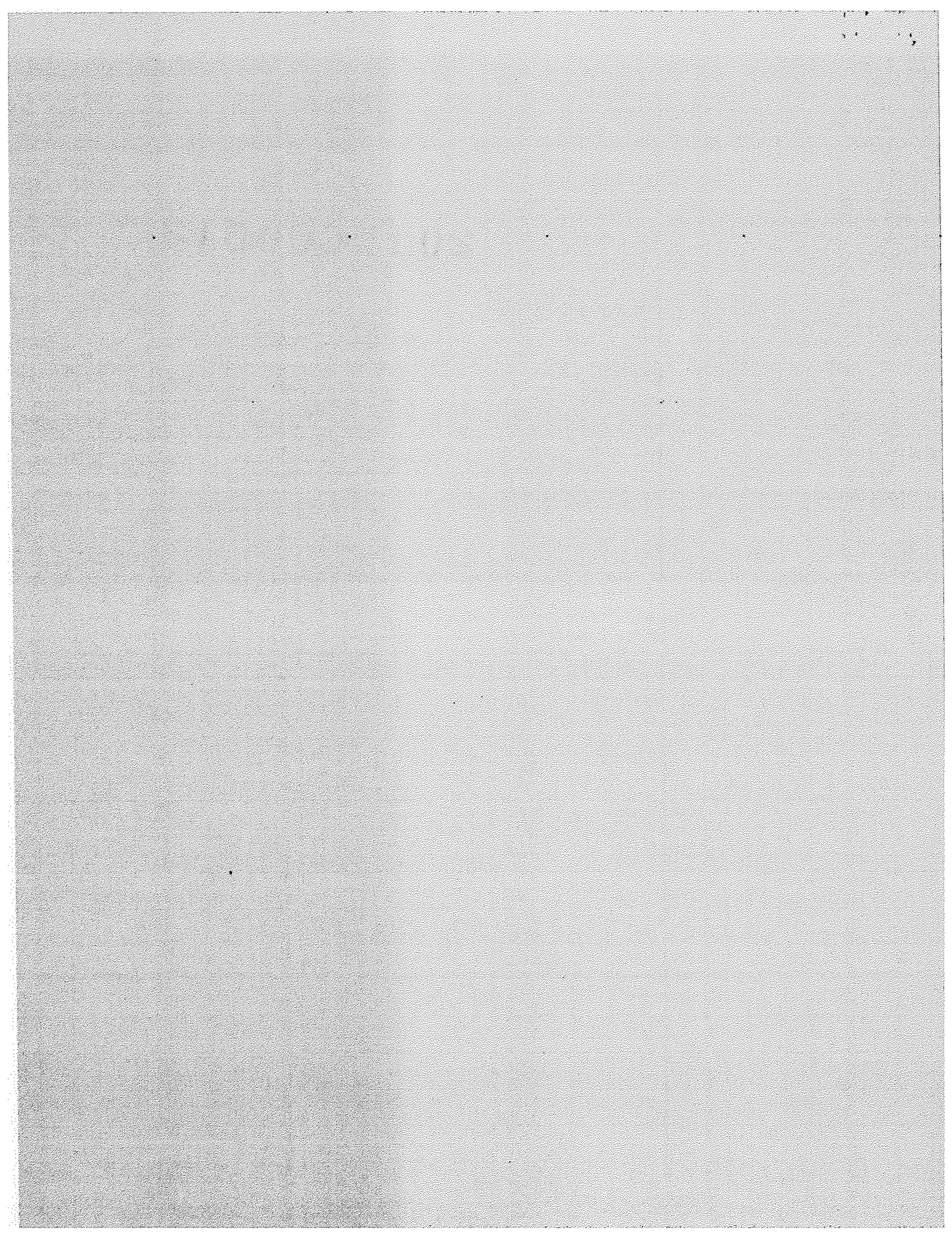
On 6/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4084 LAW OFFICE TIMOTHY J DEFFET
5875 N LINCOLN AVE
SUITE 231
CHICAGO, IL 60659

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603



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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ulises Garcia
Employee/Petitioner
v.
Southwest Airlines
Employer/Respondent

Case # **15** WC **39378**

20IWCC0513

An *Application for Adjustment 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 **4/26/2019 and 5/20/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/10/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**48,312.68**; the average weekly wage was $**929.09**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**67,425.03** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**67,425.03**.

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

ORDER

The Arbitrator awards the petitioner permanent partial disability benefits in the amount of $557.45 per week for a period of 87.5 weeks because the petitioner sustained 17.5% loss of use of a man as a whole as a result of the injury.

The Arbitrator denies the petitioner's claim to unpaid medical bills from ADCO for the compound topical pain cream and from MK Orthopedics for work hardening because the treatment requested is not reasonable or necessary.

The Arbitrator denies the petitioner's claim for penalties based on his finding regarding medical bills.

See attached Findings of Fact and Conclusions of law for detailed discussion regarding the Arbitrator's 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.
f

David A. Kane
Signature of Arbitrator

June 3, 2019
Date

JUN 3 - 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ulises Garcia,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No: 15 WC 39378
	)	
Southwest Airlines	)	
	)	
Respondent.	)	

20IWCC0513

RIDER

FINDINGS OF FACT

The petitioner was employed by Southwest Airlines as a ramp agent. He has been employed there since January 2, 2008. His job was to load 500+ bags per day onto aircraft that weighed up to 100 pounds. He also pushed large, heavy carts, as well as handled human remains which weigh up to 600 pounds. On March 10, 2015, the petitioner was working as a rover, which means working at two different gates at Midway Airport. On that date, he testified that he was offloading human remains which weighed about 300 pounds. As he was pushing and pulling, he felt a sharp pain in his low back. He testified that he called his supervisor, advised he was hurt, and was sent to the Clearing Clinic. (PX 13)

The petitioner then obtained an MRI on April 17, 2015 which showed a shallow disc bulge at L4-L5 and shallow disc bulge at L5-S1 with no spinal stenosis or disc herniation. (PX 13) On April 28, 2015 the petitioner was referred to a pain specialist for an epidural steroid injection.

20IWCC0513

The petitioner underwent a steroid injection in May of 2015, however, still had a low back ache. The petitioner was to resume physical therapy at that time. (PX 13)

The petitioner was seen by Dr. Zelby on May 22, 2015. (PX 13) At that time, the petitioner reported that his symptoms were better but still gets an intermittent feeling of pinching but sometimes turns into pain along the right side of his low back. An examination was performed of the petitioner, and the petitioner was diagnosed with a lumbar strain, and it was indicated that the MRI was normal. Dr. Zelby indicated that the petitioner could do medium physical labor now lifting 40 to 50 pounds occasionally and 20 to 25 pounds frequently. Work conditioning was also recommended at that time.

Work conditioning began on June 10, 2015. (PX 13) On June 24, 2015, the petitioner was scheduled for an epidural steroid injection which he underwent on June 26, 2015 at MacNeal Hospital. The petitioner returned to the Clearing Clinic on July 6, 2015 and the petitioner was ready to resume work conditioning at that time.

On July 27, 2015 it was indicated that the petitioner had completed work hardening and can return to full duty work. He was to continue pain medication if necessary and to continue home therapy exercises. The petitioner did return to his regular job on July 28, 2015. (PX 13)

The petitioner was scheduled for an independent medical evaluation with Dr. Graf on August 31, 2015. (RX 3) The petitioner reported a consistent history of accident, and a physical examination was performed. Dr. Graf also reviewed the medical records which were provided by

Southwest Airlines through the date of the IME. Dr. Graf indicated that the petitioner's current pain was SI joint mediated and did not appear to be from the lumbar spine. This was confirmed due to the fact that he had a normal MRI of the lumbar spine. He indicated that a right sided SI joint injection would be reasonable as well as an additional three weeks of physical therapy. Dr. Graf indicated that the petitioner can continue to work full duty at that time. Dr. Graf also indicated that the current treatment that was required was causally related to the injury in question.

The petitioner was seen at the emergency room on October 1, 2015 at MacNeal Hospital. (PX 13) It was indicated that the petitioner complained of back pain and was diagnosed with acute low back pain. The petitioner was prescribed medications. The petitioner was undergoing physical therapy and followed up with the Clearing Clinic during his physical therapy. The petitioner was again taken off work at that time.

On October 15, 2015 the Clearing Clinic indicated that the petitioner should not work lifting greater than 10 pounds and should continue physical therapy.

The petitioner was seen in consultation by Dr. Said on November 6, 2015. This is a pain clinic evaluation. At that time, they were scheduling an SI joint injection with sedation. An SI joint injection was performed by Dr. Said on November 13, 2015. The petitioner followed up with Dr. Said on December 7, 2015. He stated that he had 40% pain relief for one week, and the petitioner indicated that the pain relief for that week was much greater than when he had a prior epidural steroid injection. At this point the pain had returned to his normal severity. It was recommended that he undergo a repeat right SI joint injection at that time. (PX 13)

The petitioner came under the care of Dr. Kuo at MK Orthopedics and was seen by her on January 5, 2016. (PX 5, 8) Dr. Kuo diagnosed the petitioner with right sacroiliitis. She opined that the petitioner has exhausted non-operative care and another injection was offered, however, the petitioner was to proceed with surgery at that time. The petitioner was recommended for a right SI joint fusion.

The petitioner was seen for a follow-up independent medical evaluation with Dr. Graf on February 29, 2016. (RX 3) An examination was performed which showed a positive SI joint pain test. Additional medical records were reviewed and enumerated by Dr. Graf in his report. Dr. Graf indicated that he did previously recommended that the petitioner undergo a sacroiliac joint injection, however, the one that was performed was both with local anesthetic and steroid based, and it would not be considered a confirmatory SI joint injection. He indicates that "standardized treatment guidelines for sacroiliac joint stabilization is not only a diagnosis confirmed by a physical examination though also confirmed by a diagnostic injection without steroid." He indicated that the petitioner should return for a diagnostic sacroiliac joint injection performed with contrast and a pre and post procedure pain log should be kept. If the petitioner obtains substantial pain relief with the injection without steroid, Dr. Graf indicates that the sacroiliac joint surgery would be reasonable. Dr. Graf also discussed surgery with the petitioner and the indicated that he would prefer not to have a sacroiliac joint fusion.

The petitioner was prescribed compound topical pain medications by Dr. Kuo. The respondent obtain a Utilization Review ("UR") report from Dr. Trotter on June 15, 2016 indicating that the treatment was not reasonable

or necessary (non-certified). (RX 2) Dr. Trotter's reasoning was primarily based on the fact that topical compound creams are typically used only when the patient is not tolerating oral medications. (RX 2, p. 12) Dr. Kuo authored a short letter of unknown date appealing the UR decision indicating that the topical cream was meant to avoid side effects of oral therapies. She stated that oral therapies were not adequately controlling the petitioner's pain and inflammation. (PX 11) There is no indication in the medical records of Dr. Kuo, however, that the petitioner was not tolerating oral medications. (PX 8, 9) The respondent denied payment for the topical compound pain medications based on the UR.

The petitioner did undergo the diagnostic injections which had positive results. As such, surgery was recommended, and scheduled. The petitioner underwent surgery in the form of a right SI fusion at the hands of Dr. Kuo on August 31, 2016. (PX 1) The petitioner then began a normal, post-operative course of physical therapy.

A follow-up IME with Dr. Graf took place on January 25, 2017. (RX 3) Dr. Graf indicated that the petitioner did continue to complain of pain, however, did not exhibit any non-organic pain signs indicating that the petitioner is exaggerating his symptoms. Dr. Graf indicated that the petitioner was recommended for a CT scan of the SI joint and pelvis. He indicated that if it demonstrates that the implants are in good position that the petitioner would be at maximum medical improvement. He also released the petitioner to work at sedentary level at this time pending further review of the CT scan. The CT scan was not performed because, concurrently with the IME, the petitioner was scheduled for work hardening.

The petitioner began a course of work hardening. Dr. Steven Milos performed a Utilization Review on April 12, 2017, and stated that work hardening beyond 10 visits over four weeks (the equivalent of about 30 hours) is non-certified, or not medically necessary. (RX 1) Prior to the utilization review, the petitioner had completed 26 sessions of work hardening. Dr. Milos testified that his opinions are partially based on the ODG guidelines, however he doesn't always abide by those guidelines. (RX 1, p. 39) In this case, however, he believed that the ODG Guidelines were appropriate. He stated that the petitioner had 26 work hardening sessions already and was not progressing. (RX 1, p. 40) Dr. Milos testified that he believed he had enough information to determine the medical necessity questions asked of him. (RX 1, p. 47). There is no evidence submitted by the petitioner to rebut the opinions of Dr. Milos.

The petitioner underwent a CT scan on May 18, 2017 which showed post-surgical changes to the SI joint. (PX 8)

A follow up IME was scheduled with Dr. Graf on June 6, 2017. (RX 3) Dr. Graf indicated that upon review of the utilization review reports and the CT scan, that the petitioner had completed physical therapy and extensive work conditioning and was at maximum medical improvement. He indicated no further treatment or care is necessary as related to the injury. He also stated that the petitioner can return to his full duty level job at that time and there was no objective reason why he could not do so.

Despite a lack of full duty release from the treating physician, the petitioner did return to his full duty job pursuant to Dr. Graf's

recommendations on June 16, 2017. Dr. Kuo, the treating doctor, released the petitioner to full duty and MMI as of July 18, 2017. The last time the petitioner saw Dr. Kuo in a final follow-up was on August 29, 2017. (PX 8)

Finally, an AMA impairment rating exam was scheduled with Dr. Graf on May 22, 2018. (RX 3) Dr. Graf found a 2% man as a whole impairment based on the most recent AMA Guides to Impairment.

The petitioner testified that he still has some issues performing his job. He states that loading the bags while on his knees are tough on his knees and he does still have some pain in his right lower back. He states that he performs stretches to alleviate the pain. He stated that he sometimes takes over-the-counter Tylenol for pain, but only once or twice a week. Additionally, the petitioner states that he can only play with his children for a limited time, though if he sits down for a long time, he gets some pain. He stands up to stretch to alleviate the pain.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE F, IS THE PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The petitioner's injury while pushing and pulling heavy cargo on March 10, 2015 is not disputed. The petitioner reported an immediate onset of low back pain, which was later discovered to be related not to the low back, but to the petitioner's sacroiliac joint. Dr. Graf, the Respondent's Section 12 examiner, opined that the petitioner's SI joint condition and need for surgery were causally related to the injury of March 10, 2015. The petitioner's continued complaints of some aching pain in his right low back

area are residual effects of the injury and surgery in the form of an SI fusion. Therefore, the Arbitrator finds that the petitioner's current condition of ill-being is causally related to the injury.

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

The Arbitrator finds that the respondent has paid all appropriate charges, and the unpaid bills from ADCO and MK Orthopedics do not constitute reasonable and necessary treatment. In support of the Arbitrator's decision, the Arbitrator relies on the following facts:

First, the petitioner claims three medical bills are outstanding. The respondent stated that it shall pay the medical bills from Quest Diagnostics, so that bill is not at issue. The bills from ADCO (topical compound pain creams) and MK Orthopedics (work hardening) are at issue.

Regarding the bills from MK Orthopedics, the petitioner claims that additional work hardening was reasonable and necessary treatment. The respondent denied same pursuant to Utilization Review (hereinafter referred to as "UR"), authored by Dr. Milos on April 12, 2017. His deposition was taken on September 21, 2018. (RX 1) According to the UR, Dr. Milos stated that no treatment for work hardening beyond 10 visits over the course of 4 weeks (a total of 30 hours) was reasonable or necessary, and that the requested additional 20 visits was not reasonable or necessary. He stated that he based his opinions on the ODG guidelines as

well as his own review of the medical records. He stated that the petitioner had already undergone 26 visits of work hardening (almost three times the recommended amount), was not progressing further in work hardening, and it didn't make sense to order more. (RX 1, p. 40) The petitioner did not put forth any medical evidence rebutting the opinions of Dr. Milos.

According to Section 8.7 of the Illinois Workers' Compensation Act, "an admissible utilization review shall be considered by the Commission, along with all other evidence and in the same manner as all other evidence, and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment." Further, reliance on a UR creates a "rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act."

In this case the Arbitrator has reviewed the UR regarding work hardening, as well as the testimony of Dr. Milos, along with all other evidence submitted, and finds that the outstanding medical bill from MK Orthopedics for work hardening is not reasonable or necessary, and finds Dr. Milos's opinions to be credible and controlling. In so finding, the Arbitrator notes that the petitioner had almost triple the amount of work hardening that was prescribed as reasonable and necessary, which was approved and paid for by the respondent. The request to more than quadruple the amount of work hardening, when the petitioner was not progressing anymore, does not make sense from a logical standpoint, and is confirmed by credible physician testimony. Additionally, the petitioner did not offer any medical evidence to rebut the testimony of Dr. Milos.

Regarding the medical bills from ADCO, the Arbitrator finds that this treatment, which was specifically for topical compound pain medication, was not reasonable or necessary. The respondent denied these bills pursuant to a UR authored by Dr. Trotter on June 15, 2016. Dr. Trotter's deposition was taken on September 24, 2018. (RX 2) Dr. Trotter found that the compound medicated cream was not reasonable or necessary treatment. His reasoning was that typically these creams are prescribed when there is evidence of a failure of oral medications. He stated that, "I didn't see that the individual had a trial and failure of oral nonsteroidal anti-inflammatories and also muscle relaxants. I didn't see an intolerance to those medications. And I didn't see that there was any . . . large published studies with regards to this combination of topical medications, and therefore, I didn't feel that it was established that it was medically necessary in this case." (RX 2, p. 12)

The petitioner submitted evidence from Dr. Kuo in the form of a letter of unknown date indicating why she believed the topical compound medication was reasonable and necessary treatment. (PX 11) She stated that the creams were necessary to provide relief from pain and inflammation. However, there is no medical record to indicate that the petitioner was not tolerating oral medications. There are no examination notes indicating increased pain and swelling. Indeed, many of the notes indicate that the petitioner's pain was well-controlled at the level of 3-4 out of 10 at times. There are zero notes indicating that the petitioner had uncontrolled swelling at the SI joint. (PX 8, 9)

Considering Section 8.7 of the Act, the Arbitrator must weigh all evidence, including the UR report. The Arbitrator in this case finds the opinions of Dr. Trotter to be more credible than those of Dr. Kuo.

Dr. Trotter stated that topical creams (and typically creams that contain only ONE medication, rather than several) are used as a second resort – after there is evidence that oral medications are not tolerated. He stated that there was no evidence that there was a trial and failure of oral non-steroidal anti-inflammatories and muscle relaxants, nor were there any large studies in the medical literature pointing to the efficacy of compound creams. (RX 2, p. 12) There was no medical evidence submitted to refute Dr. Trotter's expert testimony as to when prescribing compound topical pain creams is appropriate (as opposed to oral medications). Dr. Kuo's letter simply states that the prescribed creams are necessary for the petitioner, but does not provide any reasoning as to why this prescription is better than, or more effective than oral anti-inflammatories or muscle relaxants.

Therefore, apart from the medical bill from Quest Diagnostics, which the Respondent has agreed to pay, the Arbitrator finds that the medical bills from ADCO for the topical compound cream, and the medical bills from MK Orthopedics for work hardening, are not reasonable or necessary.

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

The petitioner injured his low back and SI joint as a result of the injury of March 10, 2015. The petitioner underwent a long course of injections, which eventually led to an SI fusion surgery. The petitioner has returned to

work full duty at this point, and does have some residual complaints as a result of the injury, however is able to work his full duty job.

Because the accident occurred on or after September 1, 2011, the Arbitrator looks to Section 8.1(b) of the Illinois Workers' Compensation Act for guidance in assessing permanency. This Section sets forth five factors to be considered in determining permanent partial disability. The five factors are: 1. AMA impairment rating; 2. Occupation of the Injured Employee; 3. Age of the Employee; 4. Employee's Future Earning Capacity; and 5. Disability Corroborated by Medical Records.

1. An AMA impairment rating was proffered by Dr. Graf. (RX 3) Following multiple examinations of the petitioner, and in conjunction with the petitioner's own discussions and opinions regarding his impairment, Dr. Graf found an impairment rating pursuant to the AMA Guides to be 2% of a man as a whole. Dr. Graf described, in detail, how he reached the impairment rating, and how there is some interpretation needed of the guides with regard to SI joint injuries, due to their categorization in the Guides. Dr. Graf stated that impairment is different than disability. While this is only one of five factors for the Arbitrator to consider, it is important to note the minimal impairment value provided in this case, due to the excellent surgical result, and the Arbitrator places significant weight on this factor.

2. The petitioner's occupation is a ramp agent for a large airline. The petitioner's job is heavy, and is a very physically demanding job. The petitioner testified that he is able to perform all of the duties of his job, though sometimes has to take a moment to stretch – especially after a long period on his knees. The petitioner has been working full duty for nearly

two years following his release to return to work full duty, and continues to do so. Therefore, the Arbitrator places significant weight on this factor.

3. The petitioner's age at the time of the injury was 29. He is currently 33 years old. The petitioner is very young and may work long into the future. There was no evidence provided that this injury will significantly impact the petitioner's work-life expectancy. The Arbitrator places little weight on this factor.

4. Regarding the petitioner's future earning capacity, there was no evidence submitted that the petitioner's earning capability is impacted in any way by this injury. Indeed, the petitioner has returned to his pre-injury job and salary. The Arbitrator places little weight on this factor.

5. Regarding disability corroborated by the medical records, there is no significant disability, or residual issues as corroborated by the medical records. No future treatment is contemplated for the petitioner and he has not returned to his treating doctor for any issues since August of 2017. There were no permanent restrictions outlined for the petitioner in the medical records. As such, the Arbitrator places little weight on this factor.

Therefore, in weighing the five factors, the Arbitrator does acknowledge that the petitioner did have a significant injury to his low back and SI joint, requiring surgery followed by work hardening. The Arbitrator awards the petitioner permanent partial disability benefits in the amount of $557.45 per week for a period of 87.5 weeks because the petitioner sustained 17.5% loss of use of a man as a whole as a result of the injury.

WITH REGARD TO ISSUE M, SHOULD PENALTIES OR FEES BE IMPOSED ON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that penalties and fees should not be imposed on the respondent, because the respondent did not act unreasonably or vexatiously by denying payment for the medical bills from ADCO and MK Orthopedics, and the respondent has overcome the rebuttable presumption that the delay in payment for those bills greater than 14 days is unreasonable.

First, the denial of both of these bills pursuant to UR created a rebuttable presumption that Section 19(k) penalties would not apply according to Section 8.7 of the Act. The respondent reasonably relied on two URs as well as the credible testimony of the physicians preforming those reviews in denying treatment. The petitioner did not submit any evidence that the MK Orthopedics bill and treatment was reasonable and necessary, therefore not overcoming the rebuttable presumption created by Section 8.7. Also, the Arbitrator has found the opinions of Dr. Trotter to be more credible than those of Dr. Kuo regarding the ADCO bill for the topical cream. As such, the petitioner failed to overcome the rebuttable presumption created by Section 8.7 regarding that bill.

Second, regarding Section 19(l) penalties, there is no evidence that the denial of these bills beyond 14 days was unreasonable. In so finding, the Arbitrator points to the fact that the respondent reasonably relied on two UR reports and deposition testimony in order to deny that treatment. Next, there is no evidence to support the reasonableness and necessity of the excessive work hardening and MK Orthopedic bills. Next, there is no

pattern of delay or denial of treatment in this case. Indeed, the petitioner admits that all medical bills have been paid in this matter, except those two bills that were denied by UR. As such, there is no evidence to support that non-payment of the medical bills was unreasonable.

Therefore, based on the reasons above, and primarily because the respondent's denial of the two medical bills at issue was based on UR, the Arbitrator finds that penalties should not be imposed on the respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

[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

Timothy Murphy,
Petitioner,

vs. NO: 15 WC 23403

Ryder Integrated Logistics,
Respondent.

20 IWCC0514

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 2019, is hereby affirmed and adopted.

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

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

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

DATED: SEP 15 2020
o08/20/20
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

NOTICE OF ARBITRATOR DECISION

MURPHY, TIMOTHY
Employee/Petitioner

Case# **15WC023403**

RYDER INTEGRATED LOGISTICS
Employer/Respondent

20IWCC0514

On 4/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2902 LAW OFFICES OF PETER G LEKAS
5357 W DEVON AVE
CHICAGO, IL 60646

0734 HEYL ROYSTER VOELKER & ALLEN
TONEY J TOMASO
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824-1190

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

Timothy Murphy
Employee/Petitioner

Case # **15** WC **23403**

v.

Ryder Integrated Logistics
Employer/Respondent

20IWCC0514

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 12, 2019 and March 7, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] 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 18, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 alleged accident.

In the year preceding the alleged injury, Petitioner earned $**70,620.68**; the average weekly wage was $**1,358.09**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

The Petitioner failed to prove that an accident occurred that arose out of and in the course of Petitioner's employment by Respondent.

The Petitioner's claim for compensation is, therefore, denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

April 8, 2019
Date

APR 10 2019

FACTS:

On June 18, 2015, the Petitioner was employed by the Respondent as a truck driver and loader. His dedicated route took him from Bolingbrook, Illinois (where Ryder was imbedded in an Alro Steel facility) to Oshkosh, Wisconsin, every day, five nights per week. The Petitioner picked up his vehicle, helped load the materials he was hauling, which included tarping and strapping the load onto his flatbed trailer, and then drove from Bolingbrook, Illinois, to Oshkosh, Wisconsin. After the day's run was over, the Petitioner would return himself and his truck back to the Bolingbrook facility.

The Petitioner testified that on June 18, 2015, after tarping his load, and while he was stepping off the trailer, he fell between the cement dock and the trailer. He explained the dock is a cement cut-out into which the flatbed trailer was docked, allowing the flatbed to be loaded and an individual to walk onto the trailer from the dock easily. However, he explained there was a space between the actual cement dock and the trailer. The Petitioner testified that he mis-stepped and his leg went down and he spun like a top and landed on the concrete floor (of the dock), hitting his head on a pile of lumber. The Petitioner testified that his fall would have taken place sometime between approximately 4:30 p.m. and 7:00 p.m. on June 18, 2015.

The Petitioner testified that when he got up, just after the accident, another employee by the name of "Giovanni" came by and they discussed whether the Petitioner was okay. The Petitioner testified that he then completed his run to Oshkosh and back. The Petitioner did not present "Giovanni" to testify.

The Petitioner testified that after his fall, he continued to work without incident for an additional 30 days without seeking medical care or treatment or reporting his accident to his supervisor. The Petitioner testified that he did, however, notice he was very sore on June 19, 2015. The Petitioner testified that over the course of those 30 days of work, his elbows began to hurt and his back began to hurt. He testified that he called a supervisor who was located in the State of Michigan and spoke to "Millissa". The Petitioner testified that he told "Melissa" about the accident that occurred one month prior and he recalled being "yelled at" because he did not report his alleged injury immediately after it occurred.

The Petitioner admitted when he became a new employee with the Respondent, he underwent training which included the steps necessary to report an accident which happens at work. He admitted he was trained that the proper policy and procedure was to report the accident on the date of loss, or as soon as practical thereafter. The Petitioner admitted he did not follow the Respondent's protocol and procedure regarding reporting the alleged injury of June 18, 2015.

The Petitioner testified that after he spoke with "Melissa" he received a call from "Theresa" who instructed him to report to a Concentra facility to be checked out. The Petitioner testified that he went to Concentra on July 15, 2015 and was seen and examined by Dr. Anthony Leazzo. Dr. Leazzo examined the Petitioner and allowed him to go back to work with light-duty restrictions and contemporaneously undergo physical therapy. He was also instructed to follow up at Concentra. Physical therapy began on or about July 16, 2015. The Petitioner noted when therapy began, that it was difficult for him to do the exercises because of the pain. The Petitioner had a follow-up visit with Dr. Kevin Tu at Concentra while physical therapy moved forward, and his light-duty restrictions continued. Shortly thereafter, The Petitioner was taken off work completely by Dr. Tu. The Petitioner was referred to a specialist, Dr. Salehi, towards the end of July 2015.

The Petitioner testified that when he went in to the Concentra Medical Center on July 15, 2015, his first date of medical care following the accident, he was given a clipboard and told to fill out paperwork and then return it. That paperwork he was required to fill out included identifying the date on which his injury occurred. The Petitioner testified that, at the time, he did not recall the exact date; therefore, he did not fill out the form completely (he left the date of loss/accident date line blank). The Petitioner testified that he was told by the facility that they could not render treatment unless he filled out the form completely, so he took a calculated guess and wrote in the blank "June 24, 2015" as the date of injury. The Petitioner testified that after returning home and looking at his driver's log books, he realized that date was wrong and the actual date of his injury was June 18, 2015. The Petitioner testified that the following day, or July 16, 2015, he went into work and spoke with Supervisor Christopher Kreuzer and told Christopher that he had reported the wrong date of loss to the medical team at Concentra. He indicated he had reported the date of loss as June 24, 2015, when in reality it was June 18, 2015.

On August 3, 2015, the Petitioner initiated treatment with Dr. Dasgupta at Elmwood Park Surgery Center. The Petitioner treated at this facility for six or seven months. MRI scans of the spine (cervical and lumbar) took place on August 7, 2015. The Petitioner testified that, following the MRIs, the doctor recommended epidural steroid injections at the lumbar spine, which began on August 18, 2015. After the initial injection he felt a little better, but after a few weeks all of the pain returned. The second steroid injection took place on September 15, 2015, and it had the same effect as the first. The Petitioner was also complaining of radicular symptoms into his bilateral lower extremities which were not alleviated by the epidural steroid injections.

The Petitioner then underwent additional physical therapy at Athletico. Because his pain complaints did not subside, he was referred for a surgical consult with Dr. Kern Singh. On October 8, 2015, Dr. Singh examined The Petitioner, reviewed the objective films, and recommended surgical intervention at the cervical spine in the form of a fusion procedure. The surgery was initially scheduled for November 13, 2015, but it was cancelled because the surgery was never authorized. The Petitioner confirmed he never had surgery with Dr. Singh. His conservative management continued at Elmwood Park Surgery Center and he continued his physical therapy. He also had additional epidural steroid injections, this time at the cervical spine, beginning on October 27, 2015. The injections helped with his pain for a few weeks and then all of his pain complaints returned. The Petitioner's last date of treatment at Elmwood Park Surgery Center was April 11, 2016. He was instructed at that time to continue taking medication and move forward with a home exercise program. The Petitioner recalled his last physical therapy visit at Athletico took place on February 10, 2016.

The Petitioner noted he is a veteran and therefore he has access to the VA hospital (Hines). He undertook treatment at the VA hospital for both his lumbar spine and cervical spine. This included physical therapy, acupuncture, chiropractic management and prescription medication. The Petitioner recalled his treatment at the VA hospital included an orthopedic consult with orthopedic surgeon Dr. Lauren Burke. He also underwent a cervical spine MRI on January 8, 2017.

The Petitioner testified that he returned to work as an Uber driver beginning in July 2016. He testified that he performs that work on a part-time basis and he avoids doing any heavy lifting (such as heavy luggage). The Petitioner testified, as it relates to his cervical and lumbar spine, that he is in constant pain and in order to alleviate said pain he gets up and walks, watches TV, and tries to stay

busy to keep his mind off of the pain. He notices radicular symptoms into his lower extremities when he drives for an extended period of time.

The Petitioner acknowledged that prior to the start of the December 12, 2018, arbitration hearing, he had alleged a date of injury of June 24, 2015. It was not until the day of the arbitration hearing that he amended his allegation regarding the date of injury and specifically alleged a June 18, 2015, date of injury. The Petitioner admitted that it was on or about July 15, 2015, after reviewing his driver's log books, that he knew that his actual date of injury was June 18, 2015 not June 24, 2015. The Petitioner confirmed that his first attorney filed an Application for Adjustment of Claim on his behalf which indicated a June 24, 2015 date of injury. The Petitioner confirmed that he signed the Application for Adjustment of Claim which asserts the June 24, 2015, date of accident, although the Petitioner's signature is not dated. That Application for Adjustment of Claim was filed with the Commission on August 3, 2015. The Petitioner acknowledged that when he hired the attorney who filed the claim on his behalf in August 2015, he was aware of the actual accident date as he has alleged it (June 18, 2015), but his attorney still filed a claim asserting a June 24, 2015, date of injury.

The Petitioner testified that other than when he initially sought treatment at Concentra on July 15, 2015, he never told any of his various medical providers that he hurt himself on June 24, 2015. Rather, he testified that he told all the subsequent medical providers that he hurt himself on June 18, 2015. The Petitioner's testified that he believes that the subsequent medical records are inaccurate with regard to the date of injury because the providers took down the wrong information and relied upon the other medical records from the other treatment facilities, simply copying the information regarding the date of injury, and did not obtain a true and accurate history from him during the treatment visit. The Petitioner testified that he takes exception with the accuracy of the treatment records at these various medical providers/facilities based upon the date of loss only, and he does not call into question the accuracy of other elements of those medical records.

Millissa Warren Giacobone testified on behalf of the Respondent. She is a Logistics Manager employed by the Respondent who works in Detroit, Michigan. In June 2015, she was employed with the Respondent as a Logistics Manager and was working out of the Bolingbrook, Illinois, facility on temporary assignment. Ms. Giacobone recalled the Petitioner being one of the drivers at the facility to which she was temporarily assigned in June 2015. Ms. Giacobone testified that she recalled talking with the Petitioner on the phone on or about July 14, 2015, after her temporary assignment was over and she was back at her normal office in Detroit, Michigan, but she could not recall the specifics of that conversation. Ms. Giacobone testified that she did not fill out an Accident Report on that date, but she put the wheels in motion so that the Petitioner's supervisor would have done so.

Ms. Giacobone testified that there were security cameras in place in the docking bay area where the Petitioner alleged that he hurt himself. Further, Ms. Giacobone noted that if an employee of the Respondent is injured are in an area where there are security cameras, routine and normal investigation would include looking at the security camera footage in order to determine the accuracy of the accident report and the appropriateness of any remedial action.

The Respondent also presented Christopher Kreuzer who testified that he was serving as the Petitioner's supervisor on a temporary basis in June and July 2015. Mr. Kreuzer identified the Petitioner as one of the Respondent's drivers who worked a dedicated route between Bolingbrook, Illinois, and Oshkosh, Wisconsin. Mr. Kreuzer testified that he was familiar with the Petitioner's duties, which included loading, tarping and strapping down the loads, and taking them on a daily

basis to Oshkosh, Wisconsin, and then returning to the Bolingbrook facility. When asked about the alleged injury of June 18, 2015, as well as the alleged injury date of June 24, 2015, Kreuzer noted that the Petitioner did not report a workplace accident on either of those dates, and as a result he did not complete an Accident Report on either of those dates. Mr. Kreuzer testified that he did not become aware of an alleged accident until mid-July 2015 and that when he became aware of the alleged accident, he completed an accident report with the Petitioner. Mr. Kreuzer testified that he was told at that time that the date of injury was June 24, 2015 (and not June 18, 2015).

Mr. Kreuzer testified that after his meeting with the Petitioner, and the completion of the incident report he began an investigation into the Petitioner's claim. Mr. Kreuzer testified that he went to the Alro Steel facility and looked at the video surveillance from the security cameras in the docking bay area where the Petitioner was working on the date he allegedly hurt himself (June 24, 2015). This video was approximately 90 minutes in length and was watched by Kreuzer who testified that there was no slip and fall and no evidence of an accident depicted in the video taken on that date. Mr. Kreuzer confirmed that the video evidence admitted into the record as Respondent's Exhibit 6 is of the docking bay area where the Petitioner was working on June 24, 2015.

When asked why he did not review video evidence of the dock where the Petitioner was working on June 18, 2015, as part of his investigation, Mr. Kreuzer explained that he was not made aware of an alleged date of injury on June 18, 2015, until the initial trial date on December 12, 2018, over three years later. Therefore, when he was conducting his investigation in July 2015, there was no reason to look at June 18, 2015, as that was not the date the Petitioner had asserted he injured himself. Further, Mr. Kreuzer testified that video from June 18, 2015, would not have been viewable after 30 – 45 days as it would have been recorded over per company policy and procedure due to limited computer storage and memory.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (D.), What was the date of accident, the Arbitrator finds and concludes as follows:

The Petitioner testified that he was injured while working on June 18, 2015 but he continued working and did not report the injury for about 30 days. When the Petitioner did report the injury, he was sent to Concentra where he was seen by Dr. Leazzo on July 15, 2015. When the Petitioner was seen at Concentra, he reported an accident date of June 24, 2015. The Petitioner testified that upon returning home from that visit, he realized that this was the wrong date of accident and that the correct date of accident was June 18, 2015.

On July 15, 2015, the same day the Petitioner was seen at Concentra, an incident report was completed by the Petitioner's Supervisor. The date of injury indicated on that incident report is June 24, 2015. The Respondent's witness Christopher Kreuzer testified that he completed the incident report with the Petitioner and that the Petitioner did not offer him any date of accident other than June 24, 2015. Kreuzer testified that the first time he became aware of an alleged June 18, 2015 injury was at the time of hearing. The Petitioner testified that when the incident report was being

completed, he told Kreuzer that the June 24, 2015 date was incorrect and that the actual date of injury was June 18, 2015. The Petitioner testified that Kreuzer refused to change the date of injury or put the June 18, 2015 accident date in the incident report.

On July 16, 2005, the Petitioner underwent an initial physical therapy consultation at Concentra. In the history section of the report of that consultation, the therapist, Ms. Katie Peterson, recorded a date of injury of June 24, 2015. There is no mention of any other date of injury in the record of that date nor is there any indication that the Petitioner attempted to offer a different date of injury.

On July 17, 2005, the Petitioner again returned to physical therapy at Concentra and it was noted that he demonstrated minimal effort as well as inconsistencies with objective findings. The therapist noted that the Petitioner's gait was normal when he was walking into therapy but when he was asked to get on the treadmill he suddenly indicated that he was in pain and could not walk. There is no mention of any other date of injury in the record of that date nor is there any indication that the Petitioner attempted to offer a different date of injury.

On July 21, 2015 the Petitioner returned to physical therapy at Concentra and it was noted that he was not putting forth effort and was refusing to participate. The therapist discontinued physical therapy intervention because she did not feel the Petitioner would benefit from therapy. There is no mention of any other date of injury in the record of that date nor is there any indication that the Petitioner attempted to offer a different date of injury.

On August 3, 2015, the Petitioner initiated treatment with Dr. Dasgupta at Elmwood Park Surgery Center. The history noted in the record of that visit indicates a date of injury of June 24, 2015. The Petitioner treated at this facility for six or seven months undergoing MRI scans and injections. There is no mention of any other date of injury contained in the records of that treatment nor is there any indication that the Petitioner attempted to offer a different date of injury at any point during that treatment.

On October 8, 2015, the Petitioner was seen by Dr. Singh at Midwest Orthopaedics. The date of injury noted on the face of Dr. Singh's report is June 24, 2015 although in the body of the report the date of injury is reported as August 24, 2015. There is no mention of a June 18, 2015 date of injury contained in the records of the Petitioner's treatment at Midwest Orthopaedics nor is there any indication that the Petitioner attempted to offer a different date of injury at any point during that treatment.

At some point, the Petitioner undertook treatment at the VA hospital for both his lumbar spine and cervical spine. The only history of injury noted in the records of that treatment which were admitted into the record is a note of March 10, 2017, which indicates that the Petitioner reported that he "fell down steps and landed on his back in June 2015."

The Petitioner testified that other than when he initially sought treatment at Concentra on July 15, 2015, he never told any of his various medical providers that he hurt himself on June 24, 2015. Rather, he testified that he told all the subsequent medical providers that he hurt himself on June 18, 2015. The Petitioner's testified that he believes that the subsequent medical records are inaccurate with regard to the date of injury because the providers took down the wrong information and relied upon the other medical records from the other treatment facilities, simply copying the information

regarding the date of injury, and did not obtain a true and accurate history from him during the treatment visit. The Petitioner testified that he takes exception with the accuracy of the treatment records at these various medical providers/facilities based upon the date of loss only, and he does not call into question the accuracy of other elements of those medical records.

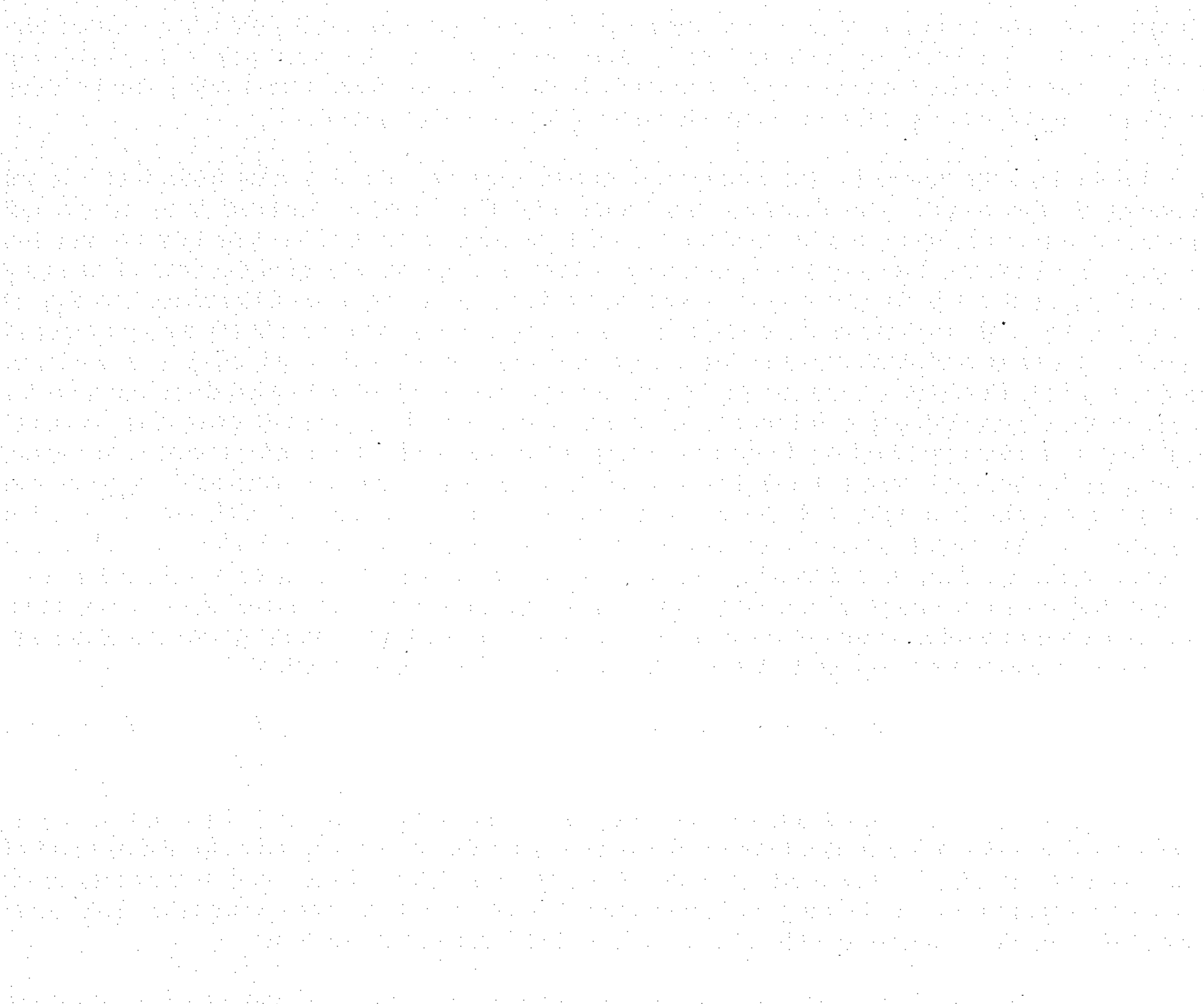
While the Arbitrator notes the Petitioner's fervent testimony, the Arbitrator finds that it is not supported by the record. The Arbitrator first notes that the Petitioner testified that he did not immediately report his injury and he continued to work his regular job until the time that he reported the injury. The Petitioner had plenty of opportunity to check his logs to determine the date of his injury before he reported it. It is difficult to believe that the Petitioner would not have determined the date of his injury during that time and would have had to guess what it was when he finally sought medical treatment. The Arbitrator also notes that that a reported date of injury of June 24, 2015 is consistently noted in all of the Petitioner's medical records, except the records of the VA which does not reflect a specific date of injury. While the Petitioner's explanation of an error being carried forward is plausible, it is difficult to believe that had the Petitioner attempted to get all of his medical providers to correct the error as he testified, that none of them would have at least noted the attempt. Similarly, the Arbitrator notes that it is difficult to believe that had the Petitioner reported a different date to his supervisor when the incident report was completed, the supervisor would flat out refuse to include the "corrected" date. Similarly, it is difficult to believe that had the Petitioner reported a different date of accident that an examination of the video tape from that date would not have been undertaken. Again, while the Arbitrator notes the Petitioner's testimony, the Arbitrator cannot ignore the testimony of Mr. Kreuzer who has no apparent interest in the outcome of the instant matter.

Finally, the Arbitrator notes that June 24, 2015 is the date of injury alleged on the Application for Adjustment of Claim filed by the Petitioner's first attorney on August 3, 2015. The Petitioner acknowledged that when he hired that attorney, he was aware of the actual accident date as he has alleged it (June 18, 2015), but his attorney still filed a claim asserting a June 24, 2015, date of injury. Despite the Petitioner hiring a new attorney some time after the initial Application for Adjustment of Claim was filed, no attempt was made to amend the date of accident alleged until immediately prior to the commencement of the hearing on December 12, 2019, more than three years later. This delay causes the Arbitrator to further question the veracity of the Petitioner's testimony.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred on either June 18, 2015 or June 24, 2015.

The Petitioner's claim for compensation is, therefore, denied.

As the Arbitrator has found that the Petitioner failed to prove an accident occurred, which arose out of and in the course of the Petitioner's employment with Respondent, determination of the remaining disputed issues is 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 SANGAMON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AARON BRUNS,

Petitioner,

20 IWCC0516

vs.

NO: 14 WC 22808

STATE OF IL – DHFS,

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

We find that Petitioner has sustained an additional 5% loss of use of the right hand. We modify the analysis of the §8.1b(b)(v) permanency factor to add that Petitioner testified he has no symptoms in his right hand and there are no activities which he is limited in doing. *T.44*.

We also overrule the objection made by Attorney Ryan on page 6 of Dr. Li's deposition transcript (*Rx4*).

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $476.09 per week for a period of 29-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that, as provided in §8(e) of the

Act, the injuries sustained caused an additional 5% loss of use of the right hand. We find that Petitioner is permanently partially disabled to the extent of 10% of the right hand, but Respondent is entitled to a credit of 5% of the right hand for prior injuries. After applying the credit, it is ordered that Respondent shall pay to Petitioner the sum of $428.48 per week for a period of 10.25 weeks.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $30,193.00, as set forth in Petitioner's Exhibit 10, for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: SEP 15 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 8/4/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUNS, AARON
Employee/Petitioner

Case# **14WC022808**
15WC001073

20IWCC0516

STATE OF IL-DHFS
Employer/Respondent

On 7/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

6236 ASSISTANT ATTORNEY GENERAL
KAYLA KOYNE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

JUL 22 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

AARON BRUNS
Employee/Petitioner
v.
STATE OF IL - DHFS
Employer/Respondent

Case # **14** WC **22808**

Consolidated cases: **15 WC 01073**

An *Application for Adjustment 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 **Springfield**, on **November 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. [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 **4/14/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,135.02**; the average weekly wage was $**714.14**.

On the date of accident, Petitioner was **41** 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**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $30,193.00, as set forth in PX 10, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $476.09/week for 29 2/7th weeks, commencing 4/15/14 through 11/5/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $11,698.95 for temporary total disability benefits that have been paid.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Arbitrator finds Petitioner is now permanently and partially disabled to the extent of 15% loss of use of the right hand, as provided in Section 8(e) of the Act. Petitioner has sustained serious and permanent injuries in this case that have resulted in an additional 10% (19 weeks) loss of use of his right hand above and beyond his prior injuries for which the Respondent is entitled to a credit of 5% of the right hand. After applying the credit, Respondent shall pay Petitioner the sum of $**428.48**/week for a further period of **19** weeks.

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

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

Signature of Arbitrator

7/18/19
Date

JUL 22 2019

FINDINGS OF FACT

Petitioner was employed by the State of Illinois in various positions from 2002 through 2015. He initially was employed in Jacksonville Developmental Center until 2008 when he changed to be an Office Assistant Option 1 with the Department of Healthcare and Family Services. His employment there began on August 18th, 2008 and ended in January of 2015 when he went to work at State Farm in Bloomington, IL. When he went to work at the DHFS he was initial an office clerk and then was promoted to his final position of Office Assistant Option 1.

Petitioner's job duties for the Respondent involved processing of significant volumes of mail through machines. He would be responsible for processing thousands of pieces of mail per day. Most of the mail was opened by a machine but he estimated that he had to use a box knife approximately 50 times per day to open packages that the machine failed to open. After the mail was opened, he would have to help get mail placed into card board boxes. This would require him to manually create those boxes. He testified that depending upon the volume of mail that he would have to create boxes 3-5 times per day and that each time he would create 10 or more boxes. He further testified that initially it would require him a fair amount of time to create each box but that eventually he got down to the point that he would only spend approximately 30 seconds per box. (pg 21-22)

Another portion of the Petitioner's job was to operate the paper folder machine. He testified in detail about how that machine was operated how he would have to forcefully grasp the stacks of paper while bent over awkwardly due to the difference between his 6'4" height and the height of the machine. He testified that he would have to grasp the paper and move it and demonstrated that type of motion for the Arbitrator. He testified that he would have to do that too many times per day to count. (pg 23-25)

Prior to the paper going into the paper folder it had to go through the paper jogger, which was a vibratory machine that sifted the paper which the Petitioner had to keep his right hand against to maintain the paper in position. (pg 30)

The Petitioner listed various other hand intensive jobs in his testimony and stated again and again that he would have to use his right hand to forcefully grasp stacks of paper or assemble boxes.

The Petitioner recalled that on April 14th, 2014 he was at work and was assembling boxes and both heard and felt a pop in his right wrist. He testified that he immediately had onset of tingling the sensation of needles through his hand from his wrist. (pg 36) He testified that this was not the first time that he had felt numbness or tingling in his right hand but that he had been having similar sensations for between 3 and 6 months prior to April 14th, 2014. He testified that it was only more noticeable that day following the popping sensation in his wrist. He testified that prior to that date he had not made mention of any problems in his hand to any supervisor but he did following the pop.

The medical records indicate that he was first seen at Memorial Medical Center ER on April 14th, 2014 with a history of:

> Patient states he was making a box at work and he turned his wrist and felt a pop and had pain shoot down his fingers. States has had tingling in his hand since the

> incident, states it feels 'asleep'. Does state he has had tingling like this for the past few months but not this 'constant'. (Px 5)

He further sought treatment with his primary care physician on April 15th 2014 and was seen in the office by a physician's assistant where they recorded the following history:

> Patient hurt his wrist yesterday at work. Patient was folding a cardboard box and he developed right wrist pain. Patient had sharp pain to his right thumb, index and 4th digit. He also had numbness to those digits. (Px 7)

Petitioner testified that his doctor released him to light duty work but that his employer chose not to accommodate but that they paid him temporary total disability payments while he was off work. While he was off his PCP referred him to Dr. Oakey. He underwent an EMG and then eventually underwent a carpal tunnel release on the right side on September 30, 2014.

Following the surgery, the Petitioner returned to work on November 6th, 2014. Upon returning to work that day or a few days after, he was assisting with the mail and attempted to lift a 50 pound box full of mail and once again felt a pop in his right wrist going up into his forearm and causing tingling down into his right hand. (pg 40) The Petitioner testified that following this incident that he attempted to continue to work because he had already missed so much time for the earlier injury and he did not want to be off work without pay again. (pg 41).

On November 17th, 2014, Petitioner was re-evaluated at McLean County Orthopedics and they recorded this history:

> He returns to the office today approximately 6 weeks out from a right open carpal tunnel release. He has been back to work full duty for about 1 ½ weeks and is now having increased pain into his right hand with associated swelling. He has also begun having numbness and tingly into median nerve distribution just at distal tips of fingers. He has sensitivity on palpation of incision with scar thickening noted. At this time his job requires him to lift 50 lbs and he feels this has aggravated his right hand. (Px 6)

He was placed upon a 10 lbs restriction and sent to physical therapy at Advanced PT and Sports Medicine. The initial history recorded at the physical therapy evaluation on November 20th, 2014 reads:

> Patient states that in April of this year, he was working with boxes at work and as he bent the wrist forward, he felt a pop and tingling from his palm to his fingertips. He states that he was placed off work and then underwent carpal tunnel release on 9/30/14. He states that he was doing well with recovery at his wrist until he returned to work on 11/6/14. He reports that 3 days after he was back to work, he lifted a 50 lbs box and felt a stretch from his wrist to his fingertips. He states that he tried to keep working but had to go off work again on 11/17/14 (Px 9)

Petitioner underwent physical therapy and was eventually released to return to work as of December 24th, 2014. He did have one final follow up at McLean County Orthopedics in January of 2015 but was then placed at MMI.

CONCLUSIONS

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The Petitioner's testimony regarding his accidents and job duties were uncontested by any other testimony and are supported by the history provided in each and every medical record as well as by the documents contained in Respondent's Exhibit one consisting of the employee's report of injury, the form 45, and the supervisor's report of injury. Each of those documents was filled out on the date of the accident and provide a similar description. It is clear from those descriptions that the Petitioner was in fact putting together boxes on 4/14/14 and that he had an accident in which he felt a pop in his wrist.

With regard to the nature of the Petitioner's job duties, his testimony was consistent and credible throughout and matched up with the medical records. Respondent provided a job description as Rx3. The Petitioner testified that this job description was consistent with much of what he did but that it was off with regard to amount of the work day spent doing various tasks and included some tasks that were not part of his job. The job description was also for a general office assistant versus his position of office assistant option 1. The Arbitrator finds Rx3 to be vague at best and the Petitioner's testimony to be more accurate and detailed as to the specific duties that the Petitioner performed.

Based upon the testimony of the Petitioner and the consistent statement made within the medical records as well as the lack of any contradictory testimony, the Arbitrator finds that the Petitioner's job duties were also repetitive in nature and that such repetitive activity constitutes an accident under the Act. Given that the Petitioner reports that he had symptoms for several months preceding the 4/14/14 accident but that he had never sought any medical treatment for it and had received no diagnosis, it is clear that 4/14/14 is the point of manifestation for his repetitive carpal tunnel as well as the date of a specific aggravation.

In assessing whether the Petitioner's accident, either as a specific event or a repetitive task that he had to perform, was causally related to the Petitioner's condition of ill being the Arbitrator turns to the opinions of the Section 12 examiner, Dr. Li, and the treating surgeon, Dr. Oakey. Dr. Oakey's testimony was provided as Px4. He stated "... I do believe that the work that he has done for the past six years as well as the aggravation of the event that occurred in April as he described were causally connected to his carpal tunnel syndrome." (Px4 pg 10)

Dr. Oakey further added, "[b]ased on the timing that he describes, having the injury and then having the aggravation immediately following that injury with the cardboard boxes he described or the boxes he described, then, I would say that it is causally connected."

In contrast, Dr. Li opined:

> Okay. I just want to make clear that Mr. Brun's injury of that date was a wrist strain. It was not carpal tunnel. So, he was putting boxes, felt a pop in his wrist, and that was the diagnosis of that particular date. The carpal tunnel was pre-existing and did not have anything to do with that particular injury. I did not specifically provide an opinion about carpal tunnel because that was not asked in the IME. (Rx4 pg 6)

Since Dr. Li did not address the diagnosis of the Petitioner's carpal tunnel in his initial report and therefore could not testify to it in his deposition, a 2nd IME was performed by Dr. Li on 8/30/18. In that report he opines that the Petitioner's carpal tunnel pre-dated the 4/14/14 incident and was not caused by the 4/14/14 accident. He maintained his position that the 4/14/14 accident caused only a wrist sprain/strain. (Rx 11) It is significant that Dr. Li was never provided any sort of job description by the Respondent nor did he go into any detail when he obtained a job description from the Petitioner. He did not know about any of the machinery that the Petitioner used, or the volume of repetitions that were involved.

Given the various opinions, the Arbitrator finds the opinions of Dr. Oakey to be more persuasive. They are consistent with the supporting evidence consisting of the medical records, accident reports, diagnostic testing and the credible testimony of the Petitioner. Thus the Arbitrator finds that the Petitioner's job duties were a causative factor in the development of his carpal tunnel and that the pop felt by the Petitioner on 4/14/14 was the point of manifestation for repetitive trauma carpal tunnel as well as a likely aggravating event as testified to by Dr. Oakey.

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?**

Having found for the Petitioner with regard to accident and causal connection, Respondent shall pay reasonable and necessary medical services of $30,193.00, as set forth in PX 10, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Issue (K): **What temporary benefits are in dispute?**

Having found for the Petitioner with regard to accident and causal connection, it is clear that the Petitioner was entitled to TTD from 4/15/14 – 11/5/14. This period of time equals 29 and 2/7 weeks of TTD. The Petitioner's TTD rate was $476.09 which means that the TTD awarded for this period equals $13,939.92. The Respondent paid $11,698.95 in TTD and thus the net TTD award after the credit is $2,242.97.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes The Petitioner was and continued to be employed doing office work much of which is hand intensive. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 at the time of the accident and accordingly has more than 25 years remaining to work prior to reaching retirement age. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The Petitioner clearly sustained an injury and received a surgical alteration of his body along with documented development of scar tissue in his right wrist. Further, it is medically documented that heavy lifting caused an aggravation of his condition. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in his hand, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds Petitioner is now permanently and partially disabled to the extent of 15% loss of use of the right hand, as provided in Section 8(e) of the Act. Petitioner has sustained serious and permanent injuries in this case that have resulted in an additional 10% (19 weeks) loss of use of his right hand above and beyond his prior injuries for which the Respondent is entitled to a credit of 5% of the right hand. After applying the credit, Respondent shall pay Petitioner the sum of \$428.48/week for a further period of 19 weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AARON BRUNS,

Petitioner,

20IWCC0517

vs.

NO: 15 WC 1073

STATE OF IL – DHFS,

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, temporary total disability, medical expenses, 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, but makes a clarification as outlined below.

Under "Issue (L)," on page 5 of the Decision, we hereby change the term "transient exacerbation" to "temporary aggravation."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2019, is hereby affirmed and adopted with the clarification noted above.

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

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

20IWCC0517

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: SEP 15 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 8/4/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUNS, AARON
Employee/Petitioner

Case# **15WC001073**
14WC022808

STATE OF IL-DHFS
Employer/Respondent

20IWCC0517

On 7/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

6236 ASSISTANT ATTORNEY GENERAL
KAYLA KOYNE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

JUL 22 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0517

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

Aaron Bruns
Employee/Petitioner

v.

State of IL - DHFS
Employer/Respondent

Case # **15** WC **001073**

Consolidated cases: **14 WC 22808**

An *Application for Adjustment 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 **Springfield**, on **November 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **11/6/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,135.02**; the average weekly wage was $**714.14**.

On the date of accident, Petitioner was **41** 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**.

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 $476.09/week for 4 weeks, commencing 11/17/14 through 12/14/14, as provided in Section 8(b) of the Act.

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

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

Signature of Arbitrator

7/19/19
Date

ICArbDec p. 2

JUL 22 2019

FINDINGS OF FACT

Petitioner was employed by the State of Illinois in various positions from 2002 through 2015. He initially was employed in Jacksonville Developmental Center until 2008 when he changed to be an Office Assistant Option 1 with the Department of Healthcare and Family Services. His employment there began on August 18th, 2008 and ended in January of 2015 when he went to work at State Farm in Bloomington, IL. When he went to work at the DHFS he was initial an office clerk and then was promoted to his final position of Office Assistant Option 1.

Petitioner's job duties for the Respondent involved processing of significant volumes of mail through machines. He would be responsible for processing thousands of pieces of mail per day. Most of the mail was opened by a machine but he estimated that he had to use a box knife approximately 50 times per day to open packages that the machine failed to open. After the mail was opened, he would have to help get mail placed into card board boxes. This would require him to manually create those boxes. He testified that depending upon the volume of mail that he would have to create boxes 3-5 times per day and that each time he would create 10 or more boxes. He further testified that initially it would require him a fair amount of time to create each box but that eventually he got down to the point that he would only spend approximately 30 seconds per box. (pg 21-22)

Another portion of the Petitioner's job was to operate the paper folder machine. He testified in detail about how that machine was operated how he would have to forcefully grasp the stacks of paper while bent over awkwardly due to the difference between his 6'4" height and the height of the machine. He testified that he would have to grasp the paper and move it and demonstrated that type of motion for the Arbitrator. He testified that he would have to do that too many times per day to count. (pg 23-25)

Prior to the paper going into the paper folder it had to go through the paper jogger, which was a vibratory machine that sifted the paper which the Petitioner had to keep his right hand against to maintain the paper in position. (pg 30)

The Petitioner listed various other hand intensive jobs in his testimony and stated again and again that he would have to use his right hand to forcefully grasp stacks of paper or assemble boxes.

The Petitioner recalled that on April 14th, 2014 he was at work and was assembling boxes and both heard and felt a pop in his right wrist. He testified that he immediately had onset of tingling the sensation of needles through his hand from his wrist. (pg 36) He testified that this was not the first time that he had felt numbness or tingling in his right hand but that he had been having similar sensations for between 3 and 6 months prior to April 14th, 2014. He testified that it was only more noticeable that day following the popping sensation in his wrist. He testified that prior to that date he had not made mention of any problems in his hand to any supervisor but he did following the pop.

The medical records indicate that he was first seen at Memorial Medical Center ER on April 14th, 2014 with a history of:

> Patient states he was making a box at work and he turned his wrist and felt a pop and had pain shoot down his fingers. States has had tingling in his hand since the

> incident, states it feels 'asleep'. Does state he has had tingling like this for the past few months but not this 'constant'. (Px 5)

He further sought treatment with his primary care physician on April 15th 2014 and was seen in the office by a physician's assistant where they recorded the following history:

> Patient hurt his wrist yesterday at work. Patient was folding a cardboard box and he developed right wrist pain. Patient had sharp pain to his right thumb, index and 4th digit. He also had numbness to those digits. (Px 7)

Petitioner testified that his doctor released him to light duty work but that his employer chose not to accommodate but that they paid him temporary total disability payments while he was off work. While he was off his PCP referred him to Dr. Oakey. He underwent an EMG and then eventually underwent a carpal tunnel release on the right side on September 30, 2014.

Following the surgery, the Petitioner returned to work on November 6th, 2014. Upon returning to work that day or a few days after, he was assisting with the mail and attempted to lift a 50 pound box full of mail and once again felt a pop in his right wrist going up into his forearm and causing tingling down into his right hand. (pg 40) The Petitioner testified that following this incident that he attempted to continue to work because he had already missed so much time for the earlier injury and he did not want to be off work without pay again. (pg 41).

On November 17th, 2014, Petitioner was re-evaluated at McLean County Orthopedics and they recorded this history:

> He returns to the office today approximately 6 weeks out from a right open carpal tunnel release. He has been back to work full duty for about 1 ½ weeks and is now having increased pain into his right hand with associated swelling. He has also begun having numbness and tingly into median nerve distribution just at distal tips of fingers. He has sensitivity on palpation of incision with scar thickening noted. At this time his job requires him to lift 50 lbs and he feels this has aggravated his right hand. (Px 6)

He was placed upon a 10 lbs restriction and sent to physical therapy at Advanced PT and Sports Medicine. The initial history recorded at the physical therapy evaluation on November 20th, 2014 reads:

> Patient states that in April of this year, he was working with boxes at work and as he bent the wrist forward, he felt a pop and tingling from his palm to his fingertips. He states that he was placed off work and then underwent carpal tunnel release on 9/30/14. He states that he was doing well with recovery at his wrist until he returned to work on 11/6/14. He reports that 3 days after he was back to work, he lifted a 50 lbs box and felt a stretch from his wrist to his fingertips. He states that he tried to keep working but had to go off work again on 11/17/14 (Px 9)

Petitioner underwent physical therapy and was eventually released to return to work as of December 24th, 2014. He did have one final follow up at McLean County Orthopedics in January of 2015 but was then placed at MMI.

CONCLUSIONS

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

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

The Arbitrator finds that Petitioner suffered a traumatic injury to his right hand in the incident of 11/6/14 when he lifted a 50 pound box noting increased right hand and wrist pain. The Arbitrator further finds that Petitioner's condition of ill-being from 11/6/14 through 12/24/14 was causally related to the accident.

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

All medical bills were awarded in 14 WC 22808. No additional award is made herein.

Issue (K): **What temporary benefits are in dispute?**

Having found for the Petitioner with regard to accident and causal connection, it is clear that the Petitioner was entitled to TTD from 11/17/14 – 12/24/14. This period of time equals 4 weeks of TTD. Respondent claims no credit for TTD benefits paid during this period.

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

Because the accident of 11/6/14 caused only a transient exacerbation of Petitioner's carpal tunnel syndrome symptoms which required a brief period of physical therapy, the Arbitrator finds Petitioner did not suffer any permanent partial disability in this accident.

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

Angela Green,

Petitioner,

vs. NO: 13 WC 39849

CTA,

Respondent.

20 I W C C 0 5 1 8

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection and nature and extent and being advised of the facts and law, affirms the Decision of the Arbitrator with the changes stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission hereby incorporates by reference the findings of fact contained in the Arbitration Decision, which delineate the relevant facts and analyses. However, as it pertains to causal connection, the Commission notes the following facts and affirms the Arbitrator's denial as stated herein.

The record reflects that, on August 24, 2013, Petitioner was employed by Respondent as a Rail Operator. Petitioner testified that on this date she was opening a window when she felt a sharp pain in her neck which radiated down her right shoulder with tingling and numbness. She reported the incident to Respondent. The following day Petitioner sought medical care and was diagnosed with neck pain, cervical radiculopathy and shoulder pain. She was prescribed medication and provided a cervical collar. She was also taken off work through August 28, 2013. Shortly thereafter Petitioner was placed on light duty, which was accommodated by Respondent with a position as a Customer Service Assistant. She also underwent physical therapy for her neck and shoulder.

On September 24, 2013, Petitioner was referred to an orthopedic doctor, Dr. Brisbin.

After a physical examination, she was diagnosed with a cervical strain and cervical radiculopathy. Dr. Brisbin recommended physical therapy and kept Petitioner on light duty. Petitioner continued treatment with Dr. Brisbin on three more occasions through November 26, 2013, including a visit on October 31, 2013 when she was released to full duty work.

As of November 26, 2013, Petitioner was discharged from care at maximum medical improvement ("MMI"). She was clinically doing very well at that time, although she did have some residual radiculopathy. Petitioner was continuing to improve and was tolerating her regular work duties, although she had very mild weakness with resisted wrist extension on the right. Petitioner was told to take ibuprofen as needed and to return for treatment if symptoms reoccur. No subsequent medical records are in evidence in this case.

At the time of the arbitration hearing, Petitioner testified regarding her neck and right shoulder that: "[w]hen I extend it or try to turn, it will hurt." She also testified that when she has pain, she either takes a break or ibuprofen depending on the time of day.

In light of the foregoing, the Commission affirms the Arbitrator's denial of causal connection to Petitioner's current condition of ill-being. There is no evidence of medical treatment received by Petitioner addressing the body parts at issue in this case after her October 31, 2013 full duty release until the arbitration date of February 21, 2018. The Commission notes the Arbitrator's recognition of an "Employee's Report of Injury on Duty" dated April 2, 2017. This document indicates Petitioner had complaints of neck, shoulder and arm pain suffered while operating a train. See RX6. However, Respondent's Exhibit 6 was offered into evidence in Case No. 11 WC 8086, not in this case, and is not appropriately considered as evidence here.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980). Given the lack of evidence of medical treatment received by Petitioner to alleviate her from the effects of this injury at work after October 31, 2013, and no apparent reason for said lapse, the Commission finds that Petitioner has failed to prove causal connection by a preponderance of evidence beyond that date when she was released to full duty work.

All else is affirmed and adopted.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has failed to establish by a preponderance of evidence a causal connection between the instant accident and her current condition of ill-being beyond October 31, 2013.

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

DATED: SEP 1 5 2020
o: 7/23/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, ANGELA
Employee/Petitioner

Case# **13WC039849**

11WC008086

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

20IWCC0518

On 8/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2902 LAW OFFICES OF PETER G LEKAS
5357 W DEVON AVE
CHICAGO, IL 60646

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angela Green,
Employee/Petitioner

v.

Chicago Transit Authority,
Employer/Respondent

Case # 13 WC 39849

Consolidated cases: 11 WC 8086

20IWCC0518

An *Application for Adjustment 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 **2-21-18 and 3-21-18. The case has been reassigned to the Honorable Arbitrator Robert M. Harris to issue this Decision for case 13 WC 39849.** 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 8-24-13, 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 her employment.

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

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

In the year preceding the injury, Petitioner earned $**64,001.60**; the average weekly wage was $**1,230.80**.

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

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

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

Respondent shall be given a credit of $**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 has failed to prove by a preponderance of the credible evidence that her current condition of ill-being is causally related to the stipulated work-related accident sustained on August 24, 2013 (Arb. X2). Therefore, her claim for compensation is denied.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

Date: August 15, 2019

AUG 15 2019

STATE OF ILLINOIS

COUNTY OF COOK

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Green,
Petitioner,
v.

Chicago Transit Authority,
Respondent

Case # **13 WC 39849** con./11 WC8086

20 IWCC0518

MEMORANDUM OF DECISION OF ARBITRATOR

Petitioner testified at her Arbitration Hearing on February 21, 2018. Both accidents cases were consolidated and evidence was admitted into the record for both claims at this single Hearing. The Transcript of Proceedings on Arbitration was prepared. However, two separate Arbitration Decisions would be issued. Arb. Andros issued his Arbitration Decision on May 29, 2018 for Case 11 WC 8086 only, date of accident September 4, 2010. Respondent filed a Petition for Review in Case 11 WC 8086 on June 26, 2018. Arb. Harris was subsequently assigned case 13 WC 39849, date of accident August 24, 2013 to issue his separate Arbitration Decision.

STATEMENT OF FACTS

The Arbitrator incorporates the following facts taken (with some editing) from the prior Arbitration Decision, 11 WC 806, for purposes of background and completeness:

Petitioner testified she is currently 46 years of age and employed by Respondent Chicago Transit Authority ("Respondent"). On September 4, 2010 Petitioner had been employed as a rail operator for 3 years. Petitioner's duties included operating the train, picking up passengers, open windows and repair the train if it breaks down (Tr. pp. 7-8).

Petitioner testified she was working on the Brown Line which runs from Kimball, around the loop and back to Kimball. Petitioner testified there are approximately 52 stops on the run. At the stops where Petitioner opens a window, puts her head through the window and opens doors with a lever, close the doors with a lever, closes the window and proceed to the next stop. At most stops Petitioner uses her right arm. In general there are 5 runs a day so Petitioner opens and closes the window approximately 260 times a day (Tr. pp. 8-11).

Petitioner testified that on September 4, 2010 she was operating a train. Petitioner opened a window and extended her wrist too much and felt pain in her shoulder and wrist. Petitioner believes she was at the Belmont stop but does not recall the time. Petitioner testified she reported to Control but finished her shift. Petitioner testified she reported to a manager at the end of her shift but could not state who that was by name (Tr. p. 12-15).

Petitioner returned to work but stated her pain continued. Petitioner initially saw Dr. Santos on September 14, 2010. Petitioner began receiving physical therapy and her last visit there was January 14, 2011. (Tr. p. 16-18).

Petitioner testified she was referred to Dr. Rashida Gray. Petitioner was developing a knot on the top of her wrist. It was a couple of weeks after the alleged accident date that Petitioner first noticed the knot on her wrist (Tr. pp. 18-19).

Petitioner was referred to Dr. Fakhouri whom she saw on January 24, 2011. After an EMG to both wrists Dr. Fakhouri recommended surgery to the right wrist. On February 24, 2011 Dr. Fakhouri took Petitioner off work. Surgery was performed on March 8, 2011. Surgery included hardware. On May 6, 20111 a second surgery was performed to remove the hardware (Tr. p. 20-24).

Petitioner then began a course of physical therapy at Athletex for roughly 3½ months. Dr. Fakhouri released Petitioner to return to work on February 14, 2011. Petitioner returned to her job as a rail operator. Petitioner testified she started feeling more pain in her wrist and shoulder. Petitioner returned to the doctor and received a cortisone injection and put

on light duty as of 9-19-11. Dr. Fakhouri released Petitioner to full duty again on November 14, 2011. (Tr. p. 24-28).

Petitioner continued as a rail operator. Due to tingling in her fingers she returned to Dr. Fakhouri on January 6, 2012. Petitioner continued as a rail operator. Petitioner returned to the doctor 7 months later on August 23, 2012. Another injection was performed and MRI ordered. Petitioner then began complaining about her elbow on her visit of September 28, 2012. A nerve test was completed with another injection performed in the wrist. Ultimately surgery was performed on the elbow on January 21, 2013 (Tr. p. 29-35).

Petitioner attended post-op physical therapy approximately for 2 months. Petitioner last saw Dr. Fakhouri on June 14, 2013 when she was discharged. Petitioner returned back to work as a Rail Operator with full duties (Petitioner is still performing those duties today). Petitioner testified she still feels pain in her wrist, elbow and shoulder. Petitioner is still required to open and close windows at the stops (Tr. p. 36-38).

13 WC 39849
August 24, 2013 Accident:

Respondent stipulated Petitioner sustained an accidental injury arising out of and in the course of her employment with Respondent on August 24, 2013 (Arb X2). The threshold issue in dispute in this claim is whether a causal connection exists between those injuries sustained on August 24, 2013 and Petitioner's current condition of ill-being, and if so, what is the nature and extent of those injuries.

Petitioner testified that on August 24, 2013 she was employed by Respondent as a Rail Operator. Petitioner testified that on that day she injured her neck but could not "recall the details really." (Tr. p. 75).

Petitioner then testified she was opening a window and she felt "a sharp pain in my neck into my shoulder" and "a pain in my neck going down my shoulders." (Tr. p. 75). Petitioner clarified it was her right shoulder. (Tr. p. 76).

Petitioner was seen the next day at Advocate. Petitioner was later seen by Dr. Beverlee Brisbin (in Dr. Fakhouri's office) on September 24, 2013. Petitioner saw Dr. Brisbin 4 times with the last visit on November 26, 2013. (Tr. p. 79). Petitioner had been previously released to work light duty but after this **last visit on November 26, 2013 Petitioner was released to full duty**. (Tr. p. 80). Petitioner worked as a Customer Service Assistant while she was on light duty for approximately two months (Tr. p.80).

Petitioner was initially examined by Dr. Brisbin on September 24, 2013. Petitioner complained of neck and right arm pain. Dr. Brisbin diagnosed Petitioner with a cervical strain and cervical radiculopathy. Dr. Brisbin recommended physical therapy, pain medication and use of a cervical collar. Dr. Brisbin instructed Petitioner to remain on light duty and not drive and operate trains.

Dr. Brisbin examined Petitioner on October 29, 2013 and released her to return to full duty employment as of October 31, 2013.

Petitioner was last examined by Dr. Brisbin on November 26, 2013. Dr. Brisbin noted that Petitioner was working full duty "which she has tolerated without difficulty". (Petitioner's Exhibit B). Dr. Brisbin indicated Petitioner has reached maximum medical improvement and **Petitioner was released from her care**. (Petitioner Exhibit B).

Petitioner identified Respondent Exhibit #6, a form report entitled, "Employee's Report of Injury on Duty". **Petitioner signed this with a date of injury noted for April 2, 2017.** The Report indicates Petitioner claimed injury to her "neck, shoulder and arm pain." Petitioner wrote she was injured when "I was operating the train when I felt the pain."

Petitioner testified she still has occasional pain in her neck and right shoulder. Petitioner takes pain pills. **Petitioner testified she has not seen Dr. Brisbin since November 2013. (Tr. p. 81). Petitioner testified she does not have any future appointment with Dr. Brisbane (Tr. p. 81). Petitioner saw no other physician besides Advocate and Dr. Brisbane (Tr. p. 81-82).**

CONCLUSIONS OF LAW

Regarding disputed issue (F), Is Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds and concludes as follows:

The burden is on the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Commission*, 115 N.E.2d 1026 (1987). The Arbitrator finds and concludes Petitioner's testimony was consistent with the medical records that she claimed pain to her neck and right shoulder when opening a train car window on August 24, 2013. This was a stipulated accident.

However, the Arbitrator finds and concludes the preponderance of the credible evidence demonstrates that Petitioner has failed to prove her current condition of ill-being is causally related to that accidental injury sustained on August 24, 2013 due to the effects of a superseding, intervening accident sustained on April 2, 2017 that severed the chain of causation, **and**, due to the gap in time when Petitioner had no treatment between her full duty release on October 31, 2013 and the intervening accident on April 2, 2017. A combination of both scenarios lead to this finding and conclusion.

Further, the Arbitrator finds and concludes that the accidental injuries sustained on August 24, 2013 resulted in **no permanent partial disability.**

Regarding the intervening accident, the Arbitrator takes note and emphasizes the significance of Respondent's Exhibit #6 which is the "Employee Injury On Duty" form Petitioner signed on April 2, 2017. This form indicates Petitioner claimed injury to her neck, right shoulder and arm on April 2, 2017, which the Arbitrator also emphasizes is more than two and half years after Petitioner was released from care, released to return to full duty work and had last seen any doctor on for the August 24, 2013 work accident. **It is clear Petitioner has had symptoms only after this April 2, 2017 incident.** Petitioner testified she still has occasional pain in her neck and right shoulder, the same body parts injured on April 2, 2107.

Treating medical records confirm Petitioner had complaints of pain. Petitioner had no lost time from work related to this August 24, 2013 matter and received only conservative care. **Dr. Brisbin examined Petitioner on October 29, 2013 and released her to return to full duty employment as of October 31, 2013**. Petitioner never visited Dr. Brisbin again. **If Petitioner had any actual problems, complaints or symptoms, she would have visited him, or another physician, during these past years.**

Significantly, Petitioner had not been back to see this (or any) treating physician in the almost 3-year gap since her full duty release on October 31, 2013 and the work accident of April 2, 2017. This gap in time indicates Petitioner's condition of ill-being had long since resolved between October 31, 2013 and April 2, 2017. Therefore, Petitioner's current condition of ill-being, if there is any, is **not related** to the long-resolved August 24, 2103 work accident.

The April 2, 2017 incident is a superseding, intervening accident that severed the chain of causal connection to the August 24, 2013 accident. Further, even if compensable, and even if there were no intervening accident, Petitioner has not proven he sustained any permanent disability as a result of the August 24, 2013 minor work accident.

Accordingly, the Arbitrator finds and concludes Petitioner's current condition of ill-being regarding her shoulder and neck are related solely to the subsequent, intervening April 2, 2017 injury and not her August 24, 2013 accident. Further, Petitioner has failed to prove she has sustained any permanent disability.

Accordingly, Petitioner's claim for benefits are denied.

Robert M. Harris

Arbitrator Robert M. Harris

August 15, 2019
Date

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

Angela Green,

Petitioner,

vs. NO: 11 WC 8086

CTA,

Respondent.

20 I W CC0519

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 29, 2018, is hereby affirmed and adopted.

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

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

20 I W C C 0 5 1 9

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

DATED: SEP 1 5 2020
o: 7/23/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, ANGELA
Employee/Petitioner

Case# **11WC008086**
13WC039849

CTA
Employer/Respondent

20IWCC0519

On 5/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2902 LAW OFFICES OF PETER G LEKAS
5357 W DEVON AVE
CHICAGO, IL 60646

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

20 I W CC0519

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

Angela Green
Employee/Petitioner

v.

CTA
Employer/Respondent

Case # **11** WC **8086**

Consolidated cases: **13 WC 39849**

20 I W CC0519

An *Application for Adjustment 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 **2-21-18& March 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] 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. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **9-4-10**, 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**47,674.12**; the average weekly wage was $**916.81**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **1** 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 $**7,323.43** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,968.00** for other benefits, for a total credit of $**10,291.43**.

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 $38,751.75, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall pay petitioner and her attorney temporary total disability benefits of $611.20 per week for 58 5/7 weeks, commencing February 14, 2011 through September 11, 2011, September 19, 2011 through November 13, 2011 and January 21, 2013 through June 14, 2013, as provided in Section 8(b) of the act.

Respondent shall pay petitioner & her attorney the permanent partial disability benefits of $550.08 per week for 23.5 weeks , because the injuries sustained caused the **10 % loss of use of the right arm** as provided in section 8 (e) , plus an additional amount of 30.75 weeks for **8.2 % permanent partial disability for "lose of the person as a whole",** for multiple surgeries/hardware to the right hand, as provided in Section 8(d)2. Act.

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

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

#001 Arb. George Andros
Signature of Arbitrator

May 22, 2018
Date

MAY 29 2018

FINDINGS OF FACT 11 WC 8086 & 13 WC 39849

Petitioner testified that she is 46 years old and employed as a rail operator for the Respondent. Her job entails operating (driving a CTA) a train, picking up passengers, opening windows constantly all day and repairing her train if it breaks down. Petitioner testified that she began working for the Respondent in 2007.

Petitioner testified that she was operating a train on the brown line on September 4, 2010. The Brown line starts at Kimball Avenue (from the north) , goes around the Loop and returns to Kimball. Petitioner testified that there are approximately 52 stops on the Brown Line.

Petitioner testified that there are procedures rail operators follow when stopping a train at stops. They must bring the train to a complete stop, pull a lever to open up the doors, open the side window to make sure all passengers have safely exited and entered the train, close the lever to close the doors and then close the window. It is then safe to proceed to the next stop. Petitioner testified that most of the stops on the Brown line are on the right side of the train. She testified that she opens and closed the train window approximately 260 times during a work shift.

Petitioner testified that rail operators are also required to address mechanical problem on trains. They look at ta panel to pinpoint the problem, then climb down a ladder to track level; They may pull activators with a sleet scraper on both train sides.

The worker further stated she injured her right wrist and shoulder on September 4, 2010, while opening a train window. She testified that while operating the train she opened a window and extended her right wrist too much and that she felt pain in her shoulder and wrist.

Further, the accident occurred at the Belmont stop. She called the control center and reported the accident. She finished her shift and then reported the incident to her manager. Her manager filled out a report to manager form that she signed ..

Petitioner was initially treated by Dr. Delos Santos at Damen Medical Center on September 14, 2010. Dr. Delos Santos diagnosed petitioner with a right shoulder sprain and prescribed ibuprofen and a course of physical therapy. Dr. Delos Santos examined the petitioner on December 10, 2010 and noted complaints of right wrist pain and found a cyst on the right wrist. {Petitioner Exhibit No. 3} Dr. Santos referred her to Dr. Rashida Gray.

Petitioner was examined by Dr. Rashida Gray on December 30, 2010. Dr. Gray diagnosed petitioner with a ganglion cyst on the dorsal surface of her right wrist. Dr. Gray noted decreased range of motion of the right wrist due to the cyst.

Dr. Gray then referred her to Dr. Anton J. Fakhouri, a hand and upper extremity specialist in Tinley Park, per his record.

Petitioner testified that she noticed a knot on the top of her right wrist a couple weeks after her September 4, 2010 accident. She testified that the knot became smaller over time but then came back and became larger.

Petitioner was initially examined by Dr. Anton Fakhouri on January 24, 2011. Dr. Fakhouri noted a right wrist mass which has been present for several months. Petitioner complained of numbness and tingling in both hands, worse on the right side. Dr. Fakhouri recommended EMG's of the petitioner's upper extremities. Petitioned underwent electrodiagnostic studies of both upper extremities on February 9, 2011. Dr. Fakhouri examined the petitioner on February 14, 2011, and noted that approximately in September she pushed on a window firmly to try to open it and that hyper extended her wrist; since then she has been having pain and thereafter the mass developed. She also had developed paresthesia subsequent to that. D r. Fakhouri diagnosed petitioner with chronic right wrist pain with scapholunate dissociation, right wrist ganglion cyst and right carpal tunnel syndrome. Dr. Fakhouri recommended a right wrist arthroscopy. {Petitioner's Exhibit No.5} Petitioner testified that Dr. Fakouri took her off of work effective February 14, 2011.

Importantly in evaluating the nature and extent of this injury, Dr. Fakouri performed surgery to the petitioner's right wrist on March 8, 2011. He performed a right carpal tunnel release, excision of a 2.5 CM mass, right wrist arthroscopy, debridement, synovectomy, repair of the triangular fibrocartilage complex, scapholunate ligament reconstruction with dorsal capsulodesis and pinning of the scapholunate joint along with a posterior interosseous neurectomy.

Petitioner followed up with Dr. Fakhouri subsequent to her surgery and was examined on March 21, 2011, April 4, 2011 and May 2, 2011. Sutures were removed and a long arm thumb spica splint was applied. On May 2, 2011, Dr. Fakhouri recommended removal of the pin from petitioner's right wrist. Dr. Fakhouri performed a right wrist surgery to insure the removal of retained hardware on May 6, 2011.

Dr. Fakhouri examined the petitioner on May 16, 2011 and removed the sutures and recommended a course of physical therapy. Dr. Fakhour further instructed the petitioner to remain off of work . {Pet. Ex. 5} Petitioner testified that she underwent physical therapy for about 3.5 months at Athletex physical therapy by Tom Mulvey PT, MBA. Petitioner testified that while in physical therapy she felt pain in her right hand along with restricted range of motion in the hand.

Dr. Fakhouri examined the petitioner on September 1, 2011. As a result he released her to return to work on September 12, 2011 {Pet. Ex. 5} Petitioner testified that she was off of work form February 14, 2011 through September 11, 2011, and did not receive any worker's compensation.

Petitioner returned to work as rail operator on September 12, 2011. Petitioner testified she started feeling more pain in her right wrist and shoulder while performing her work duties.

On September 19, 2011 Dr. Fakhouri noted that petitioner overdid it at work and diagnosed her with extensor tendinitis and synovitis. Dr. Fakhouri gave petitioner a cortisone injection into her right wrist and applied a wrist splint. Dr. Fakhouri placed the petitioner on light duty with a 15 pound weight restriction. Petitioner confirmed CTA would not accommodate her work restrictions.

On November 10, 2011, he noted that she was 100% better. Dr. Fakhouri released the petitioner to return to work on November 14, 2011, without restrictions. Dr. Fakhouri further discharged the petitioner and found her to be at maximum medical improvement. Petitioner testified that she did not receive any worker's compensation benefits from September 19, 2011 through November 13, 2011.

Petitioner testified that she returned to work as a rail operator on November 14, 2011. She testified that she worked for a number of months. She testified that she noticed pain in her right writ and tingling in all of her fingers.

Dr. Fakhouri examined the petitioner on January 6, 2012. X-rays of the wrist showed postoperative changes. Dr. Fakhouri noted that the petitioner may need further intervention and that she has ulnar plus variance and may experience symptoms related to impaction. Dr. Fakhouri instructed the petitioner to return in the future on an as needed basis.

The petitioner returned to see Dr.Fakhouri on August 23, 2012. Petitioner complained of right wrist pain while working as a train operator. Dr. Fakhouri gave petitioner a cortisone injection into her right wrist, prescribed a wrist splint, Naprosyn and a course of physical therapy. Petitioner underwent a MRI of her right wrist on August 27, 2012.

Dr. Fakhouri on September 28, 2012 exam diagnosed her with right cubital tunnel syndrome and medial epicondylitis of the right elbow. He recommended a EMG of the right Arm, physical therapy and prescribed Naprosyn. petitioner underwent a EMG of her right arm on October 18, 2012. Dr. Fakhouri examined the petitioner on October 26, 2012, and injected petitioner's right wrist and right elbow.

Dr. Fakhouri next examined the petitioner on November 26, 2012. Dr. Fakhouri noted that the petitioner continues to be symptomatic and recommended surgery. His impression was medial epicondylitis right elbow with cubital tunnel syndrome. Dr. Fakhouri opined that petitioner's present condition and symptoms were related to petitioner's work activities. His opinion was based on a reasonable degree of medical and surgical certainty.

Petitioner testified that she was taken off of work as of January 21, 2013. Petitioner further testified that she received worker's compensation benefits after her third surgery.

O February 5, 2013 Doctor recommended a course of physical therapy. Petitioner testified that she underwent physical therapy for 2 to 3 months. Dr. Fakhouri last examined the petitioner on June 14, 2013. Dr. Fakhouri released petitioner to full duty employment and discharged her. Imortantly for the matter at bar, Doctor's last exam notes show an excellent recovery. {Pet. 5}

Petitioner testified that she returned to work as a rail operator on June 15, 2013 and did so presently. She asserted to currently experiencing pain in her right wrist, right elbow and right shoulder. She takes ibuprofen daily to ease the pain.

Petitioner testified that prior to September 4, 2010, she did not experience any pain in her right wrist, right elbow or right shoulder. Petitioner further testified she did not have any medical treatment to her right wrist, right elbow or right shoulder prior to September 4, 2010.

Petitioner testified she experiences pain in her right wrist, right elbow and right shoulder while operating the trains matter controller. The master controller operates the train to go to power and to coast and stop. Petitioner constantly puts pressure on the master controller to operate the train.

Petitioner testified on cross – examination that she is currently working full duty as a rail operator on the orange line. She testified that the train window was normally opened and closed at each stop. She did not leave it open while operating the train because of the wind and birds and things that fly in (the train cab).

Petitioner presented under section 12 for exam by Dr. Ben Goldberg in January of 2011 at the request of the Respondent. Dr. Goldberg reported she was non cooperative by declining much history. His conclusions plus findings are stated in his report in evidence.

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision relating to (c) Did an accident occur that arose out of and in the course of the Petitioner's employment by Respondent; the Arbitrator concludes as follows:

Based upon the totality of the evidence, The Arbitrator finds that the Petitioner sustained accidental injuries that arose out of and in the course of her employment as alleged with Respondent on September 4, 2010.

Petitioner testified that she injured her right wrist and shoulder on September 4, 2010, opening a train window. She testified that she extended her right wrist too much while opening the window and noticed pain in her right wrist and shoulder. Petitioner testified that she reported the injury to the Control Center and then signed a Report to Manager after finishing her shift on September 4, 2010. The Report to Manager indicates that petitioner injured her right wrist on September 4, 2010, opening a window. {Pet. 1} Petitioner testified that she subsequently signed an Interview record on September 21, 2010. She testified that she was interviewed regarding a injury on Duty and then signed the interview records. The interview record indicates that the petitioner hurt her arm on September 4, 2010 while opening a motorcar window. Petitioner had the same car on September 10, 2010 and hurt her arm again. The date of accident noted on the Interview Record is September 4, 2010. {Pet. 2} Petitioner's credible testimony is corroborated by the Report to manager and interview record.

Petitioner's testimony is further corroborated by the histories noted by Dr. M. Delos Santos, Dr. Anton Fakhouri and Dr. Benjamin Goldberg. Dr. Delos Santos examined the petitioner on September 14, 2010. Dr. M. Delos Santos noted that petitioner complained of shooting pain in her right shoulder after closing the window of the train. {Pet.Exh. 3} Dr. Fakhouri noted on February 14, 2011, that the petitioner hyperextended her right wrist pushing on a window and opening it. Petitioner was examined by Dr. Benjamin Goldberg on January 3, 2011, at the request of the Respondent. Dr. Goldberg's report indicated that the petitioner noticed pain in her right arm on September 4, 2010 while trying to open a window. She noticed the same pain on September 10, 2010 while attempting to close the same window on the same train. The Petitioner was deemed essentially noncooperative, see the terms used by the section 12 doctor. {Resp.1}

In support of the Arbitrator's Decision relating to (f)Is Petitioner's current condition of ill-being causally related to the injury;

Based upon the totality of the evidence , the Arbitrator finds that petitioner's current condition of ill-being is her right wrist and right arm is causally related to the injury she sustained on September 4, 2010, while employed by the Respondent.

The Arbitrator adopts and relies upon the credible testimony subject to inciteful cross examination of the petitioner along with the opinion of Dr. Anton J. Fakhouri. Petitioner testified that she injured her right arm on September 4, 2010, while opening a train window. She further testified that she never experienced pain in her right wrist and right shoulder or sought medical treatment to her right wrist or right shoulder prior to September 4, 2010. Petitioner's testimony was persuasive, forthright on cross examination. No evidence was introduced showing right wrist and right shoulder pain or medical treatment to the upper extremity prior to September 4, 2010.

Dr. Anton J. Fakhouri treated the petitioner from January 24, 2011 through June 14, 2013. Dr. Fakhouri examined the petitioner on February 14, 2011. There was a discussion about petitioner's specific history of trauma to the right wrist. In September petitioner pushed on a window firmly to try to open it and she hyperextended her wrist and since then she has been having pain and thereafter the mass developed. She also had developed paresthesia subsequent to that. Dr. Fakhouri found scaphlunate dissociation and opined that it is possible that the ganglion cyst may also be associated with this.

Dr. Fakhouri examined the petitioner on November 26, 2012. D r. Fakhouri opined that as far as petitioner's present symptoms and conditions as it relates to her work I do believe that in my humble opinion that her present symptoms and condition is related to her work activities. The above opinion is based on a reasonable degree of medical and surgical certainty.

In Support of the Arbitrator's Decision relating to (J) Were the medical reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; the Arbitrator concludes as follows:

Based upon the totality of the evidence Respondent shall pay reasonable and necessary medical services of $38,751.75, as provided in Section 8(a) and 8.2 of the Act.

The Arbitrator finds the unpaid medial bills introduced into evidence to represent reasonable and necessary treatment pursuant to Section 8(a) of the Act. {Petitioner's Exhibit No's. 7,8, 9 &10} These bills were incurred within the normal course of treatment and the responsibility of the Respondent.

In support of the Arbitrator's Decision relating to (k) what temporary total disability benefits are in dispute; the Arbitrator concludes as follows:

Based upon the totality of the evidence, Respondent shall pay petitioner and her attorney temporary total disability benefits of $611.20 per week for 58 5/7 weeks, commencing February 14, 2011 through September 11, 2011, September 19, 2011 through November 13, 2011 and January 21, 2013 through June 14, 2013, as provided in Section 8(b) of the act.

Respondent shall pay petitioner and her attorney the temporary total disability benefits that have accrued from September 4, 2010 through February 21, 2018, and shall pay the remainder of the Award, if any, in weekly payments.

Respondent shall be given a credit of $7,323.43 for temporary total disability benefits that have been paid.

Petitioner testified that she was disabled and off of work form February 14, 2011 through September 11, 2011, September 19, 2011 through November 13, 2011, and January 21, 2013 through June 14, 2013. Petitioner's testimony was credible and supported by the medical records from Anton Fakhouri. Petitioner was examined and taken off of work by Dr. Fakhouri on February 14, 2011. Dr. Fakhouri examined the petitioner on September 1, 2011 and released her to full duty employment of September 12, 2011. petitioner testified that she did not receive any worker's compensation benefits form February 14, 2011 through September 11, 2011. Petitioner testified that she returned to work on September 12, 2011.

Petitioner was examined by Dr. Fakhouri on September 19, 2011. Dr. Fakhouri put the petitioner on light duty restrictions of no lifting greater than 15 pounds. petitioner testified that the Respondent would not accommodate her work restriction. Dr. Fakhouri examined the petitioner on November 10, 2011 and released her to full duty employment on November 14, 2011. Petitioner testified that she did not receive any worker's compensation benefits form September 19, 2011 through November 134, 2011. Petitioner testified that she returned to work on November 14, 2011.

Dr. Fakhouri performed surgery to the petitioner's right arm on January 21, 2013 at Tinley Woods Surgery Center. Petitioner testified that she was taken off of work as of January 21, 2013. Dr. Fakhouri examined the petitioner on June 14, 103, and discharged her and released her to return to unrestricted work duties. Petitioner testified that she returned to work on June 15, 2013.

The Arbitrator concludes that the petitioner is entitled to receive temporary total disability benefits form February 14, 2011 through September 11, 2011, September 19, 2011 through November 13, 2011, and January 21, 2013 through June 14, 2013, representing 58 5/7 weeks.

In Support of the Arbitrator's Decision relating to (L) What is the nature and extent of the injury; the Arbitrator concludes as follows:

Based upon the totality of the evidence, Respondent shall pay petitioner and her attorney permanent partial disability benefits as stated in the Decision.

Dr. Fakhouri performed three (3) surgical procedures to the petitioner's right wrist on March 8 2011. The Postoperative diagnoses were right wrist scapholunate Dissociation, right wrist dorsal ganglion cyst, right carpal tunnel syndrome and triangular fibrocartilage complex tear.

On May 6, 2001, Dr. Fakhouri removed the retained hardware in petitioner's right wrist. Dr. Fakhouri performed surgery to the petitioner's right arm on January 21, 2013, at Tinley Woods Surgery Center. Dr. Fakhouri performed a right cubital Tunnel Release, medial epicondylitis release and partial medial epicondylectomy with tendon repair.

Petitioner testified that she currently experiences pain in her right wrist, right elbow and right shoulder. She testified that she takes ibuprofen on a daily basis to ease the pain. Petitioner further testified that she notices pain in her right arm while operating the trains master controller.

The doctor's last report shows a fine examination result as did the last therapy record.

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

JOSEPH BELONGIA,

Petitioner,

vs. NO: 19WC 5115

B & B TRUCKING,

Respondent.

20IWCC0520

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 29, 2020 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 $1400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 6 2020
o090320
MP/jrc
068

Marc Parker

Barbara N. Flores

Deborah L. Simpson

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

BELONGIA, JOSEPH
Employee/Petitioner

Case# **19WC005115**

B & B TRUCKING
Employer/Respondent

20IWCC0520

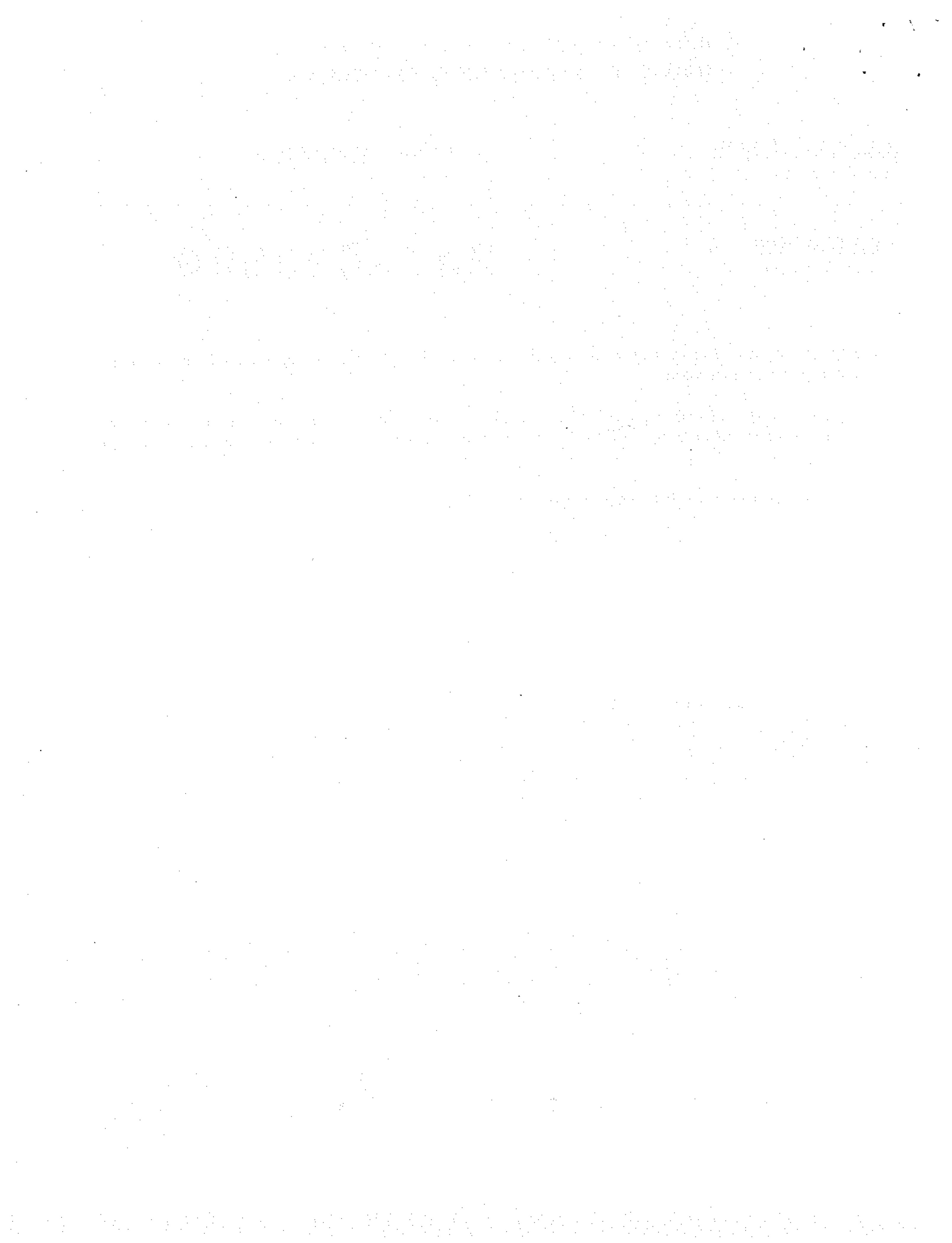
On 1/29/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0258 HELLER HOLMES & ASSOC
FRED JOHNSON
1101 BROADWAY AVE
MATTOON, IL 61938

0264 HEYL ROYSTER VOELKER & ALLEN
JOHN FLOODSTROM
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824



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) & 8(A)

JOSEPH BELONGIA
Employee/Petitioner

Case # **19** WC **05115**

v.

Consolidated cases: ______

B & B TRUCKING
Employer/Respondent

20IWCC0520

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **11/15/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] 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, **08/27/2017**, 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 **$63,364.04**; the average weekly wage was **$1,237.77**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$589 (DOS 11/16/2018) to Bonutti Clinic and $658 (DOS 03/06/2018) to Bonutti Clinic**, as provided in Sections 8(a) and 8.2 of the Act. Furthermore, Respondent shall pay for prospective medical care and treatment in the form of total knee replacement surgery as recommended by Dr. Didi Omiyi, subject to the terms of the fee schedule.

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

1/27/20
Date

ICArbDec19(b)

JAN 2 9 2020

MEMORANDUM OF DECISION OF ARBITRATOR
Finding of Facts:

On August 27, 2017, the Petitioner was employed as a truck driver for B&B Trucking. (A.T. 7.) The Petitioner drove a 53-foot semi. While in Memphis, Tennessee, the Petitioner was hooking up to a different trailer, at a "drop lot" that his employer had in Memphis. While doing a pre-trip walk around between 3:00-4:00 a.m., the Petitioner squatted down under a trailer to ensure that the pin was locked in place on the fifth wheel. (A.T. 9.) After the Petitioner checked the pin, he turned to come out from underneath the trailer at which time he twisted his left knee while in a pothole and fell to the ground with "a lot of pain." (A.T. 10.) The Petitioner reported the incident on the same day to his dispatcher.

The Respondent referred the Petitioner to Dr. Karl Rudert at the Bonutti Clinic, Effingham, IL. Dr. Rudert placed the Petitioner in therapy. (A.T. 11.) The Petitioner's knee pain did not improve after therapy. Dr. Rudert next referred the Petitioner to Dr. Omiyi, an orthopedic surgeon at the Bonutti Clinic. (A.T. 13.) Dr. Omiyi treated the Petitioner with injections and thereafter with arthroscopic surgery. (A.T. 13.) The Petitioner's knee pain did not improve The Respondent paid for the treatment with Dr. Rudert and Dr. Omiyi. Prior to the Petitioner's accident on August 27, 2017, the Petitioner had ACL surgery on his left knee approximately seventeen to eighteen years earlier. (A.T. 15.) The Petitioner was released from that surgery and resumed full activities. The record is unrebutted that from the time the Petitioner was released from ACL surgery until the time of his accident on August 27, 2017, he did not have any restrictions or treatment on his left knee and had not consulted or been seen by a doctor, nurse, therapist or other healthcare provider. (A.T. 16.) The Petitioner had not taken any medication for his knee condition since he was released from his ACL surgery until the time of his accident. The Petitioner further testified that he did not have pain or problems in his left knee since being released from the ACL surgery until the time of his accident. (A.T. 17.)

Since the time of the accident, the Petitioner has experienced pain in his left knee. On two separate occasions, since the time of his accident, Petitioner briefly attempted to install a "t-post" to string a fence on his property. The "t-post" was on a hillside. The Petitioner noticed an increase in pain in his left knee when he briefly tried to "tap" the post in the ground. (A.T. 20.) On each instance, the increase in pain the Petitioner felt was temporary and reverted to the baseline pain he previously was experiencing from the trauma of the accident on August 27, 2017. (A.T. 22.)

Prior to the Petitioner's accident, the Petitioner in 2015 lost approximately one hundred pounds to relieve pressure on his ankles which had previously caused him pain. The Petitioner testified that he was familiar with the knee replacement surgery that Dr. Omiyi has recommended and that he desires to have the procedure performed knowing the risk and benefits of the procedure. (A.T. 14.)

The medical evidence before the Arbitrator consists of the evidence deposition of Dr. Didi Omiyi, Petitioner's treating physician, taken October 22, 2019 and the evidence deposition of Respondent's IME, Dr. Michael Nogalski, taken November 20, 2019. Dr. Nogalski examined the Petitioner on January 15, 2018 and last saw the Petitioner on November 20, 2018. The Nogalski reports are included in Respondent's exhibit list. Dr. Nogalski testified, beginning at page 21 of deposition, that the Petitioner suffered injury to his left knee while working under a fifth wheel and twisting his leg on August 27, 2017, and that his subsequent treatment with Dr. Rudert and Dr. Omiyi was traceable to such trauma. (Nogalski deposition pg. 21-22.) Dr. Nogalski further testified that the injury to the Petitioner's knee could have required the need for diagnostic and therapeutic arthroscopy. (Nogalski deposition pg. 25.) More specifically, Dr. Nogalski testified: "Therefore, I believe his best course of action is reasonably to consider knee arthroscopy as a form of treatment of 8/27/17 event." Is that correct? Answer: Yes." (Nogalski

deposition pg. 25.) Dr. Nogalski further testified that the Petitioner was a candidate for a total knee replacement, although Dr. Nogalski disputed a causal relationship between the need for such surgery and the accident on August 27, 2017. (Nogalski deposition pg. 28.).

Dr. Omiyi, a board-certified orthopedic surgeon, testified that the trauma to the Petitioner's knee on August 27, 2017 caused an aggravation of a pre-existing degenerative condition in the Petitioner's knee, as well as a tear to the Petitioner's meniscus. (Omiyi deposition pg. 9-12.) Dr. Omiyi testified that the trauma from the work accident, with the resulting tear to the meniscus and aggravation of the pre-existing arthritis, resulted in the need for a total knee replacement. (Omiyi deposition pg. 12.) Dr. Omiyi attempted to conservatively treat the Petitioner's injury from the work accident with viscoelastic supplementation injection, as well as a prescription for fitted specialized Varus unloader brace. (Omiyi deposition pg. 17.) Eventually, Dr. Omiyi performed an arthroscopic meniscus surgery on the Petitioner's left knee. (Omiyi deposition pg. 19.) Dr. Omiyi explained that the arthroscopic procedure would only be able to address the tear in the meniscus and would not address the aggravation to the degenerative changes in the Petitioner's knee from the work accident. The arthroscopic procedure was performed because that was the only procedure which the workers' compensation carrier would approve at that time. (Omiyi deposition pg. 20-22.) See also page 36 of Dr. Omiyi's deposition.

Dr. Omiyi further identified the remaining bills for the Petitioner's last two office visits as bills for services which were causally related and necessitated by the trauma of the accident on August 27, 2017. (Omiyi deposition pg. 38.)

CONCLUSIONS OF LAW

C.

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

The Arbitrator finds the Petitioner suffered an accident that arose out and in the course of the Petitioner's employment by Respondent. The record is undisputed that on August 27, 2017 the Petitioner was employed by the Respondent as a truck driver. The Petitioner drove a semi-truck with a 53ft. trailer. (A.T. 7.) At approximately 3:00 or 4:00 a.m., as part of his duties, the Petitioner performed a "pre-trip walk around." The Petitioner checked a pin on the fifth wheel under the trailer. In order to check the pin, the Petitioner squatted down under the trailer with a flashlight and while attempting to come out from underneath the trailer twisted his left knee and rolled his left ankle in a pothole. (A.T. 9-10.) The Petitioner felt the immediate onset of significant pain and attempted to "hobble" back to his truck and promptly notified his dispatcher. (A.T. 10.) Under cross-examination, the Petitioner described in great detail the mechanism of the traumatic injury to his knee. (A.T. 36-39.) The Arbitrator finds and concludes the trauma to the Petitioner's knee, while performing the aforesaid activities, constitutes a "accident" that arose out of and in the course of the Petitioner's employment as defined in the Act.

An injury under the Act arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and accidental injury. See *Robinson v. SOI/Vienna Correctional Center*, 17 IL.W.C. 30770, 18 I.W.C.C. 0708, 2018 WL 6626130, holding an accidental injury occurs within the meaning of the Act if a petitioner suffers a disabling injury arising out of and in the course of his employment and traced to a definite time, place, and cause. The Petitioner met his burden in the present case.

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

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

K.
Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that the issues of the causal relatedness of the Petitioner's condition of ill-being relative to his work accident and the reasonableness and necessity of medical services provided, as well as prospective medical care are interrelated and, as such, the Arbitrator will address the aforesaid issues together. The Arbitrator finds and concludes that the Petitioner's current condition of ill-being is causally related to the accident on August 17, 2017, and that the medical services provided to the Petitioner were reasonable and necessary and further that the Petitioner is entitled to prospective medical care and treatment in the form of a total knee replacement as recommended by Dr. Omiyi. The surgery proposed by Dr. Omiyi is both reasonable and necessary to treat the Petitioner secondary to the trauma to the Petitioner's left knee on August 27, 2017.

The Arbitrator finds the testimony of the Petitioner was credible. Moreover, the record is clear that although the Petitioner, approximately 17-18 years prior to the time of his accident, underwent ACL surgery on his left knee and recovered from that surgery and was released approximately one year after the surgery and resumed full activities. (A.T. 15-16.) The Petitioner testified, without rebuttal, that since his released from the ACL surgery he had no restrictions or ongoing treatment on his left knee until the time of his accident on August 27, 2017. Furthermore, the Petitioner had not consulted or been seen by a nurse, doctor, therapist, or any other healthcare provider for any condition in his left knee from the time he was released from the ACL surgery until the time of his accident. (A.T. 16.) The Petitioner had not taken any medications and had no difficulty performing his job duties, nor did he experience any pain or problems with the knee, from the time he was released from the ACL surgery until the time of his accident on August 27, 2017. The Petitioner explained that his statement to his therapist that he

has always had some pain in his knee (A.T. 18) was a reference to the fact that he has always had pain in his since the time of the accident.

Since the time of the Petitioner's accident on August 27, 2017, the Petitioner has experienced pain in his left knee and received treatment from Dr. Karl Rudert and Dr. Didi Omiyi. The Petitioner was seen by Dr. Karl Rudert on August 29, 2017. (Exhibit 2 attached to Omiyi deposition.) The Petitioner's treatment since the time of his work accident has consisted of therapy, viscoelastic supplementation injection, as well as a prescription for fitted specialized Varus unloader brace and arthroscopic surgery, none of which relieved the Petitioner's pain. Since the time of the Petitioner's accident, the Petitioner has experienced loud popping in his knee as documented in the therapy note of September 22, 2017. (A.T. 19-20.) The Respondent's IME also noted that since the time of the trauma, on August 27, 2017, the Petitioner has experienced a positive patella femoral grind and positive McMurray's finding with no prior record of such conditions prior to the work accident. The arbitrator concludes that the Petitioner's asymptomatic condition prior to the time of the accident, rapidly followed by the onset of significant pain and other positive objective findings, is compelling circumstantial evidence of a causal relationship between the trauma to the Petitioner's knee on August 27, 2017 and the need for his ongoing care and treatment.

With respect to the Petitioner's need for prospective medical care in the form of a total knee replacement and the causal relatedness of the knee replacement surgery to the Petitioner's accident on August 27, 2017, the Arbitrator on balance defers the opinions of the Petitioner's treating orthopedic surgeon Dr. Didi Omiyi over the Respondent's IME. Beginning at page 17 of his deposition, Dr. Omiyi testified as follows:

> "A. So at that point in time my impression was that patient had a left knee work-related injury with a meniscal tear and aggravation of his osteoarthritic symptoms.

> Q. Was your impression at that time with regard to the tear and the aggravation of the osteoarthritic symptoms causally related to the trauma of the incident at work described in the history from August 27 of '17?
> A. Yes.
> Q. Okay. I'll ask it another way.
> Doctor, do you have an opinion either way whether his condition regarding the meniscal tear and the aggravation of osteoarthritic symptoms you charted was or was not related in whole or in part to the trauma of the accident charted in the history from August 27 of '17?
> And you can answer it, doctor.
> A. In my opinion that I felt his meniscal tear and aggravation of osteoarthritic symptoms was the result of his work injury on August 27, 2017.
> Q. Even at this date. Right?
> A. Yes."

Dr. Omiyi explained that a total knee replacement would involve removal of all the degenerative changes, as well as damaged meniscus and replacing the joint with an artificial joint. When asked why such surgery was the better option for the Petitioner, Dr. Omiyi stated: "An arthroscopic procedure would only be able to address the tear in the meniscus and would not be able to address the aggravation to the degenerative changes in the knee." (Omiyi deposition pg. 19-20.) Dr. Omiyi explained that the only reason he performed the arthroscopic procedure, to address the meniscal tear, was to see if such surgery would improve the Petitioner's symptoms to the point it would become tolerable, although Dr. Omiyi's strong preference was for a total knee replacement. Dr. Omiyi made clear that the arthroscopic procedure was performed because it was the only procedure the workers' compensation carrier would approve based upon the IME report. (Omiyi deposition pg. 22.)

Beginning at page 28 of his deposition, Dr. Omiyi testified on the subject of the necessity of a total knee replacement as follows:

> "Q. Absent a total knee replacement, do you have an opinion, to a reasonable degree of medical certainty, whether the patient's condition will continue to worsen?

A My opinion given his history and all his clinical findings is that he'll continue to have severe debilitating pain in this knee that is very likely to continue to worsen and progress without definitive management with a knee replacement surgery.
Q. And the benefit of the total knee replacement would be what?
A The primary goal would be pain relief for this patient and then hopefully with the improvement in pain he will have improved function over what he currently has."

Dr. Omiyi further elaborated on the causal relatedness and necessity of the knee replacement surgery relative to the trauma at work on August 27, 2017 as follows:

"Q. Do you have an opinion, doctor, to a reasonable degree of medical certainty whether a total knee replacement is reasonably necessary and causally related to the incident on August 27, 2017, at work as described in the history charted in your records?
A. I believe that it is.
Q. And what is the basis of your opinion?
A. The patient has a history of aggravated degenerative changes in his left knee as a result of his work-related injury. He has had multiple attempts of non-operative treatments, including medicines, injections, viscosupplmentation, bracing which haven't help to adequately treat his symptoms.
He had a knee arthroscopy which did not adequately address his symptoms, and so he's met the criteria for a knee replacement for definitive treatment." (Omiyi deposition pg. 30.)

When further pressed on the issue of causal relatedness and necessity of surgery, relative to the accident on August 27, 2017, Dr. Omiyi responded as follows:

"Q. As of your last visit with the patient and your knowledge of his subsequent course of examination and treatment with Nurse Hess can you explain to the arbitrator how it is that that original trauma would still be precipitating pain in his knee?
A. Given the patient's history he never recovered from that injury and continued to have symptomatically a painful knee that did not get better despite all treatments, and so that was where all of this - - all of his problems began, and as a result it's my opinion that it was directly related to that injury that precipitated the event." (Omiyi deposition pg. 31.)

At page 67 of his deposition, Dr. Omiyi explained that during the arthroscopic surgery he noted the Petitioner had a "complex flap" and a longitudinal tear involving the anterior horn body

and posterior horn of his lateral meniscus. Dr. Omiyi testified such tears are "almost always traumatic in nature versus degenerative in nature.

Dr. Omiyi further explained that the pre-existing arthritis of the Petitioner's left knee prior to the accident on August 27, 2017 would not necessarily have caused the Petitioner to experience pain. Dr. Omiyi explained that although the Petitioner had degenerative changes in his knee, the trauma of the accident aggravated, exacerbated and accelerated the pre-existing osteoarthritis to the point it became symptomatic and now requires surgery. (Omiyi deposition pg. 33.) Dr. Omiyi emphatically disagreed with the opinion of the Respondent's IME that the trauma of the accident did not aggravate Petitioner's pre-existing condition. (Omiyi deposition pg. 35.) Under cross-examination Dr. Omiyi explained that some patients with Grade 4 osteoarthritis in a knee may experience "no pain whatsoever" yet with superimposed trauma become permanently symptomatic.

At pages 10-12 of his deposition, Dr. Omiyi explained how the trauma of the accident injured not just the meniscus but also the articular surfaces of the femur and tibia:

> "A. So the meniscus is a ring-like structure that cushions the cartilage in the knee joint and also helps to resist forces sustained when going - - with a knee joint going back and forth with the femur on the tibia, so it give some sort of stability.
>
> Any sort of forceful twisting or back and forth motion in the knee can put an abnormal stress on the meniscus and can result in a tear or damage of that tissue as the tissue fails under all that stress or all that tension. Whether or not the meniscus was abnormal before and this injury aggravates that and creates a bigger tear or creates a new tear, those are all methods by which that can happen.
>
> Q. Is that what occurred in this case?
>
> A. In this case my assessment was that he sustained a tear - - at the minimum he sustained a tear of his meniscus during the injury.
>
> He had no symptoms of pain prior to it and so I could feel comfortable in concluding that he had no meniscus tear prior to this.
>
> Q. And can you explain to us again, doctor, with reasonable medical certainty in layman's terms, how it is that the trauma the

patient had at work with the accident would aggravate the pre-existing osteoarthritis you told us about.
A. So the meniscus serves as a cushion in the joint, and its job is to protect the surface or articular cartilage in the knee.
In the knee that has degenerative changes or arthritic changes in the knee, that meniscus is helping to protect the symptoms of that condition.
Once you tear the meniscus, you lose that protective function, and with a force that's required in order to tear the meniscus you also are going to damage or have contusions of those articular surfaces hitting each other on the femur and the tibia.
If those surfaces are already abnormal due to degeneration, they're going to get more inflamed and irritated and have more pain.
Q. And is that, in your opinion, what occurred in this particular patient from the trauma?
A. That was my opinion of what his - - how he presented in terms of what happened to him."

Also, under cross-examination, Dr. Omiyi was asked about the two instances wherein the Petitioner attempted to briefly install a fence post, as well as Petitioner's pre-existing conditions. On redirect examination, Dr. Omiyi testified the Petitioner's pre-existing conditions and brief activities of attempting to install a fence post, did not alter his opinions on causation or necessity of the total knee replacement surgery secondary to the Petitioner's accident at work. Beginning at page 68 of his deposition, Dr. Omiyi was asked the following questions and provided the following answers:

"Q. And counsel asked you a series of questions about other conditions, and I'll just go through those and ask you a question.
If the patient reported a history of his knee not going straight after an ACL surgery 18 years ago, having had ankle surgery in the past, a changed gain, walking on the balls of his feet, a varus deformity, and weighing 270 pounds, and having a Grade 4 osteoarthritis, taking into account if those conditions and facts are true, would that alter your opinion that you voiced in answer to my questions on causation and necessity of surgery relative to the work accident on August 27 of 2017, doctor?
A. No, that would not change my opinion.
Q. Okay. And if he did have some level of pain from the incident of working on a fence on two different occasions as described by counsel, would that alter your opinion on the

causation of the need for a total knee replacement surgery and its relationship to the accident on August 27 of 2017, in your opinion?
A. No, it would not."

With respect to Dr. Nogalski's opinions, the Arbitrator notes that even Dr. Nogalski concedes that the Petitioner suffered an injury to his knee on August 27, 2017 and that it was reasonable for the Petitioner to receive treatment from Dr. Rudert, as well as Dr. Omiyi, that was traceable to the work injury. Dr. Nogalski acknowledged that the Petitioner had a positive McMurray sign in his left knee following the trauma of the accident, as well as a positive patella femoral grind. Dr. Nogalski also acknowledged that there was no documented finding of either prior to the time of the accident. (Nogalski deposition pg. 22-23.) Dr. Nogalski further conceded, at a minimum, that the Petitioner required arthroscopic surgery on his knee secondary to the August 27, 2017 accident. (Nogalski deposition pg. 25.)

Ultimately, the issue of causation and necessity of total knee replacement surgery, relative to the accident on August 27, 2017, is a medical dispute between Respondent's IME and Petitioner's treating surgeon. Dr. Omiyi's explanation for the necessity of a total knee replacement and its causal relatedness to the work accident is persuasive. Dr. Omiyi was intimately familiar with the Petitioner's condition based upon the many office visits and procedures he performed upon the Petitioner.

At page 30 of his deposition, Dr. Nogalski was asked:

"Q. Do you know how much time you spent with Mr. Belongia?
A. Uh.
Q. If you remember.
A. It - - its been too long ago. I can't remember. I think the answer is enough as far as I'm concerned."

When asked how much time he devoted to this case, Dr. Nogalski responded:

"Q. In this particular case, how much time have you devoted to preparing your reports and examining the patient if you know?

A. I don't know. I have about an inch worth of records.
Q. Okay.
A. I'd estimate that I'd spent about - - about an hour reviewing records."

Dr. Nogalski further testified that approximately ninety percent of his IME(s) are at the request of a respondent or the defense. When asked if the percentage was, in fact, higher, Dr. Nogalski responded:

"Q. Would that percentage actually be closer to 98 to 99 percent for the defense over the past 2 years?
A. No, I wouldn't say so.
Q. When was the last time you performed an IME at the request of the Plaintiff or his attorney?
A. Um.
Q. If you can remember.
A. I honestly can't sitting here. I can't - -
Q. That's fair enough.
A. - - come up with one. Sorry."

Accordingly, the Arbitrator orders Respondent to pay the two remaining bills for treatment with Dr. Omiyi in the respective sums of $589 for date of service 11/16/2018 and $658 for date of service 03/06/2019 which Dr. Omiyi found were related to the accident. The Arbitrator further orders the Respondent to authorize and pay for prospective medical treatment in the form knee replacement surgery as recommended by Dr. Omiyi subject to the terms and conditions of the fee schedule.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura E. Guroian,

Petitioner,

vs. NO: 14 WC 29130

Northwestern Memorial Hospital,

Respondent.

20IWCC0522

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision, which delineate the relevant facts and analyses. However, as it pertains to permanent disability, the Commission views the evidence differently than does the Arbitrator and modifies the awards as stated below.

The record reflects that on September 19, 2013 Petitioner, employed by Respondent as a Cardiac Sonographer at the time, suffered an injury to her left hand while scanning the breast area of a patient. She was subsequently diagnosed with a left hand strain and placed on work restrictions. After a brief reprieve, Petitioner's symptoms escalated and she was soon diagnosed by Dr. Rimington with trigger finger of the left small finger and ulnar nerve entrapment of the wrist. Petitioner was treated with testing, injections, medication and physical therapy.

By August 22, 2014 Petitioner still had pain in the small finger flexor tendon sheath. Pain increased when performing ultrasounds and she also had limitations performing activities of daily living. She had pain and swelling in the hand with strenuous activity, especially grasping and twisting activities. Dr. Rimington opined that conservative care had failed and discussed surgical intervention with Petitioner, who exhibited no interest in the same. Dr. Rimington thus recommend no further treatment and released Petitioner at maximum medical improvement ("MMI") with a return to work, but restricted from performing ultrasound exams.

Petitioner subsequently worked administratively for Northwestern University until mid-May of 2015 when she testified she moved to Florida for a warmer climate, which provided optimal physical therapy. In the interim, Petitioner consulted with Dr. Gewirtz in Stamford Connecticut, followed by treatment with Dr. Patel at the Cleveland Clinic. Petitioner testified that she was still seeking answers for her condition, which was not improving. On March 4, 2015, the Cleveland Clinic noted Petitioner had left hand pain in a band-like distribution on the palmar ulnar aspect. Petitioner described the pain as burning and tightness. Pain was episodic and provoked by the use of her left hand and is exacerbated by physical activity or heavy lifting. Petitioner was diagnosed with neuropathic pain of the left hand. Medication and physical therapy was prescribed.

On April 5, 2016 Petitioner underwent a section 12 exam ("IME") at Respondent's request with Dr. Fernandez. Dr. Fernandez diagnosed left hand pain and dysfunction of unknown etiology, and found no objective justification or explanation which would enable him to diagnose Petitioner's condition. He released Petitioner to full duty.

II. CONCLUSIONS OF LAW

As pertaining to permanent disability, the record reflects that Petitioner suffered a work-related accident on September 19, 2013. Accordingly, a determination of permanent disability under section 8.1b of the Act must follow.

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.* Specifically, Section 8.1b states:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria.

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

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

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

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

With regard to subsection (i) of § 8.1b(b), the record reflects that IME physician Dr. Fernandez determined an impairment rating of 0% given the lack of objective findings and his exam of Petitioner. However, Dr. Fernandez acknowledged that impairment is different than disability. Accordingly, the Commission gives moderate weight to this factor.

With regard to subsections (ii) of § 8.1b(b), the record reflects that Petitioner was a Cardiac Sonographer, but has been unable to return to her pre-injury position. The Commission gives moderate weight to this factor.

With regard to subsection (iii) of § 8.1b(b), Petitioner was 29 years old at the time of accident. Thus Petitioner has over three decades before reaching normal retirement age and will have to live and work with the residual effects of her injury for that time. The Commission gives significant weight to this factor.

With regard to subsection (iv) of § 8.1b(b), the record reflects that Petitioner did not attempt to return to work as a cardiac Sonographer after being released to full duty by IME physician Dr. Fernandez. Further, the record reflects that Petitioner's earnings at her subsequent employment with Northwestern University was comparable to that of a Cardiac Sonographer. The Commission gives little weight to this factor.

With regard to subsection (v) of § 8.1b(b), Petitioner still complains of pain, swelling and stiffness with anything requiring sustained force or pressure or fine motor skills with her left hand, as well as anything requiring rotational activity. She has hand weakness and periodically gets excruciating pain and stiffness for no reason. She can make a fist but would have difficulty making a fist and holding a transducer with sustained pressure. She runs her hand under hot water for relief, or wraps it. Petitioner's testimonial complaints are corroborated by her most recent medical records with Dr. Rimington and those of the Cleveland Clinic. The Commission gives significant weight to this factor.

The Commission hereby incorporates by reference the Arbitrator's analysis of subsections (i) through (iv) of § 8.1b(b) of the Act. However, upon analyses, the Commission views the evidence

differently and finds that Petitioner has suffered injuries causing a 35% loss of use of her left hand.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner sustained permanent injuries to the extent of a 35% loss of use of her left hand under section 8(e)(9) of the Act, thus she is entitled to permanent disability benefits of $721.66/week for a period of 71.75 weeks.

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 $51,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 16 2020
o:7/23/20
SJM/wde
45

Stephen J. Mathis

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUROIAN, LAURA E
Employee/Petitioner

Case# **14WC029130**

NORTHWESTERN MEMORIAL HOSPITAL
Employer/Respondent

20IWCC0522

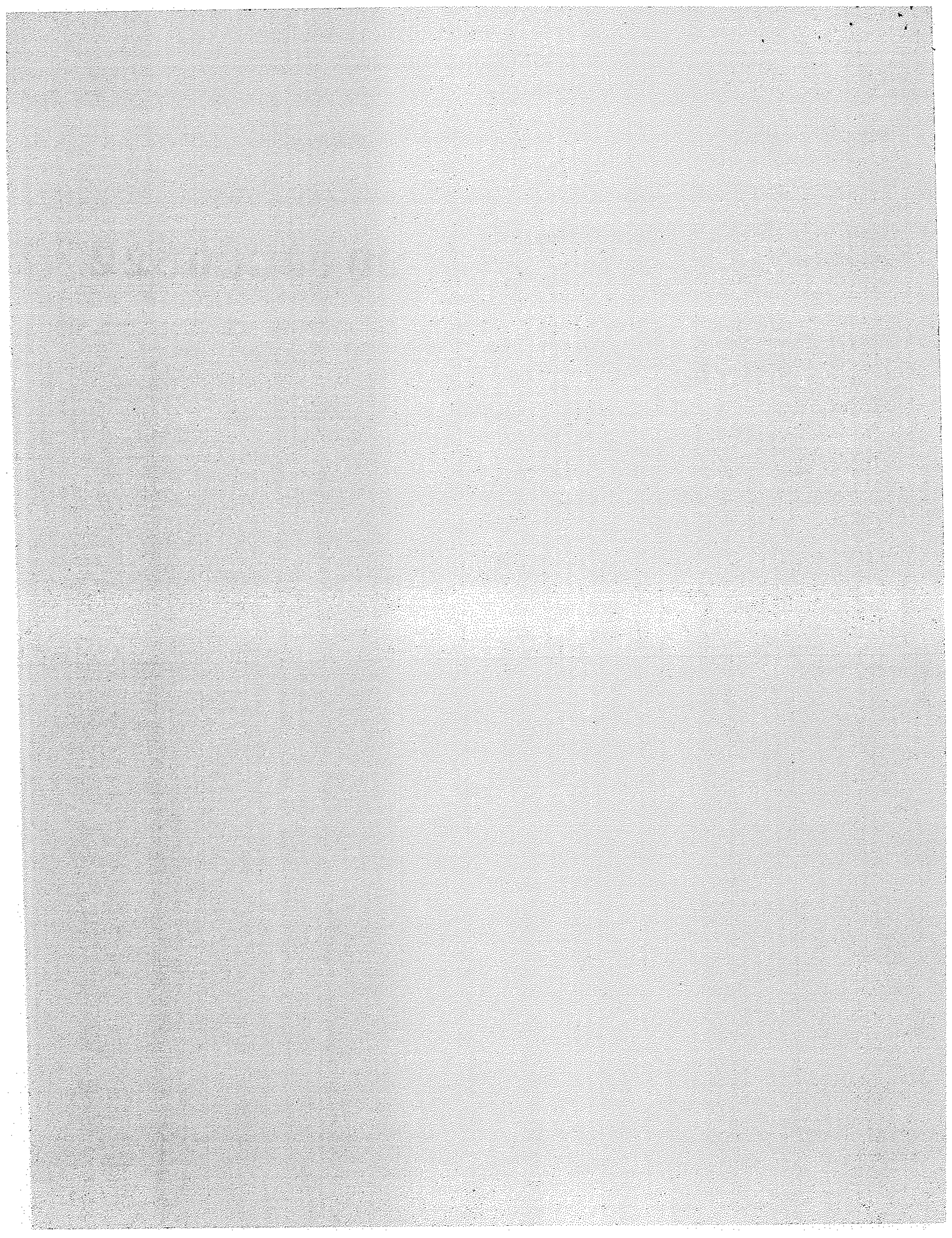
On 4/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195



STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LAURA E. GUROIAN,
Employee/Petitioner

Case #14 WC 029130

v.

20IWCC0522

NORTHWESTERN MEMORIAL HOSPITAL,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JEFFREY HUEBSCH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **December 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 **9/19/2013**, 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 **$71,177.60** ; the average weekly wage was **$1,368.80**.

On the date of accident, Petitioner was **29** 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 **$7,300.56** for TTD, **$14,835.86** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$22,136.42**. The Parties stipulated that all TTD and TPD owed by Respondent has been paid and neither party claims aany overpayment or underpayment of said benefits.

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

Order

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 20.5 weeks, because the injuries sustained caused the 10% loss of use of Petitioner's left hand, as provided in section 8(e) of the Act.

Respondent shall pay Petitioner all compensation benefits that have accrued from September 19, 2013 to December 6, 2018 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

April 5, 2018

Date

APR 8 - 2019

FINDINGS OF FACT

Petitioner was employed by Respondent as a cardiac sonographer. She is left handed. Her job duties included performing echocardiograms according to a standardized protocol. She uses an ultrasound machine and is required to move patients. Petitioner went to cardiac ultrasound school in Hartford, Connecticut. Her educational background includes a BS in Biology, as well as a Master's degree in Exercise Physiology.

The cardiac sonographer job is a highly skilled position. The sonographer is required to move the ultrasound machine and manipulate a transducer, or probe, to acquire images. Petitioner has to use sustained pressure and force on the patient's body, while manipulating the probe with fine motor movements. She grips the probe with her 4th and 5th fingers and rotates and twists the probe. She feels pressure on her hand wrist and arm when performing her job tasks. She testified she was required to move parts of patients' bodies as well as to move the machine. During the course of an echocardiogram, she would take 100 to 120 images.

The Parties stipulated that on September 19, 2013 Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent. Petitioner testified that she performed an echocardiogram of an obese patient and had the stress of having the weight of the patient's breast tissue resting on her left hand, wrist, and arm while using the probe with that hand. She used her right hand simultaneously to operate the machine. She experienced sharp pain in her left hand along the palm of her hand directly beneath the fourth and fifth fingers. She stated it happened quickly and she felt a pulling sensation. She immediately stopped scanning the patient and experienced swelling, discoloration and stiffness. Petitioner had excruciating pain and so advised her manager. She went to Corporate Health to file an incident report and receive treatment.

Petitioner received treatment at Corporate Health (RX 4) and was referred to Dr. David Kalainov, MD at Chicago Center for Surgery of the Hand. (PX 1) Dr. Kalainov made an assessment, obtained x-rays, and prescribed physical therapy. She treated with Dr. Kalainov for approximately one month. Petitioner then started treating with Dr. Todd Rimington, MD in early March, 2014. This was Petitioner's choice of physician, after extensive research trying to find the best orthopedic doctor to help identify her issues and what to do about it. Before she saw Dr. Rimington, she experienced pain, swelling, decreased manipulation ability and she could hardly do any daily activity motions such as cutting an apple. Dr. Rimington recommended physical therapy and prescribed medication. Petitioner agreed that Dr. Rimington pronounced her at maximum medical improvement on August 22, 2014. (PX 2, RX 7)

Petitioner then sought treatment with Dr. Harold Gerwitz. The Parties agreed that Dr. Gerwitz suggested that she could seek pain management. Petitioner then presented to the Cleveland Clinic on March 4, 2015. Tests were performed and she received a prescription for Gabapentin and specialized therapy. Petitioner testified that she went to the Cleveland Clinic to seek answers for a condition that was not improving. (PX 4)

Petitioner testified she was paid temporary total disability benefits when she was authorized completely off work and she was also paid temporary partial disability benefits when she worked reduced hours. She testified that before June 14, 2014, she did not perform any ultrasound examinations and only did administrative work. Petitioner stated she was taken off work and received TTD benefits following her visit with Dr. Rimington on August 22, 2014 until September 21, 2014.

Petitioner accepted a database coordinator position at Northwestern University after September 21, 2014. The rate of pay for this position was comparable to her earnings as a sonographer and she worked this job until May, 2015. It was not a physical job. Respondent helped Petitioner to get this job. Petitioner decided to move to Florida to enjoy a warmer climate and optimal physical therapy treatment. Her first job in Florida was at 192 Fitness Club as a manager. Her duties included administrative work, overseeing employees and keeping track of programs at the gym. She performed computer work, took phone calls, oversaw classes for adults and kids and was involved in marketing and advertising. Petitioner testified she applied for many hospital jobs when she arrived in Florida, but was unsuccessful in obtaining same. She currently is the co-owner of Evermore Café in Largo, Florida. She has owned this Café for two years. Petitioner oversees day to day activities, manages the employees, and she will sometimes fill in and take orders using a computer program. She also attends events including expos to market the Café. Petitioner had one other job in Florida when she worked as a hostess seating guests at Ming Court.

When asked on direct examination whether she had treatment for her left hand prior to September, 2013, Petitioner stated she had no medical treatment for her left hand. She testified she had no physical therapy for her left hand and she did not recall taking medicine for her left hand prior to September 19, 2013. Petitioner then testified that she remembered an incident in 2011 where she had to make a Corporate Health report as a preventative measure, but she did not have an injury or time off from her regular job duties. Records from Corporate Health do show some treatment for a left hand strain in 2011. (RX 3)

When asked to describe what she notices about her left hand, Petitioner stated she has things she is not able to do on a daily basis and it is complicated and frustrating since her left hand is her dominant hand. Petitioner said that any sustained force or pressure with her left hand is an issue and she has difficulty with fine motor movement. Specifically, she has problems while pushing a vacuum cleaner on carpet. She stated she is not able to use her hand in a normal fashion hand due to stiffness, redness, and swelling. She has difficulty driving due to gripping a steering wheel for prolonged periods, as well as opening a door handle. The area where she experiences pain is along her palm and below the fourth and fifth fingers. She has episodes approximately every six weeks, late in the evening where she experiences pain, stiffness and limited function of her fingers. She then places her hand in hot water and this helps. Petitioner does not take any medication and has not taken medication since it was last prescribed by her doctors.

On cross-examination, Petitioner agreed her pain occurred after performing cardiac sonography on an obese patient on September 19, 2013. She said that she did not have problems with her left hand the day prior to September 19, 2013. When asked if she had any reason to dispute the accuracy of the Corporate Health records which state that her left hand problems started on September 18, 2013,

Petitioner said that she thought the records were accurate. When questioned about whether she performed ultrasound exams prior to June 14, 2014, Ms. Guroian first indicated that she was unsure and then admitted that she did not perform complete scans, but she tried to perform test scans on a trial basis per Dr. Rimington's recommendations. Petitioner agreed that she last saw Dr. Rimington on August 22, 2014. She disagreed that Dr. Rimington recommended surgery and that she declined to undergo surgery.

Petitioner testified she was not part owner of 192 Fitness with Nazim Ali. She agreed that she co-owns Evermore Café with Mr. Ali. She testified she first met Mr. Ali in 2008 in Connecticut when she attended a Tai Chi class taught by him. She stated that she knew Mr. Ali lived in Florida.

When asked whether she had any work restrictions after the incident she reported in 2011 to Corporate Health, Petitioner denied having any work restrictions or physical therapy for that incident and claimed she continued to perform her full duties as a cardiac sonographer. She testified she is able to put her hand in a fist and she did attend fitness classes at 192 Fitness when she worked there including Zumba, yoga and kickboxing class. She stated she avoided exercises that caused a problem with her left hand. She currently does not take a salary while working at Evermore Café.

Petitioner testified that she applied for a variety of jobs at Florida hospitals but has not found such work. She has made multiple attempts over the years to reinvent herself.

Petitioner agreed that she was pictured in Respondent's surveillance video. She stated she was carrying a plastic shopping bag with a manila envelope containing three pieces of paper in her left hand along with a plain silk short dress on a metal hanger. (RX 6) She also admitted she is included in a picture on the website for 192 Fitness in a boxing ring with other people. (RX 10a) Petitioner also agreed that she is depicted in another picture included in an article about Evermore Café from the Tampa Bay Times where she is leaning against a counter with her left hand on the counter. (RX 10b)

Medical Treatment prior to September 19, 2013:

On April 12, 2011, Petitioner presented to Corporate Health Services reporting a strain to her left hand while scanning a patient on April 9, 2011. (RX 3) She stated that she overexerted her left hand while struggling to get images as the patient was not cooperative. She wanted to allow the area to rest. Upon examination, Dr. Samo noted full strength, no swelling, minimal discomfort of the mid-dorsal musculature, and full range of motion. He restricted Petitioner to light duty with no use of the left upper extremity, no lifting, pushing, or pulling, and no repetitive use of the wrist, hand or elbow. Dr. Samo prescribed a wrist splint and Advil. Petitioner returned to Corporate Health Services on April 15, 2011. She had not been working since April 12, 2011, due to restrictions. She asked to return to work performing limited scans the following week. Dr. Joseph Mitton recommended she rest for the next few days and return to work on April 18, 2011, performing four scans per shift, or half of the normal number. (RX 3)

As of April 20, 2011, Petitioner reported improvement and had returned to work, performing four scans on April 18, 2011. Dr. Cullen noted that her exam was normal and released her to perform 6 scans as

of April 21, 2011 and to continue advancing the number of scans to full duty. Petitioner returned to Corporate Health Services on May 11, 2011. She reported mild discomfort, but denied further pain in the wrist/hand. She performed seven to eight portable scans/shift or five stress echos/shift, which is the normal number. Dr. Mitton discharged her and instructed her to return if her symptoms worsened. (RX 3)

Medical Treatment beginning September 19, 2013:

Petitioner presented for treatment at Corporate Health Services on September 19, 2013. (RX 3) She reported a history of left hand pain due to scanning 4 obese patients in a row on September 18, 2013. Her left hand hurt and was swollen since yesterday and she scanned one patient today when it hurt to grasp the transducer. She felt she is unable to do her job. Upon examination, Dr. Cullen noted mild swelling in the left hand on the ulnar aspect of the fifth metacarpal was appreciated. Full extension and flexion of the wrist and fingers was noted. Dr. Cullen diagnosed Petitioner with a left hand strain and restricted her from heavy grasping or gripping with the left hand. (RX 3)

On September 23, 2013, Petitioner returned to Corporate Health Services reporting increased pain with gripping and extending the left hand. She stopped taking over the counter anti-inflammatories. Upon examination, she reported pain with forced flexion and extension of the left fifth finger. The doctor noted mild edema along the left palmer aspect and slightly decreased grip strength. Dr. Gustas prescribed a Medrol Dosepak. On September 30, 2013, Petitioner returned to Corporate Health Services reporting decreased left hand pain. She had not been performing her regular duties for one week. She exhibited full range of motion of her fingers, thumb, and wrist without pain. Dr. Gustas released her to return to work full duty and instructed her to follow-up in three days. (RX 3)

Petitioner returned to Corporate Health Services on October 3, 2013, reporting increased left hand pain after performing her full duties. Moderate tenderness to palpation was noted on the fifth MCP joint. Left hand x-rays were normal. Dr. Munoz diagnosed her with a left hand strain, restricted her from heavy grasping or gripping with the left hand, and referred her to Dr. David Kalainov, a hand surgeon. (RX 3)

On October 7, 2013, Dr. Kalainov examined Petitioner. (RX 4) He noted that she is a left hand dominant cardiac sonographer who was seen in consultation for management of left hand pain. She first experienced pain and swelling after performing cardiac sonography on four patients approximately three weeks earlier. She stated that she is required to lift, push, and press with her left hand during these evaluations. Her treatment included ice, one Medrol Dosepak, Aleve, and activity modification. Her pain had subsided, but was not completely resolved. She experienced an exacerbation of pain when she attempted to scan a patient the week before. She was no doing office work, rather than her sonography duties. She did note that she had pain in the ulnar aspect of her left wrist approximately three years earlier that resolved with rest, ice and an anti-inflammatory. Her pain was similar in character, but different in location. The patient noted that she exercises regularly using a treadmill, weight training, and kick boxing. The doctor noted subtle swelling around the fifth metacarpal, but no signs of Complex Regional Pain Syndrome. She exhibited full range of motion of both wrists. Pain was elicited with palpation over the left small finger extensor and flexor tendons around the fifth

metacarpal. The fifth carpal metacarpal joint was minimally tender. X-rays of her left hand were normal. Sensation was intact. Dr. Kalainov diagnosed Petitioner with flexor tendonitis of her left hand. He restricted her to light duty work with limited use of her left hand and she was instructed to avoid ultrasonography tasks with the left hand. He also recommended hand therapy two days a week. (RX 4)

Dr. Kalainov re-examined Petitioner on October 21, 2013. She denied any further improvement in her left hand. She did have some partial pain relief with application of the Voltaren gel and warm hand soaks. She continued working restricted duty. Dr. Kalainov restricted her to light duty work again and instructed her to avoid sonography work with the left hand. He prescribed Voltaren Gel, occupational therapy, and ice. He noted that MRI studies may be necessary or a local steroid injection if she did not improve. (RX 4)

Petitioner began occupational therapy on October 22, 2013. She reported pain with soft tissue massage. She attended a second session on October 29, 2013, with no improvement of her pain. The therapist eventually provided a volar wrist orthosis at a visit on November 7, 2013. (RX 4)

On November 11, 2013, Petitioner returned to Dr. Kalainov. A light duty position at work was not available. She did report some improvement with application of Voltaren gel. Upon examination, Dr. Kalainov noted some pain with palpation of the small finger extensor and flexor tendons around the 5th metacarpal shaft with no triggering or tendon subluxation. Dr. Kalainov recommended activity modification, Voltaren gel, ice and occupational therapy. He instructed Petitioner to avoid sonography work with the left hand and limit lifting to two pounds with the left hand. Petitioner continued to attend occupational therapy over the next few weeks. (RX 4)

Petitioner returned to Dr. Kalainov on December 4, 2013. She reported increased pain during her second week of light duty activities when she returned to work. Her exam was unchanged. Dr. Kalainov diagnosed her with tendonitis of the left hand. He recommended that she discontinue formal therapy, as there was no benefit at that point. Her work restrictions remained the same. He referred her for MRI studies of the left hand. (RX 4)

On December 24, 2013, Petitioner underwent left hand MRI studies. The results revealed fifth MCP joint effusion with mild tenosynovitis of the flexor tendon at the level of the distal fifth metacarpal. (RX 4)

Dr. Kalainov re-examined Petitioner on December 26, 2013. The doctor noted that tenosynovitis was likely the source of most of her pain, as there was nonspecific swelling along the fifth MP joint according to the MRI. Petitioner elected not to undergo a steroid injection. Dr. Kalainov recommended a trial return to sonography examinations, limiting her to four examinations a day. (RX 4)

Petitioner presented to Dr. Todd Rimington on January 7, 2014. (RX 7) She stated she did multiple studies on obese patients on September 19, 2013, when she developed pain in her left hand. She denied improvement with therapy and reported that she had no issues with her left hand prior to this injury. Upon examination, she had mild swelling along the small finger. She complained of tenderness with

full resisted flexion and her grip strength was weak. Dr. Rimington noted mild clicking with flexion-extension of the small finger. He diagnosed her with left small finger flexor tenosynovitis. He recommended an injection, which he administered, and hand therapy two to three times a week for 4 weeks. A follow-up visit was scheduled in three weeks. (RX 7)

On January 14, 2014, Petitioner presented for an initial occupational therapy visit. She reported excruciating pain on September 19, 2013 while performing multiple echos. Dr. Rimington had recently administered an injection and she had pain after, which has subsided. The therapist planned to work on her sustained grip, as Petitioner expressed concern about returning to work. (RX 7)

On January 28, 2014, Petitioner was seen by Dr. Rimington. Her pain improved approximately one week after the injection. She also completed three therapy sessions and reported improvement. She had been working light duty. She reported difficulty with gripping and grasping activities and she was unable to lift anything with significant weight. She was minimally tender at the MP joint. There was some mild tenderness along the small finger. Dr. Rimington noted that she was improved status post injection and therapy. He recommended therapy three times a week for four weeks and a follow-up visit was scheduled in one month. He continued her light duty work restriction for one additional month. Petitioner continued to attend occupational therapy. (RX 7)

Petitioner returned to Dr. Rimington on March 3, 2014. She reported progress with therapy, but had a setback after doing too much over the last week. He prescribed Naprosyn, Voltaren, and additional therapy. She continued to attend therapy. Dr. Rimington evaluated Petitioner on March 28, 2014. She had not performed an ultrasound exam, but had been lifting about two pounds. He recommended she stop therapy and return to work full duty for two hours a day with light duty the rest of the day. The second week, he recommended she work full duty six hours a day full duty with light duty the rest of the day. Petitioner was to follow-up in two weeks. (RX 7)

On April 11, 2014, Petitioner returned to Dr. Rimington and reported she was unable to perform ultrasound examinations. He explained to her that the clinical appearance of her hand was okay and recommended she work light duty. She planned to try to do some ultrasound exams before her next visit in one month. (RX 7)

Petitioner then presented to Dr. Rimington on May 9, 2014. She reported severe pain while performing ultrasound exams. Dr. Rimington recommended EMG studies to evaluate ulnar nerve compression at the wrist at the Guyon's canal. He instructed Petitioner to continue working light duty. (RX 7)

On May 22, 2014, Petitioner underwent EMG studies. The results were normal. She than saw Dr. Rimington on June 9, 2014. Her grip strength increased to 70 pounds on the left compared to 65 pounds on the right. The EMG studies were not available, but Dr. Rimington released her to return to work for a half-day working full duty and the other half day working light duty for two weeks and then instructed her to resume her full duties. (RX 7)

On July 7, 2014, Dr. Rimington re-examined Petitioner. She had returned to work full duty and noted that her left hand started swelling and becoming painful after she performed an ultrasound on the

second patient. She was ultrasounding 3-4 people per day. She reported that she had been doing more administrative work and less ultrasound scanning the last week, with resolution of her pain. Dr. Rimington diagnosed her with trigger finger and ulnar nerve entrapment at the wrist. He noted that she was unable to tolerate full duty at work with a full day of ultrasound work. Petitioner reported that she had not been performing her normal workout routines. Dr. Rimington recommended full duty work for a half day and the other half day at restricted duty. Dr. Rimington also recommended lab work to rule out any inflammatory conditions such as rheumatoid arthritis or another vascular disease. He also noted that Petitioner may not be able to return to full duty work as an ultrasonographer. (RX 7)

On July 25, 2014, Petitioner returned to Dr. Rimington and noted that she was performing ultrasound tests with severe pain. She stated that she could not bend her fingers for three days. She regained function in the fingers, but had significant swelling and difficulty bending. Dr. Rimington noted mild swelling along the left small finger flexor tendon sheath. There was no active triggering. Her lab work revealed that her C-reactive protein was abnormal. Dr. Rimington's notes reflect that he discussed treatment options to include a repeat injection or an A1 pulley release. He noted that she may have to stop performing ultrasound exams at this point. He recommended that she follow-up in one month to determine if she wanted to proceed with surgery or he would declare her at MMI. (RX 7)

On August 22, 2014, Petitioner presented for a final visit with Dr. Rimington. She had worked light duty, without doing exams for one month. She still had some pain in the left hand along the flexor tendon sheath. This increased with ultrasound exams. She had not performed any exams since her last visit. She also had some pain during normal daily activities as well as athletic activities. Dr. Rimington explained to Petitioner at this point that surgical treatment would involve a release of the A1 pulley of the small finger and at the same time he would biopsy the flexor tenosynovium to evaluate for a pathological diagnosis for the persistent swelling. He did not believe another injection would cure her symptoms. After discussing the details of surgery, Petitioner decided not to undergo surgery. Dr. Rimington released her to return to work with the restriction of no ultrasound exams. He pronounced her at maximum medical improvement as of August 22, 2014. (RX 7)

Petitioner presented to the Cleveland Clinic on March 4, 2015 with complaints of left hand pain. (PX 4) She described her pain as burning with tightness and rated her pain at a 6 on a scale of 10. Physical activity or heavy lifting exacerbated her pain. She reported an occasional tremor in her left hand. Upon examination, she exhibited interosseous motor weakness which the doctor attributed to disuse atrophy. She reported that her past medical history was significant for reflex sympathetic dystrophy. Dr. Patel applied the Budapest criteria and noted that she did not have CRPS. He diagnosed her with neuropathic pain of the left hand and CRPS susceptibility. Dr. Patel recommended that she take Gabapentin and attend specialized hand therapy at RIC. (PX 4)

There has been no further medical treatment after Petitioner's visit to the Cleveland Clinic.

Deposition Testimony of Dr. John Fernandez:

Dr. John Fernandez examined Petitioner for purposes of an independent medical examination on April 5, 2016. The Parties took his evidence deposition on September 21, 2018. (RX 2) Dr. Fernandez testified he is licensed to practice medicine in the State of Illinois. He is a board certified orthopedic surgeon and has a certificate of added qualification. Dr. Fernandez stated he is certified to provide impairment ratings according to the Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment. Dr. Fernandez concentrates his practice on hand, wrist, and elbow conditions. In addition to performing independent medical examinations, about one third of his practice involves treating patients who have had work injuries.

Dr. Fernandez testified that he examined Petitioner on April 5, 2006. He reviewed medical records, EMG studies, and the MRI report (he did not review the film). Dr. Fernandez has an understanding as to what job duties are required for a cardiac sonographer and he has observed a person performing this job. Dr. Fernandez noted that the incident described by Petitioner in the records was not a sudden trauma or event, but rather is more attributable to the fact she was doing echocardiograms on larger or obese patients. At the time of his examination of Petitioner, it was his understanding that she worked as a hostess and she felt that she could not return to work as an echocardiogram technician.

Petitioner reported intermittent swelling. She told Dr. Fernandez that she moved to Florida, as she had more pain and more swelling when exposed to a cold climate. She reported that it did not matter if she was inside and warm or if she was outside and it was cold, because she had similar problems as long as she was in a cold climate. She informed Dr. Fernandez she engaged in aerobic activities including using the treadmill and elliptical, weightlifting, and martial arts, but she did not engage in those to a significant degree, due to her problems. Dr. Fernandez testified he obtained x-rays on the date of his evaluation and they were normal.

Dr. Fernandez took temperature readings of Petitioner's hands bilaterally, tested two-point discrimination, and observed her hands to determine if there were any asymmetric findings evident. He did not observe any atrophy, but she did report pain to very deep palpation along the ulnar palm at the base of the fifth metacarpal. She subjectively reported weakness. There was no tenderness at the A1 pulley, no locking, and no triggering. Dr. Fernandez was unable to come up with a diagnosis for her reported pain to deep palpation at the ulnar base. He ultimately diagnosed her with left hand pain and dysfunction of unknown etiology, which he admitted was more of a descriptive diagnosis, as he was unable to come up with a reason or diagnosis for her complaints. With regard to the MRI findings of tenosynovitis, Dr. Fernandez noted that she did not have findings consistent with tenosynovitis on his exam in April 2016 and the MRI had been done in 2013, which was almost three years prior. She had no pain at the A1 pulley, there was no triggering or locking, and there was no fusiform swelling along the flexor tendons or crepitus to suggest findings consistent with tenosynovitis when he saw her on April 5, 2016. Petitioner told Dr. Fernandez that she "was never told that surgery could cure or treat this," even though Dr. Rimington indicated he spoke with her about surgery. The Arbitrator will assume that Dr. Rimington, as a competent orthopedic surgeon, offered Petitioner the option of surgery, which is not inconsistent with Petitioner's statement to Dr. Fernandez or with her testimony that no one recommended surgery.

Dr. Fernandez testified there was a mismatch in terms of severity of Petitioner's complaints and reported dysfunction and what he noticed on an objective basis. He said that she did have a positive finding when bloodwork was obtained of an elevated C-reactive protein, which could be an indication of underlying systemic disease like inflammatory arthritis, as well as some reported eczema or plaque on her hands, which could be further indication of an underlying systemic condition. Dr. Fernandez does not think that Petitioner is a faker, but he did not have an explanation for the severity of her pain or dysfunction.

Dr. Fernandez noted that by giving Petitioner the full benefit of the doubt, she may have had temporary tenosynovitis which was not present on April 5, 2016, so he could not relate her current state as of April 5, 2016 to anything work-related. He noted that if she wanted to have any further work-up, she could do so, but this would not be related to her alleged work injury. Dr. Fernandez testified that the initial evaluation and initial treatment as well as the shot that she got from Dr. Rimington and those initial restrictions would have been reasonable and work-related, but after that initial treatment, it would not have been work-related any longer. Dr. Fernandez testified that when he saw her on April 5, 2016, he was of the opinion that she was capable of working as a cardiac sonographer and working in her previous capacity. She has the capacity to do her prior job without risk or danger. She reported pain complaints and felt that she could work as a cardiac sonographer. From a medical standpoint, he noted there was no explanation why she could not perform those job duties, as she physically had the capacity to engage in those activities without risk or danger.

Dr. Fernandez testified about the impairment rating that he prepared after his initial IME on April 5, 2016. An impairment rating is derived from a combination of the history from the patient, the DASH score, clinical studies such as the EMG, MRI, and x-rays, as well as the physical examination. Dr. Fernandez discussed the tables he used to arrive at the impairment determination. Dr. Fernandez noted that Petitioner did not have any loss of motion, so he could not give her an impairment rating based on loss of motion. Even if she had subjective complaints of loss of motion, he still could not apply a rating based on self reported loss of motion. The second way to derive an impairment rating would be based on a neurologic diagnosis, but her EMG was normal, so he could not derive an impairment rating based on compression neuropathy. The third and last component, other than diagnostic based, would be CRPS. When he looked at the CRPS impairment criteria per the Guide,, Dr. Fernandez testified it is strict and even higher than the Budapest criteria. He stated that she would not be able to be rated based on CRPS, per the Guide, and she did not have CRPS.

Dr. Fernandez testified that an examiner could rate her through her diagnosis in two ways. One could come to the conclusion due to a nonspecific diagnosis, such as a person who has complaints which result in nonspecific hand pain post-acute injury or surgery not otherwise specified. Dr. Fernandez testified even if you argue she did not really have an acute injury, this would be the closest diagnosis you could come up with in the book. He stated that the other way to rate her would be to give her a diagnosis such as a tendon problem, like trigger finger or A1 tenosynovitis and apply the tables through that diagnosis. Dr. Fernandez testifieded that he rated her both ways.

Dr. Fernandez applied different ways to evaluate Petitioner's impairment and arrived at the same result, 0% impairment. Petitioner was placed in Class 1 with a default rating of 1% of the digit. This

would be the best possible average impairment of 1% of her finger. Dr. Fernandez testified it would then force you to apply her functional status which would be the DASH, as well as things like clinical studies and the physical exam and then you adjust that number. He then applied the class of impairment, whether it be soft tissue digit, soft tissue tendon, and adjusted it and her rating went back to a 0% impairment rating. (RX 2)

CONCLUSIONS OF LAW

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

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 her employment and the 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)

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding her left hand (to wit: left hand small finger flexor tenosynovitis at MMI as of 8/22/2014 per Dr. Rimington, with option of surgery to release the A1 pulley of the small finger with concurrent biopsy of the flexor tenosynovium to evaluate for pathological diagnosis regarding persistent swelling, with restriction of no ultrasound exam work, additionally with diagnosis of neuropathic pain of left hand and CRPS susceptibility per Dr. Patel) is causally related to the injury.

This finding is based upon the testimony of Petitioner, which is found to be credible, and the treating medical records.

The bottom line is that Petitioner did not return to work performing cardiac ultrasounds after being released from care by Dr. Rimington and her left hand condition appears to have gotten better. Dr. Fernandez's diagnosis of left hand pain and dysfunction of unknown etiology is considered, but the fact is that he examined Petitioner more than 2 years after she stopped performing cardiac ultrasounds. Dr. Fernandez also endorsed that Petitioner at least had a symptomatic tenosynovitis condition, with additional effusion at the 5th MC joint in 2014 and he does not consider Petitioner to be a faker.

The records of Corporate Health, Dr. Kalainov and Dr. Rimington support a finding of causation and do not undermine same. From a completeness standpoint, perhaps the recommended therapy at RIC might have demonstrated a complete recovery, but this treatment was not pursued. Further, Petitioner did not follow up on Dr. Fernandez's full duty release to return to work as a cardiac sonographer. If she had attempted return to work and the symptoms did not intensify, then her condition could have been said to have resolved.

The inconsistencies in the exact onset of Petitioner's complaints: gradual?; gradual and then a specific onset after the last obese patient? are not significant enough to persuade the Arbitrator to determine no causal connection. The Arbitrator also considered Petitioner's testimony regarding a prior left hand injury and the records of Corporate Health. These factors are not significant enough to determine no causation, especially in light of the Arbitrator's finding regarding the credibility of Petitioner's testimony.

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

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

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

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

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

No single enumerated factor shall be the sole determination 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 Dr. Fernandez' permanent partial disability impairment report and his deposition testimony were admitted into evidence. Dr. Fernandez explained how he arrived at a 0% impairment rating given the lack of objective findings, the normal diagnostic findings, and his examination of Petitioner on April 5, 2016. Of course, impairment is different than disability. This factor is given moderate weight in determining PPD.

With regard to subsection (ii) of § 8.1b(b), the Arbitrator notes that Petitioner testified that she attempted to return to work as a cardiac sonographer in 2014 and was unable to do so. The Arbitrator assigns some weight to Dr. Fernandez's opinion that there was no objective evidence on exam in April 2016 which would prevent her from returning to work as a cardiac sonographer. Since 2014, Petitioner worked as a research technician (with no loss of wages) and then she chose to relocate to Florida where she has worked as a manager of a fitness club and a hostess. Currently, she is part owner of a café in Florida. Petitioner admitted that she has "made multiple attempts to reinvent" herself and the café was one of the last attempts to reinvent herself. Of course, she did not attempt to return to work as a cardiac sonographer after being released to work at full duty by Dr. Fernandez, a quite reputable hand surgeon. This factor is some weight in determining PPD.

With regard to subsection (iii) of § 8.1b(b), the Arbitrator notes that Petitioner was 29 years old at the time of the accident. While generally this factor could be given more weight as she is younger and would have to live with the effects of the injury for some time, the Arbitrator assigns less weight to this factor given the lack of objective findings on exam on April 5, 2016 when Petitioner was examined by Dr. Fernandez, suggesting her condition possibly resolved, despite her testimony that she has ongoing difficulty using her left hand. This factor is given some weight in determining PPD.

With regard to subjection (iv) of § 8.1b(b), the Arbitrator notes that Petitioner's testimony regarding subjective complaints could not be attributed to a diagnosis by Dr. Fernandez in April 2016. While Petitioner stated that she could not work as a cardiac sonographer and Dr. Rimington told her to avoid cardiac sonography, the Arbitrator does note that Petitioner did not attempt to return to her skilled position after being released to full duty by Dr. Fernandez. This factor is given slight weight in determining PPD, as the Arbitrator is not convinced that a loss of earning capacity occurred for this well-educated Petitioner.

With regard to subsection (v) of §8.1b(b), the Arbitrator notes that the Petitioner exhibited no objective evidence of ongoing problems at the time of Dr. Fernandez' evaluation on April 5, 2016 and she had no active medical treatment for over a year. The treating records persuade the Arbitrator that disability exists, in accordance with the finding above regarding causal connection. The injury was to Petitioner's left, dominant, hand. This factor is given moderate weight in determining PPD.

Based on the above factors, and the Record as a whole, the Arbitrator finds that the injuries sustained caused Petitioner to suffer the 10% loss of use of her left hand, in accordance with §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose L. Garcia,

Petitioner,

vs. NO: 18 WC 22613

Atlas Staffing, Inc.; Midwest Molding, Inc., American Ins. Co.; and Compensation Trust of Illinois,

Respondents.

20IWCC0523

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) by both the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability, and penalties and attorney 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 (1980).

1. **Causal Connection**

Regarding the issue of causal connection, the Arbitrator ruled that Petitioner's current condition of ill-being was causally connected in part to his injury at work. In particular, the Arbitrator ruled that Petitioner's left shoulder contusion and soft tissue injury to the low back were causally connected but resolved as of October 23, 2018. Petitioner claims that his current condition of ill-being is causally connected to his accident. Respondent contends that Petitioner's condition of ill-being is not causally related after October 23, 2018 as found by the Arbitrator.

In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205. Our supreme court has held that "medical evidence is not an essential ingredient to support the conclusion of the [Commission] that an industrial accident has caused the disability," but rather, "[a] chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in a disability" may be sufficient to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

In this case, Petitioner claims that his condition of ill-being is causally connected, and remains, causally connected to his injury at work beyond the date determined by the Arbitrator based on a chain of events theory. Although Petitioner had a motorcycle accident in 2016 and sought brief follow-up treatment in 2017, Petitioner was working full-duty for Respondents prior to the stipulated accident. Petitioner claims that he worked long hours at a physically demanding job for Respondents without restrictions and that Respondents provided no medical evidence that Petitioner continued to experience low back pain affecting his right leg. In contrast, following the accident, Petitioner was disabled for some period of time, as even the Section 12 examiner concluded.

The Arbitrator's ruling on causal connection does not contest the chain of events. Rather, the finding of partial causal connection is based on three factors: (1) the initial treatment record was not submitted into evidence; (2) Petitioner's credibility was diminished; and (3) the opinions of the Section 12 examiner, Dr. Gleason, were persuasive. The Commission addresses these factors in turn.

The Arbitrator correctly notes that the missing initial treatment record may have corroborated or undermined Petitioner's claim. However, Dr. Gleason, the Section 12 examiner in this case, testified that he reviewed an Advocate record for July 2 reflecting that Petitioner reported that a heavy weight fell on his shoulders and indicating injuries to the left neck, left shoulder, upper back and left leg. Although this record purportedly contained no findings regarding the spine and lower extremities, Advocate's records for July 3, 2018, which were in Respondent's possession, contained diagnoses of a left shoulder contusion and lumbar strain, with complaints regarding neck, back, left leg, and hip bone pain. The medical records thus establish that the symptoms at issue in this case were known on the day or day after the accident.

The Decision is also based on the Arbitrator's opinion that Petitioner's credibility was diminished by his representations regarding his immigration status and his failure to mention his prior motorcycle accident. Petitioner's representations regarding his immigration status arguably might bear on his claim for temporary total disability benefits. The fact also remains that Petitioner failed to mention his motorcycle accident to treating doctors and the Section 12

examiner. However, neither directly bears on the substance of Petitioner's claim regarding his current condition of ill-being. Petitioner consistently complained of pain regarding his left neck, left shoulder, upper back and left leg. He was diagnosed with cervical and left shoulder dysfunction, and later with a lumbar sprain/strain, cervical sprain/strain and left shoulder tendonitis. His work status notes and accompanying patient care records indicated a diagnosis of lumbosacral sprain. Even Dr. Gleason noted that Petitioner's records and examination could be consistent with a left shoulder contusion and soft tissue-type sprain, albeit resolved. The record thus indicates no reason to believe Petitioner's complaints were not credible.

Dr. Gleason's opinions are based primarily on an examination that found that Petitioner's subjective complaints were outweighed by the (lack of) objective findings. Even when considering that subsequent cervical and lumbar spine MRIs showed herniated discs, Dr. Gleason testified that the opinions in his Section 12 report would not change. He explained that he would not have expected Petitioner's ranges of motion for the cervical and lumbar spine to be normal, being able to bend and touch his toes and extend 10 degrees. Dr. Gleason testified that he would have expected some further objective findings such as spasm, testing, asymmetry, or some change in Petitioner's contours or curvatures.

Dr. Gleason's opinions were based on the incomplete medical and therapy records provided to him. Dr. Gleason testified that he did not see an indication of hip pain in the medical records he reviewed. However, a July 3, 2018 patient care record submitted by Respondent contains a complaint of hip bone pain. The August 24, 2018 physical therapy record also contains a complaint of hip pain and Dr. Gleason conceded he had not reviewed the physical therapy records (other than certain occupational therapy records included in the treatment records he received). Dr. Gleason did record groin pain during his examination of Petitioner.

Dr. Gleason testified that blunt force trauma to the back can cause acute low back pain but did not see evidence of it in his examination. However, to reach this conclusion, Dr. Gleason had to dismiss Petitioner's reported tenderness in the affected area. Moreover, Dr. Gleason's examination could not have included the spinal MRIs taken after his examination. Indeed, Dr. Gleason conceded he had not reviewed any of the records of Petitioner's treatment with Dr. Ankur Chhadia at Suburban Orthopaedics. Dr. Gleason adhered to his position that he would have expected corroborating symptoms in his examination. Yet Dr. Gleason testified that if a patient had low back pain with radiculopathy, had undergone physical therapy, medication and had the appropriate physical examination findings, he would consider ordering an MRI after six to eight weeks. He also agreed that radiculopathy could be caused by irritation from a herniated disc. He further agreed that a herniated disc at the L4-5 level might be associated with L5 radiculopathy. In addition, Dr. Gleason testified that it was his impression that Petitioner fell backwards, but did not fall on the ground, which is contrary to Petitioner's testimony and the treatment records indicating a lumbar issue from July 3, 2018 onward.

Dr. Gleason dismissed spinal MRI results that are consistent with Petitioner's complaints throughout the treatment records, despite Dr. Gleason's own concessions regarding the possibility of herniated discs causing radiculopathy similar to that described in the treatment records. His opinions are even less persuasive when considering the apparent errors in his

Section 12 report resulting from having been provided an incomplete set of Petitioner's treatment records.

For all of the aforementioned reasons, the Commission finds that Petitioner's left shoulder contusion and soft tissue injury to the low back were causally connected and were not resolved as of October 23, 2018. The Commission concludes that Petitioner's current condition of ill-being is entirely causally connected to his work injury.

2. Medical Expenses

Regarding medical expenses, the Arbitrator ordered Respondent to pay necessary and reasonable charges of $11,327.78, representing medical bills incurred prior to October 23, 2018. The Arbitrator excluded one bill from Integrated Imaging Consultants because there was no date or description of services and there was an updated statement indicating a zero balance. A $4.00 prescription was also disallowed because there was no testimony regarding it and an indication in the record that it had been paid.

Petitioner argues that based on a complete causal connection, Respondent should be ordered to pay $20,796.24 in medical expenses, inclusive of charges incurred after October 23, 2018. Petitioner's argument is based on the Commission finding a complete causal connection in this matter. Having found a continued causal connection beyond that found by the Arbitrator, the Commission affirms the Arbitrator's award of medical expenses and additionally awards medical expenses charged by Suburban Orthopedic and ADCO Billing Solutions on or after October 23, 2018.[1]

3. Prospective Care

Regarding prospective care, having found a complete causal connection, the Commission finds Respondent liable to pay for the physical therapy for the upper and lower left extremities, the consultation with spinal specialists, as recommended by Drs. Thompson, Khan and Chhadia, and the cost of treatment related to Petitioner's work injury recommended by those specialists.

4. Temporary Total Disability

Regarding temporary total disability (TTD) benefits, Petitioner claims TTD benefits for the period from September 28, 2018 through the hearing date of March 8, 2019. The Arbitrator awarded benefits for the period commencing September 29, 2018 through October 23, 2018. The Arbitrator ruled that Petitioner was not entitled to benefits for September 28, 2018 because Petitioner testified that this was his last day of work. The Arbitrator terminated benefits as of October 23, 2018, the date on which Petitioner was found to be at MMI.

Respondent Atlas maintains in its appeal that the Arbitrator erred in awarding these benefits. Respondent argues that it had accommodated Petitioner's light duty restrictions until it was notified by ICE on or about September 25, 2018 that Petitioner was unable to work legally

---

[1] The nominal amount of the total medical expenses (excluding the two bills properly disallowed by the Arbitartor) is $20,748.24, subject to the fee schedule.

in the United States. Respondent claims that because Petitioner was unable to produce employment verification documents, Petitioner removed himself from the workforce and "in essence, has rejected a valid light duty job offer." Respondent therefore concludes that Petitioner is not entitled to TTD benefits for the period commencing September 29, 2018.

The Arbitrator relied in part on the rule that "when an employee who is entitled to receive workers' compensation benefits as a result of a work-related injury is later terminated for conduct unrelated to the injury, the employer's obligation to pay TTD workers' compensation benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill. 2d 132, 136 (2010).[2] In so holding, however, the Illinois Supreme Court noted that TTD benefits may be suspended or terminated if the employee refuses to submit to treatment essential to his recovery, fails to cooperate in good faith with rehabilitation efforts, or where the employee refuses work falling within the physical restrictions prescribed by his doctor. *Id.* at 146 (and authorities cited therein).

The Arbitrator also relied on *Economy Packing Co. v. Illinois Workers' Compensation Comm'n*, 387 Ill. App. 3d 283, 295 (2008), in which the Illinois Appellate Court concluded that "the Act allows workers' compensation benefits, including PTD benefits, to be awarded to undocumented aliens and that an award of such benefits is not preempted by federal immigration law." The Commission also awarded TTD benefits to the employee in *Economy Packing Co.*, though this was not the subject of the appellate court's opinion. See *id.* at 285.

Respondent relies in part upon *Gomez v. Illinois Sportservice*, 7 IWCC 798, in which the Commission affirmed and adopted a Decision concluding that further TTD benefits were not owed by the Respondent where the Petitioner could not return to light duty based on her immigration status. Notably, a witness for Respondent in *Gomez* testified that the Petitioner was fired for using an incorrect social security number. *Gomez* predates *Economy Packing Co.* and *Interstate Scaffolding,* but Respondent suggests that Petitioner should be considered to have voluntarily declined light duty work and thus ineligible for TTD benefits.

In this case, Respondents' assertions notwithstanding, there is no evidence that Petitioner voluntarily resigned from his job. Moreover, despite the diligence of Respondents' counsel in objecting to questions referring to Petitioner's termination as such, Petitioner ultimately testified in passing to the time of his termination. The record here suggests that Petitioner was content to work for Respondents knowing that his immigration status rendered him unable to do so legally. Conversely, the record indicates that Petitioner's employment ceased days after Respondent Atlas received a letter from ICE regarding Petitioner's immigration status and warning that knowingly employing undocumented workers carried legal penalties. Given this record, the Commission modifies the Arbitrator's ruling to extend the award of TTD benefits through the hearing date.

---

[2] In *Interstate Scaffolding*, the employee was fired for defacing the employer's property with religious graffiti. *Id.* at 137.

5. **Penalties and Fees**

Lastly, Petitioner requested penalties pursuant to sections 19(l) and 19(k) of the Act and attorney fees pursuant to section 16 of the Act. The Arbitrator denied Petitioner's claims, finding that the dispute over the TTD benefits was not unreasonable, vexatious, or in bad faith. The Arbitrator also found that Petitioner had failed to demonstrate Respondents' liability for penalties regarding the medical bills, noting that the payment log submitted by Respondent Atlas indicated that many of the claimed bills had been paid.

The standard for granting penalties pursuant to section 19(l) differs from the standard for granting penalties and attorney fees under sections 19(k) and 16. Section 19(l) provides in pertinent part, as follows:

> "*If the employee has made written demand for payment of benefits* under Section 8(a) [820 ILCS 305/8] or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d) [820 ILCS 305/8.2]. 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." (Emphases added.) 820 ILCS 305/19(l) (West 2016).

Penalties under section 19(l) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763 (2003). In addition, the assessment of a penalty under section 19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10 (1982).

The standard for awarding penalties under section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides, in pertinent part, as follows:

> "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." (Emphases added.) 820 ILCS 305/19(k) (West 2016).

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2016). "The amount of [attorney] fees to be assessed is a matter committed to the discretion of the Commission." *Williams v. Industrial Comm'n*, 336 Ill. App. 3d 513, 516 (2003). The calculation of a penalty award under section 19(k) is simply a mathematical computation of 50% of the amount payable at the time of the award. *Williams*, 366 Ill. App. 3d at 516.

The standard for awarding penalties and attorney fees under sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under section 19(l) because sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan*, 183 Ill. 2d 499, 514-15 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *Id.* at 515. Instead, section 19(k) penalties and section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *Id.* In addition, while section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and section 16 fees is discretionary. *Id.*

In this case, the Petition for Penalties and Attorney Fees contains no allegations that Petitioner demanded payment from Respondent in writing, let alone exhibits that would support such allegations. Accordingly, there is no evidentiary basis upon which the Commission could award penalties pursuant to Section 19(l). The petition alleges that Petitioner's treating physician imposed work restrictions that Respondent was unable to accommodate, but the record indicates that Petitioner accepted Respondents' offers of light duty employment until that employment was terminated for reasons related to Petitioner's immigration status. The Arbitrator correctly noted that the payment log submitted by Respondent Atlas indicates that it paid numerous charges (in seemingly prompt fashion, allowing for normal bureaucracy) through October 23, 2018, the date Dr. Gleason concluded Petitioner was at MMI.

Given the record, it does not appear thar Respondents acted in bad faith or with an improper purpose. Accordingly, the Commission affirms the Arbitrator's denial of penalties and fees in this case.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS FOUND BY THE COMMISSION that Petitioner proved his current condition of ill-being is completely causally connected to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses to Advocate Sherman Hospital, Advocate Sherman Physical Therapy, Smart Choice MRI, Suburban Orthopedic, and ADCO Billing Solutions, as stated in Petitioner's Exhibits 6, 7, 9, 10, and 11, pursuant to the fee schedule and §§8(a) and 8.2 of the Act.

 20 I CC0523

IT IS FURTHER ORDERED THAT Petitioner is awarded prospective medical care including physical therapy for the upper and lower left extremities, the consultation with spinal specialists, as recommended by Drs. Thompson, Khan and Chhadia, and the cost of treatment related to Petitioner's work injury recommended by those specialists, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $389.05 per week for the period from September 29, 2018 through March 8, 2019, for a period of 23 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for Penalties and Attorney Fees is denied.

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

Bond for the removal of this cause to the Circuit Court is hereby fixed at the sum of $29,800. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 6 2020
o: 7/23/20
BNF/kcb
045

Barbara N. Flores

Marc Parker

DISSENT

I respectfully dissent from the Decision of the majority and would have affirmed and adopted the well-reasoned Decision of the Arbitrator in its entirety. The Arbitrator correctly found that Petitioner's causally related left shoulder and low back injuries had resolved as of October 23, 2018, which is the date Dr. Gleason opined that Petitioner had reached maximum medical improvement. At the §12 examination on October 23, 2018, Dr. Gleason determined that Petitioner's subjective complaints outweighed, and could not be confirmed by, the lack of objective findings. Dr. Gleason provided persuasive medical reasoning in support of his opinion, whereas none of Petitioner's treating doctors offered any contradictory causal opinion.

In addition to Dr. Gleason's persuasive opinion, Petitioner's diminished credibility further supports the finding that he failed to meet his burden of proving a current causal connection. Petitioner told Dr. Gleason that he had no prior complaints involving his low back,

neck, or left shoulder before the July 2, 2018 accident. Petitioner further admitted that he denied having any prior back pain to his treating doctors at Advocate Occupational Health Clinic and Suburban Orthopedics. However, Petitioner was not forthcoming as to his prior history of pain, because he neglected to tell the doctors that he had low back pain after a motorcycle accident in 2017 that prompted him to seek three weeks of chiropractic treatment. Petitioner also testified at the hearing that he did not have any prior low back pain. However, an August 31, 2017 treatment note from Greater Elgin Family Care Center indicates that Petitioner had complained of, and sought treatment for, low back pain following his motorcycle accident. Neither Petitioner's treating doctors nor the §12 examiner were advised of Petitioner's prior motorcycle accident.

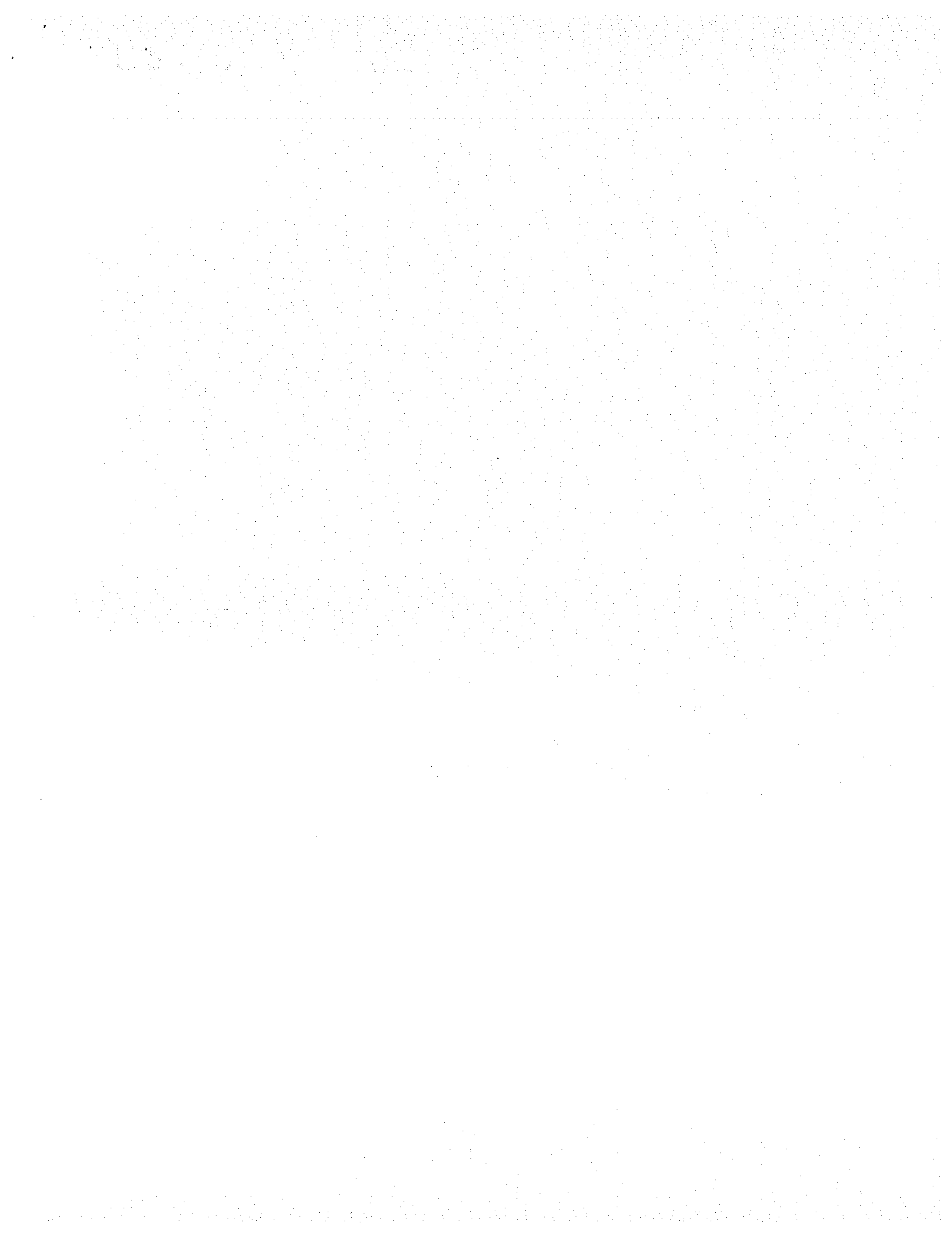
Petitioner's credibility is further diminished by his falsification of his Social Security Number on his employment documents. Petitioner's testified that he was not legally allowed to work in the United States, but he would not agree that it was untrue when he told Respondent that he could legally work. Although Petitioner's immigration status does not alter his entitlement to temporary total disability benefits, his testimony regarding his Social Security Number and telling Respondent he could legally work cuts against his credibility.

In addition to the diminished credibility, Petitioner's burden of establishing current causation was also affected by the failure to include his initial treatment note in the record. The Advocate Occupational Health Clinic note from the accident date was not submitted into evidence by either party. The only record from July 2, 2018 was a work status form and not the doctor's treatment note. Although Dr. Gleason indicated that he had reviewed the full treatment note from July 2, 2018, the Commission was not provided with a copy of it for its own review. As such, the Commission cannot make a determination as to whether the initial treatment record corroborates Petitioner's testimony.

For these reasons, the record supports the finding that Petitioner failed to meet his burden of establishing a causal connection between his work accident and injuries beyond the date that Dr. Gleason placed him at maximum medical improvement. Thus, I would have affirmed and adopted the Decision of the Arbitrator accordingly.

DLS/met
46

Deborah L. Simpson
Deborah L. Simpson



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

GARCIA, JOSE L
Employee/Petitioner

Case# **18WC022613**

ATLAS STAFFING INC MIDWEST MOLDING INC ET AL
Employer/Respondent

20IWCC0523

On 10/30/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

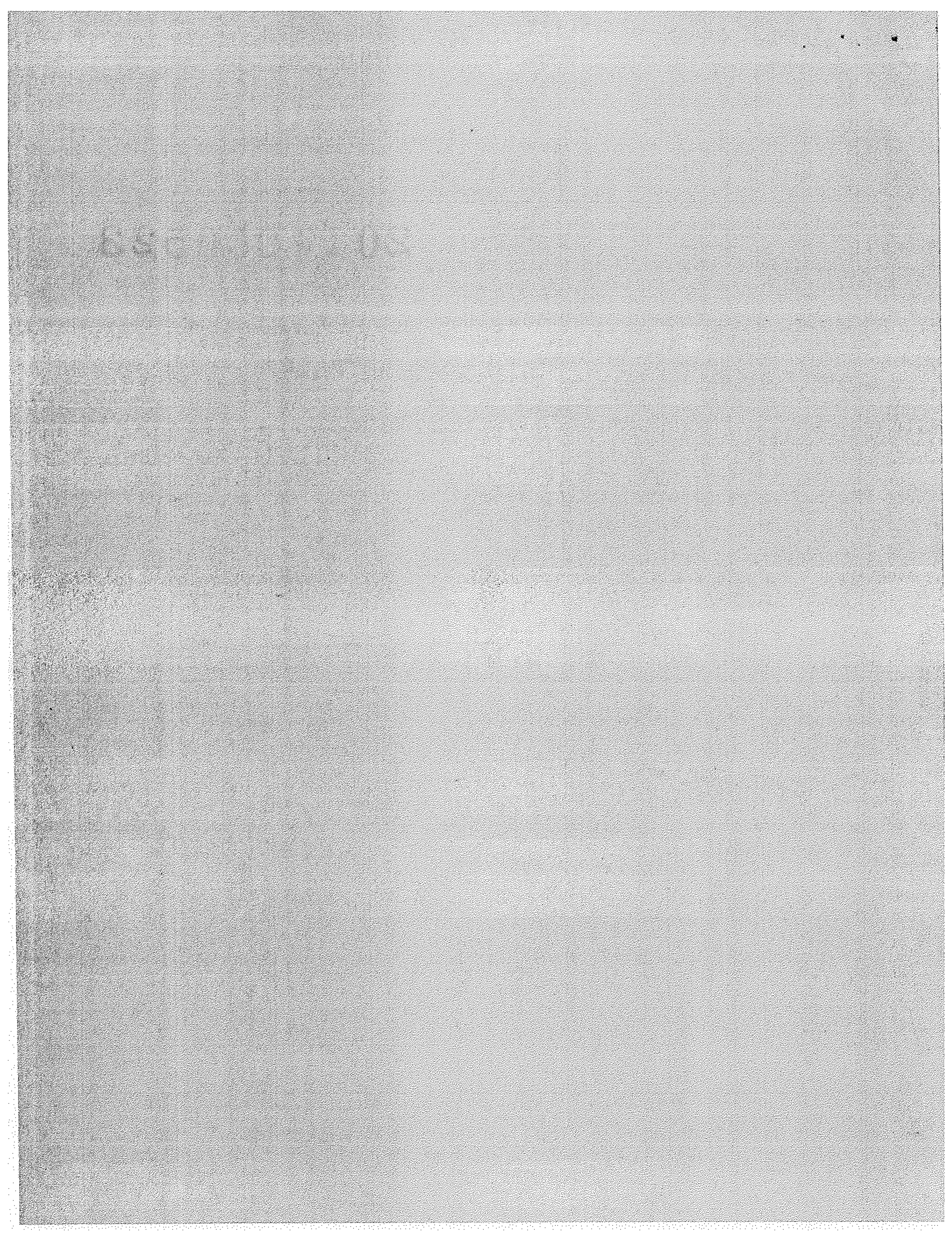
If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5625 GRAUER & KRIEGEL LLC
KARINA B MEJIA
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

2461 NYHAN BAMBRICK KINZIE & LOWRY
JAMES A MORAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

4866 KNELL O'CONNOR DANIELWICZ
TORRIE N POPLIN
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)/8(a)

Jose L. Garcia
Employee/Petitioner

Case # **18** WC **022613**

v.

Atlas Staffing, Inc.; Midwest Molding, Inc., et al
Employer/Respondent

20 I W C C 0 5 2 3

An *Application for Adjustment 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 **March 8, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/2/2018**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was $**583.57**, per the Parties' stipulation.

On the date of accident, Petitioner was **40** years of age, *single* with **2** dependent children.

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

Respondent shall be given a credit of **$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 $11,327.78, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner temporary total disability benefits of $389.05/week for 3-4/7 weeks, commencing 9/29/2018 through 10/23/2018 as provided in Section 8(b) of the Act.

Petitioner's claim for penalties and attorney's fees is denied.

Petitioner's claim for prospective medical treatment is denied.

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

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

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

Signature of Arbitrator

October 30, 2019
Date

ICArbDec19(b)

OCT 30 2019

FINDINGS OF FACT

20 I W CC 0523

Petitioner testified via a Spanish/English interpreter.

Petitioner was an employee of Atlas Staffing, Inc. ("Atlas"), working at Midwest Molding, Inc. ("Midwest") at the time of his July 2, 2018 work injury. Petitioner had worked for Atlas since September of 2017. (RX 1) Petitioner had worked at Midwest for approximately 4 months before his injury. Petitioner's job at Midwest was material handler-forklift driver. Atlas and Midwest will be referred to collectively as "Respondents".

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondents on July 2, 2018. He was in the warehouse, assisting in cleaning an area, when a co-worker struck a pallet with a jack, causing a pallet to fall on Petitioner, striking him on the left shoulder. Petitioner testified that the pallet bent him to the left side and threw Petitioner down to the ground, causing him to land on his low back. The pallet of material that fell on Petitioner weighed about 200 pounds. It was stacked on top of another pallet and was about 7'6" high. Petitioner identified PX 13 as a representation of what the pallets looked like. It appears that the pallets were stacked with un-assembled boxes. (PX 13) A supervisor was called and Petitioner was taken to the company clinic, via Uber.

Petitioner testified that after the accident, he had pain in his neck, left arm, back around the left hip area and left leg. He couldn't lift his left arm and he couldn't turn to the left. He had pain in his back and left leg. Petitioner said that he had tingling from the anterior and top portion of the left shoulder, going down to the left 4th and left 5th fingers. An injury report was prepared.

The first medical treatment was at Advocate Occupational Health Clinic ("Advocate") on July 2, 2018. According to Petitioner the treatment consisted of x-rays and medication. He was taken off work for the remainder of July 2nd. He was to follow-up on July 3rd. PX 4 is the records of Advocate Sherman occupational Health and the only record from July 2, 2018 contained therein is a "Work Status Discharge Instructions" document which has a diagnosis of left shoulder injury and a treatment plan of "sling + Motrin." (PX 4) Dr. Gleason testified that there was a record from Advocate Sherman Hospital of 7-02-18 reflecting injury to the left neck, left shoulder, upper back and left leg with a history of a heavy weight falling on the patient's shoulders. The physical exam was said to reveal tenderness and swelling, along with limited range of motion of the left shoulder. There were no findings noted to the spine and lower extremities. (RX 6, pp.18-19)

On July 3, 2018, Petitioner was seen at Advocate and was diagnosed with a contusion of the left shoulder and lumbar strain. Petitioner was given work restrictions of sitting work only, no use of the left arm and was ordered to follow up in a week. (PX 4) While the only documentation of treatment on July 3rd contained in PX 4 is another Work Status Discharge Instructions document, Respondent attached a copy of the chart from July 3, 2018 to RX 7. The history was that a pallet fell on the patient's left shoulder and the left side of his body. The patient was said to have complaints of left neck, leg, arm and hip bone pain. (RX 7)

On July 6, 2018, Petitioner returned to Advocate. He was diagnosed with left shoulder injury and muscle spasms. He was allowed to return to work with a mostly sitting restriction and no use of the left shoulder or arm. (RX 7)

On July 10, 2018, Petitioner returned to Advocate. He had complaints of left neck pain 3/10, only with movement. Back pain and leg pain were not mentioned. Petitioner was released to work light duty with a 10 pound maximum lifting restriction. He was diagnosed with a left shoulder contusion. No medication was prescribed. (RX 6, RX 7)

On July 17, 2018, Petitioner returned to Advocate with left shoulder and left arm complaints, suggesting LUE radiculopathy, per Dr. Gleason. (RX 6) He was diagnosed with a left shoulder contusion and cervical radicular pain of left upper extremity. He was allowed to continue working with restrictions of no forceful pulling or pushing of the left arm and therapy was recommended. (PX 4)

On July 24, 2018, Petitioner returned to Advocate. He had complaints consistent with a left shoulder contusion. He was scheduled to begin physical therapy the following day. (RX 6)

On July 25, 2018, Petitioner had the initial physical therapy evaluation. On examination, Petitioner had decreased strength of the left shoulder and arm and abnormal motion of the scapula and humerus during shoulder movement. He tested positive for painful arc and tenderness over the left cervical spine, scapula and shoulder. (Px. 4) Petitioner also indicated where he had pain on a chart by shading in five areas: 1) over the top of the left shoulder, neck, and described a pinching feeling on the neck and shoulder area; 2) left arm pain into the lower extremity with tingling; 3) left-sided back pain; 4) pain in the low back into the left buttocks and posterior thigh; and 5) pain in the low back and right buttocks. Petitioner said that movement of his head towards the left and walking aggravated his symptoms The therapist identified decreased active and passive range of motion, improper body mechanics, decreased functional ability, gait deficits, hypomobility, muscle imbalance, posture problems, pain, and decreased strength. (PX 4)

Per Dr. Gleason, Petitioner was seen at Advocate on July 31, 2018 and August 5, 2018. Petitioner was said to be in no distress with full range of motion. (RX 6)

On August 22, 2018, Dr. Thompson ordered a left shoulder MRI. (PX 4) On August 24, 2018, Petitioner complained of constant low back pain and left hip pain, with small improvements to the neck and left shoulder. Petitioner was also observed to have an antalgic gait, positive for SI/ileum dysfunction of the left hip. (PX 4)

On August 31, 2018, Petitioner's therapist noted that he still had numbness and tingling of the left arm with certain head movements; and pain in the back and left hip was unchanged. Petitioner underwent 11 sessions of physical therapy for the neck, left shoulder and arm pain from July 25, 2018 through August 31, 2018. Additional therapy was never approved and therapy was never approved for the back and left leg. (PX 4)

On September 17, 2018, Petitioner underwent an MRI of his left shoulder. The study revealed low grade supraspinatus tendinosis without tear. (PX 5)

On September 25, 2018 and on October 2, 2018, Petitioner was referred to an orthopedic back specialist and received work restrictions of maximum lifting of 10 lbs. with no frequent lifting, bending, or working at heights. (PX 4) Petitioner was not seen by an orthopedic back specialist at Advocate Occupation Health because approval was never granted by workers' comp. (PX 4)

On October 10, 2018, Petitioner was seen by an orthopedic doctor, Dr. Chhadia at Suburban Orthopedics. Petitioner gave a history of injuring his neck, left shoulder, the lower back and left leg on July 2, 2018 when a 200 lb. pallet fell on him. (PX 5) Petitioner complained of neck and left shoulder pain radiating into the left

arm with numbness and tingling, pain across the lower back with radiating pain into the bilateral buttocks and bilateral posterior thighs, and pain into the left groin and hip with walking. On examination, Petitioner demonstrated tenderness over the cervical paraspinal muscles with decreased range of motion of the neck with pain, left shoulder and arm tenderness with decreased range of motion with pain, and tenderness over the lumbar paraspinal muscles and decreased range of motion with pain when turning left and looking up. Straight leg raising and Spurling's tests were negative. Both of the lower extremities had full range of motion, intact neurological findings, full strength and were pain free. X-Rays were benign. Dr. Chhadia ordered physical therapy for the left arm and back, and diagnosed Petitioner with a lumbar sprain/strain, cervical sprain/strain, and left shoulder tendonitis. Petitioner was given work restrictions of no lifting over 10 lbs. (PX 5)

On October 30, 2018, Petitioner began physical therapy and completed 12 sessions through December 3, 2018. At the first visit, he had full range of motion of his shoulders and denied pain on resisted movement. He did not exhibit radicular symptoms in his arms and legs. He was observed to move freely throughout the clinic. (PX 5)

On November 7, 2018, Petitioner presented with continued complaints regarding the neck, left shoulder and low back, which were noted to be less intense. Dr. Chhadia prescribed nalfon and pantoprazole, discussed a lumbar spine MRI if the pain and symptoms persisted and gave Petitioner work restrictions of no lifting over 10 lbs. (PX 5)

On December 5, 2018, Petitioner reported continued pain to the neck, left shoulder, and lower back but with less intensity, and he reported numbness and tingling to the left upper extremity to the 4th and 5th digits. At this time, Dr. Chhadia ordered that Petitioner continue physical therapy, work within the same restrictions and ordered a cervical and lumbar spine MRI. (PX 5)

On January 2, 2019, Petitioner underwent a lumbar and cervical spine MRI. On January 11, 2019, Dr. Chhadia reviewed the lumbar and cervical spine MRIs which revealed a C5-C6 focal left paramedian disc herniation encroaching left lateral recess and orifice of left foramen and contacting the cord, but not grossly compressing it, and a L4-L5 right paramedian disc herniation impinging right lateral recess and distorting the dural sac. Petitioner was also referred to spine specialists, Dr. Pelinkovic or Dr. McNally, for evaluation and treatment of the spine. (PX 5)

Petitioner testified that he would attend an appointment with either spine specialist, Dr. Pelinkovic or Dr. McNally, if it was approved. He currently experiences pain in the neck and shoulders. He has tingling and "numbing" and his fingers bother him. When he turns left or lifts his left arm, it gives him difficulty. He has pain when he bends or walks. Sitting or standing for too long bothers him. He has pain in his left leg, down the calf. He no longer does prior activities such as jogging, walking a lot and bicycling. Petitioner denied prior low back pain down his left leg. He denied prior left shoulder pain radiating down his left arm.

Petitioner also testified that the only other injury he suffered was when he fell off a motorcycle as he turned right and injured his right side, and that it was temporary. Petitioner was turning right at approximately 40 kilometers (24.85 mph) when his motorcycle slid. Petitioner testified that he sought treatment with a chiropractor for about three (3) weeks after the non-work related accident. Petitioner testified that he experienced low back pain that radiated to the right foot after the motorcycle accident. The chiropractic treatment is corroborated in the Greater Elgin Family Care Center note dated August 31, 2017 (RX 5) The note indicates that Petitioner did not seek emergency care due to no symptoms or distress, and that symptoms were relieved with ibuprofen, rest and sitting. The examination was positive for back pain and muscle stiffness and negative for neck pain or weakness. Petitioner had a normal gait and normal left and right knees. Dr. Him did

not order further treatment, and Petitioner was only seen on August 31, 2017 for the back stiffness, status post motorcycle accident, per the evidence adduced.

Petitioner admitted that he denied any prior back pain, short-term or otherwise, to the doctors at Advocate. Petitioner admitted he told his doctors at Suburban Orthopedics on October 10, 2018 that he did not have any neck, left shoulder, or lower back pain prior to the July 2, 2018 incident. Petitioner also admitted that on October 23, 2018 he told Dr. Gleason he did not have a history of prior complaints or injury to his neck, left shoulder, and back prior to July 2, 2018.

Petitioner further testified on cross examination that prior to July 2, 2018, he did not have any pain in his lower back. Petitioner than agreed that he was in a motorcycle accident in 2017. Petitioner stated he was travelling 40 kilometers per hour when his bike skidded while making a turn. Petitioner testified he fell off his motorcycle and landed on his right side. Petitioner testified he was not injured but he went to a chiropractor for a checkup for the "pain I was experiencing." Petitioner testified he only had pain on the right side, the right hip, and the right leg. Petitioner further testified after treating with the chiropractor for three weeks, he felt better and he was "pain free." Petitioner initially testified he did not treat with any other physician after this injury. Petitioner later admitted he treated at Greater Elgin Family Care on August 31, 2017, which was after the chiropractor and reported he had therapy with some improvement. Petitioner testified he could not remember anything else about this doctor's visit.

Petitioner was working full time, full duty, 50 hours a week at Midwest prior to July 2, 2018.

Dr. Thomas Gleason, M.D. examined the Petitioner at the Respondents' request on October 23, 2018, and testified via deposition on January15, 2019. (RX 6) Dr. Gleason's report was admitted into evidence as a part of RX 7. Dr. Gleason is a Board Certified Orthopedic Surgeon.

Dr. Gleason testified that during the examination, Petitioner denied any low back or left lower extremity pain prior to July 2, 2018 and denied any prior complaints or injuries to his neck and left shoulder. Dr. Gleason testified that Petitioner's subjective complaints outweighed the objective findings. For example, he noted diffuse tenderness even on superficial palpation over the entire cervical, upper thoracic and entire lumbar spine, which could not be explained in absence of objective findings.

Petitioner was diagnosed with a resolved left shoulder sprain or contusion, which likely resolved six to eight weeks after the injury or by the latest August 27, 2018. Dr. Gleason testified his opinion is based on his review of the medical records, physical findings reported, and his knowledge and experience. The medical records from July 31, 2018 and August 5, 2018 noted "no acute distress with full range of motion." Upon examination, Petitioner had full range of motion in his shoulders and his cervical spine and did not exhibit any signs of referred pain stemming from his neck or shoulder. Petitioner had a negative impingement test bilaterally and a negative Spurling test. Petitioner also exhibited full muscle strength in his shoulder, elbow, wrist, hand, and fingers.

Regarding Petitioner's low back, Dr. Gleason testified that upon examination, Petitioner's range of motion was normal with respect to this cervical spine and lower back. Dr. Gleason noted that Petitioner was able to bend and touch his toes and extend to ten degrees. Petitioner also did not exhibit any sign of nerve impingement or complaints of pain radiating into his legs

If Petitioner had a back injury with a disc herniation or radiculopathy, Dr. Gleason would have expected objective findings such as spasm, asymmetry, or other changes in Petitioner's contours or curvatures but

Petitioner did not have any of that. Dr. Gleason also testified if Petitioner had a back injury, he would have tested positive for the Britton test or had a positive straight leg raising test. If Petitioner had an injury present at that time, he would not be able to bend over with his knees straight and touch his toes and he would have had other findings of nerve root irritation, which were missing.

If any subsequent examinations demonstrated that Petitioner had a herniated disk or nerve impingement, it would not have been related to the July 2, 2018 work accident. Dr. Gleason testified Petitioner's diagnosis for his lower back injury was "no positive objective findings on physical examination with respect to the spine." Dr. Gleason testified he performed at least 100 spine surgeries a year. In light of Petitioner's medical records and examination of Petitioner, Dr. Gleason testified Petitioner's injury could not cause a disk herniation. If Petitioner sustained a back injury in the July 2, 2018 work incident, he would have been capable of working full duty six to eight weeks after the injury.

Dr. Gleason testified it would be unusual for someone to experience hip and groin pain from a back injury because they are two completely different areas. He testified it would not be plausible for Petitioner to develop hip and groin pain after a blunt trauma to his shoulder. Dr. Gleason testified a Fabre test result was inconsistent with any lumbar spine pathology. Dr. Gleason diagnosed Petitioner with diminished range of motion and pain in the left hip unrelated to July 2, 2018 work injury.

At the time of the examination, Petitioner was at MMI and not in need of further treatment. He was capable of returning to full duty work, without restrictions. Petitioner had no current diagnosis as a result of the July 2, 2018 accident, with respect to any symptomatic pathological condition. There was likely a contusion of the left shoulder or a soft tissue type strain that had resolved. (RX 6)

After the accident, Respondent had restricted duty work available for Petitioner. (RX 2) Petitioner worked light duty through September 28, 2018. Atlas always had light duty work available. Petitioner no longer works at Midwest Molding. He is no longer employed by Atlas. His last day worked was September 28, 2018.

Respondent received a Notice of Suspect Documents from U.S. Immigration and Customs Enforcement, dated September 25, 2018, advising that Petitioner and other employees were not authorized to work in the United States. (RX 3) Petitioner's documentation did not satisfy the Form I-9 employment eligibility requirements of the Immigration and Nationality Act. Atlas was subject to civil penalties if it continued employing Petitioner without acceptable documentation. Petitioner did not furnish acceptable documentation, so it was unlawful for Atlas to continue to employ Petitioner.

Petitioner identified RX 1 as the W4 form that he completed for Atlas. He identified his signature on the document and claimed that it had his Social Security Number ("SSN") on it. Petitioner testified as to the SSN without referring to any documents. Petitioner testified that he was not legally allowed to work in the U.S. He would not agree that it was untrue when he told Atlas that he could legally work.

The Arbitrator finds that Petitioner falsified his SSN when he applied to work for Atlas. Petitioner's testimony that the SSN was his was not truthful, at least as to any lawful SSN. He was also wrong in not agreeing that it was untrue when he represented to Atlas that he could legally work. Thus, Petitioner's credibility is found to be diminished.

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and 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 PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? , THE ARBITRATOR FINDS:

Petitioner's current condition of ill-being is, in part, causally related to the injury. The causally related condition is contusion of the left shoulder and soft tissue injury to the low back, resolved as of October 23, 2018.

The basis of this finding is the persuasive opinions of Dr. Gleason and the medical records that were submitted into evidence.

Unfortunately, the initial treatment record of July 2, 2018 was not submitted by the Parties. The initial history, complaints and physical examination either would support Petitioner's case, or undermine it. Here, the absence of corroborating information, coupled with Petitioner's failure to provide Dr. Gleason, the physicians at Advocate and the physicians at Suburban with the history of a prior back injury and Petitioner's testimony about the SSN do not allow the Arbitrator to endorse causation beyond that supported by Dr. Gleason. This is especially true where there is no causation opinion set forth by any of the treating physicians.

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:

Any claimed medical bills incurred after October 23, 2018 are denied, based upon the Arbitrator's finding on the issue of Causation, above. The bills incurred prior to October 23, 2018 are found to be reasonable and necessary to cure or relieve the effects of the injuries and the same are awarded, pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills that it has paid.

The awarded bills are as follows:

Advocate Sherman Occ. Health:	**$2,054.86**
DOS: 7/2/2018-10/2/2018	
Advocate Sherman PT:	**7,222.00**
DOS: 7/25/2018-8/31/2018	
Smart Choice MRI:	**600.00**
DOS: 9/17/2018	
Suburban Orthopedic:	**303.00**
Adco Billing Solutions:	**1,147.92**
DOS: 10/10/2018	
TOTAL:	**$11,327.78**

The bill from Integrated Imaging Consultants (PX 8) is not awarded because there is no date of service and no description of the services, along with an updated statement with a zero balance. PX 12 (Walmart, $4.00 DOS: 7/2/2018) is not awarded, first because there was no testimony about it. Second, because it appears that Petitioner already was reimbursed for the claimed charge ("I Jose Gonzalez recibi 4 dollar cash de Atlas Staffing.").

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?, THE ARBITRATOR FINDS:

Based on the Arbitrator's finding on the issue of Causation, above, Petitioner's claim for prospective medical treatment is denied, as he is at MMI for any condition related to the injury and not in need of further treatment, per the persuasive opinion of Dr. Gleason.

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

Petitioner claims TTD from September 28, 2018 to the trial date of March 8, 2019, a period of 23 weeks.

First, Petitioner is not entitled to TTD for September 28, 2018. It was his testimony that this was his last day worked for Respondent. If you work on a day, you can't get TTD for that day, as you weren't temporarily and totally disabled if you worked.

Second, given the Arbitrator's decision above regarding the issue of Causation, Petitioner is not entitled to TTD on and after October 23, 2018, as that was the day that Dr. Gleason determined Petitioner to be at MMI, an opinion that the Arbitrator endorses and finds persuasive. See: Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010)

This case presents the novel issue of whether an employee who sustains a compensable workers' compensation injury is entitled to TTD benefits where he is not at MMI, the employer has work available for him within the restrictions prescribed by his treating physician, at which he was working until his employer became aware of his inability to be lawfully employed in the United States. In other words, is

an employer liable for TTD to an injured worker, not at MMI and on restricted duty, where the injured workers' immigration status makes it unlawful for the employer to allow him to work?

The Arbitrator finds that Petitioner is entitled to TTD benefits from September 29, 2018 (the day that he was first prevented from working for Atlas due to improper Form I-9 Employment Eligibility Verification documents) through October 23, 2018 (the day that he was declared to be at MMI by Dr. Gleason), a period of 3-4/7 weeks.

The determinative inquiry for deciding entitlement to TTD benefits is whether the claimant's condition has stabilized, i.e. has the injured worker reached MMI. Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010) The claimant in Interstate Scaffolding was fired for cause (defacing company property) while he was working restricted duty and not yet at MMI. As the claimant was not at MMI and he was on restricted duty, he was entitled to TTD benefits. The propriety of his discharge is a separate issue from the employee's entitlement to TTD. If the employee is not at MMI and is not working due, in part, to work restrictions (such as Petitioner is in the case at bar), the employer must pay TTD.

An employer's liability for TTD to a disabled claimant who is discharged for thievery is in place until the employee reaches MMI. Matuszczak v. Illinois Workers' Compensation Comm'n, 2014 IL App (2d) 130532WC A claimant is not precluded from receiving workers' compensation benefits simply because he is an undocumented alien. Economy Packing v. Illinois Workers' Compensation Comm'n, 387 Ill. App. 3d 283 (2008)

Current Illinois caselaw supports the award of TTD for the above time period under the unique facts of this case.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?, THE ARBITRATOR FINDS:

The Arbitrator denies Petitioner's claim for penalties and attorney's fees.

Respondents' dispute on liability for TTD in this case of first impression was not unreasonable, vexatious, or in bad faith.

Petitioner failed to demonstrate Respondents' liability for penalties regarding medical bills. Indeed, Respondent's bill payment registry (RX 10) shows that many of the claimed bills have been 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 COOK	)	☒ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alejandro Oseguera,

Petitioner,

vs. NO: 18 WC 22306

AQS Services, Inc.,

Respondent.

20IWCC0524

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

A. Background

On June 22, 2018, Petitioner had been employed by Respondent for eight months as a HazMat Laborer. He operated a vacuum truck with a 100-foot hose attached that had an eight-inch diameter to clean up contaminated dirt left by conveyor spills. Petitioner testified that it required four men to operate the hose: one to operate the vacuum, one to watch the operator, a third to hammer on the hose to loosen any material that gets stuck, and one to keep the hose tied to the truck. He stated that it took three to five guys to carry the hose from one location to another. Once in operation, the hose could weigh up to 200 pounds. When the hose got too

heavy, they switched to a new hose. Petitioner worked eight hour shifts five to six days per week. Occasionally he worked ten- or twelve-hour shifts.

Regarding prior medical treatment, Petitioner had prior right hip/lumbar sciatica in 2013. On May 30, 2013, he complained of non-injury related sharp left leg pain that radiated to his left thigh. On June 28, 2013, Petitioner complained of hamstring pain after playing basketball. He was prescribed Prednisone and, on July 15, 2013, indicated that his hamstring pain was improving. No further medical treatment was required. During 2013, Petitioner treated with a chiropractor six times for back pain and radiating leg pain. He did not undergo such treatment again until after the instant accident.

B. Accident

On June 22, 2018, Petitioner arrived at work and took his usual 30-45 minutes to suit up in his astronaut-like HazMat suit. While carrying a hose to a new location, it kept getting stuck between two beams. Petitioner and his co-workers began pulling and yanking on the hose to get it loose. Petitioner moved to the middle of the hose and pulled. The hose was above his head and his back was to his co-workers while he pulled over his shoulder. At that time the hose got caught up and Petitioner grabbed it and it "zapped" him towards the beam. He testified that it felt like being hit by a car. Petitioner fell to his knees and crawled to the trailer and told his supervisors that he thought he snapped something. He also testified that he heard a crushing sound and was unable to sit or stand. Petitioner experienced pain in his right hip/lumbar area and he explained that his supervisor told him to just sit down and give it a while. Subsequently Petitioner received a ride to the front gate of the facility, which was near his car. He then drove twenty minutes to Liberty Physical Therapy. He testified that this was where laborers regularly went for massages. Petitioner stated that, usually, after a spinal massage and maybe a painkiller "you're good." Petitioner testified that he has not worked since the accident.

C. Medical Treatment

The record reflects that Petitioner was referred to Liberty Physical Therapy on the date of accident, June 22, 2018. He reported that the pain had been increasing and intermittent but was aggravated with activity. The pain was mildly better "in the medication and resting hours." Petitioner also had pain in the sacroiliac joint, along with difficulty standing and limited ambulation. Although the medical record itself indicated Petitioner had no similar prior issues, Petitioner testified that these symptoms were similar to the ones he had in 2013. He was diagnosed with low back pain, underwent a muscular and lumbar spine massage and was told to follow up. Petitioner returned for two more sessions but had no pain relief.

On July 12, 2018, Petitioner presented to his primary care physician, Dr. Griffin, at Chicago Family Health Center complaining of acute right hip pain for one month after pulling a heavy object while doing some heavy moving. He was unable to bear weight, sit or walk. Dr. Griffin noted no prior medical issues except for some sciatica suffered while lifting many years

ago. Exam revealed right hip tenderness and moderately reduced range of motion. Right hip x-ray revealed a femoral head fracture.

On July 18, 2018, Petitioner followed up with Dr. Griffin, noting the development of severe right hip pain nearly one month ago. The record indicates Petitioner denied any immediate trauma but heard a snap while pulling a device and had severe pain and significantly reduced mobility. Dr. Griffin diagnosed a "[c]losed fracture of head of right femur, initial encounter" and referred Petitioner to an orthopedic surgeon.

On July 25, 2018, Petitioner presented to Dr. Psaradellis at Midland Orthopedics for his right hip pain which occurred one month ago while at work. Dr. Psaradellis noted Petitioner was pulling a heavy hose when he felt and heard a pop in his right hip and has been having pain since. Pelvic and right hip x-rays revealed advanced bilateral avascular necrosis with femoral head collapse, more advanced on the right. Upon examination and review of the medical history, Petitioner was diagnosed with bilateral hip avascular necrosis, right worse than left. Petitioner was taken off work and kept on Naproxen. Dr. Psaradellis noted Petitioner's avascular necrosis was asymptomatic prior to the instant incident, "therefore it appears that the work injury aggravated this condition." By September 12, 2018, Dr. Psaradellis opined that conservative treatment had been exhausted and that a right total hip replacement would be beneficial.

On October 1, 2018, Petitioner's complaints continued, and Dr. Brooker at Midland Orthopedics diagnosed severe bilateral avascular necrosis of the hips further agreeing with Dr. Psaradellis' surgical recommendation. Dr. Brooker opined Petitioner's condition was work-related.

On October 9, 2018, Petitioner sought medical clearance for his hip replacement surgery from Dr. Griffin. Clearance was granted and Dr. Griffin noted that Petitioner had always been anxious in clinical or hospital settings and that an anxiety drug should be considered as needed during his hospital stay for surgery.

D. Section 12 Examination & Report – Dr. Thangamani

On October 26, 2018, Petitioner underwent a Section 12 exam at Respondent's request with Dr. Thangamani, who noted that on June 22, 2018 Petitioner "was pulling a long, 6-inch diameter hose between two beams. As he was pulling this hose, he heard a snap, and thought he injured himself, particularly in the right hip region." Petitioner complained to Dr. Thangamani of significant bilateral hip pain, right worse than left. Dr. Thangamani reviewed medical records and diagnostic studies and examined Petitioner and diagnosed bilateral avascular necrosis of the hips. However, Dr. Thangamani opined that the alleged accident was not a causative factor in the development of Petitioner's condition, and that the described mechanism of injury would not aggravate, exacerbate or cause his pain. Dr. Thangamani opined that Petitioner's medical treatment to date had been reasonably necessary and that a right hip replacement was necessary. He also opined that a left hip replacement was also likely necessary, although neither surgery

was related to the alleged accident. He opined Petitioner had reached maximum medical improvement (hereinafter "MMI") in relation to the alleged accident and was not capable of full duty work. After this exam temporary total disability ("TTD") benefits were terminated and the right hip replacement surgery was not authorized.

E. Deposition Testimony - Dr. Brooker

Dr. Brooker is a board-certified orthopedic surgeon. He overtook treatment of Petitioner due to Dr. Psaradellis' illness. He testified that he only examined Petitioner once but relied on the history taken by Dr. Psaradellis, as well as his records. Dr. Brooker testified that it was customary for physicians at Midland Orthopedics to rely upon treatment rendered by co-physicians at the practice.

Dr. Brooker testified that avascular necrosis is a loss of circulation to the ball of the femur portion of the hip joint. Over time the shape of the ball can change, become weaker and collapse. The most common cause of this is the use of Prednisone which can directly cause a loss of circulation to the hip. Other causes include alcohol abuse, being a scuba diver, idiopathic causes and trauma. Based on the July 25, 2018 right hip x-ray, Dr. Brooker opined that there was an acute component to Petitioner's condition, stating that it looked like someone "took a bite" out of the femoral head. He opined that the instant accident exacerbated Petitioner's degenerative hip condition to the point where surgery became necessary sooner rather than later.

Dr. Brooker further testified that additional proof of the acute nature of Petitioner's right hip condition is the comparison to Petitioner's left hip, which did not look as bad and did not show evidence of collapse. Dr. Brooker also noted that Petitioner was able to perform his job duties prior to the accident, and that after the accident Petitioner suffered from symptoms which never abated. He was also aware of Petitioner's prior back issues but was not aware of any prior hip issues.

F. Deposition Testimony – Dr. Thangamani

Dr. Thangamani is a board-certified orthopedic surgeon with a sub-specialty in orthopedic sports medicine. Dr. Thangamani examined Petitioner on Respondent's behalf on October 26, 2018. He reviewed medical records and diagnostic studies and examined Petitioner, but admittedly was unsure if he reviewed any x-rays. He diagnosed bilateral avascular necrosis of the hips. Dr. Thangamani agreed with Dr. Brooker's testimony regarding causes of this condition but stated that the majority of causes are idiopathic.

Dr. Thangamani opined that Petitioner's condition was not work-related. He testified that avascular necrosis takes a while to develop, and that if it is caused by trauma, it is typically trauma of the severe kind, such as a car accident or something that would cause a broken bone. Further, he stated that even if trauma causes the condition, it still takes years for the necrosis to develop to the point where there is deformity. Dr. Thangamani maintained his opinion that any

activity of daily living could have caused Petitioner's right femoral head to collapse. He also testified that Petitioner's condition was so advanced that a collapse was inevitable and went on to state that a collapse typically does not occur with just one specific incident, but an accumulation of incidents. Dr. Thangamani opined that Petitioner had already suffered a femoral hip collapse prior to the instant accident and that he had a near 100 percent chance of needing a hip surgery even without the accident.

Dr. Thangamani admitted that the accident at work did gave rise to the onset of pain which stopped Petitioner from working on the date in question. Also, he could not explain why Petitioner did not have hip pain prior to this incident. Dr. Thangamani acknowledged that pulling a six-inch diameter hose through two beams is not an activity of daily living. However, he testified that, absent this act, Petitioner's femoral collapse could have happened at any time.

II. CONCLUSIONS OF LAW

A. Accident

Initially, Respondent argues that Petitioner waived the issue of accident by failing to check "did it occur" in his Petition for Review, as well as by failing to argue the issue in his Statement of Exceptions. The Commission finds Respondent's argument to be factually incorrect. Petitioner argues that an accident did occur which arose out of and in the course of his employment with Respondent. His brief highlights medical records referencing a work accident, followed by stating: "The Arbitrator's conclusion that petitioner failed to prove that he was injured in an accident that arose out of and in the course of his employment is not consistent with the weight of the evidence in this record." Petitioner's Statement of Exceptions, p. 13. Accordingly, Respondent's waiver argument is not persuasive to the Commission.

With regard to the issue of accident, the Arbitrator found that Petitioner failed to prove an accident arising out of and in the course of his employment with Respondent, and that Petitioner's current condition of ill-being is not related to any workplace accident or in any way connected to his employment. In so doing, the Arbitrator noted that the July 18, 2018 medical record of Dr. Griffin reflects that Petitioner denied any immediate trauma. He also noted that the records of Liberty Physical Therapy indicate Petitioner complained of back pain rather than hip pain and that the July 12, and July 25, 2018 x-rays revealed advanced bilateral avascular necrosis with femoral head collapse.

The Arbitrator ultimately relied on the testimony of Dr. Thangamani, who opined that it would take years for trauma to cause the development of Petitioner's condition, which was so advanced that it was inevitable that a hip replacement would become necessary. Compared to Dr. Thangamani, the Arbitrator noted that Dr. Brooker did not take his own history from Petitioner, did not know his job title, and did not examine Petitioner. Based on the foregoing, the Arbitrator found that Petitioner failed to meet his burden of proof regarding accident and denied further benefits. The Commission disagrees with the Arbitrator's assessments.

The Arbitrator's conclusion that Petitioner's day-of-accident back pain complaints rule out a hip injury is misplaced. Such a conclusion places an expectation on the Petitioner to appropriately diagnose his medical condition. Although initial medical records indicate Petitioner had back pain, he shortly thereafter described it as hip pain. Indeed, the totality of medical evidence suggests that Petitioner's initial back pain was, in fact, hip pain.

Petitioner testified that he was not treating for back pain prior to the accident. The record reflects that he was working full duty at that time as well. In contrast, immediately after the accident Petitioner testified to increased pain in his hip area and sought out physical therapy followed by additional medical care for his ongoing symptoms. This timeline is corroborated by the testimony of Dr. Brooker, who opined that Petitioner's condition was in fact work-related and was, at least in part, acute. Dr. Brooker explained that it looked like someone "took a bite" out of the femoral head and opined that the instant accident exacerbated Petitioner's degenerative hip condition to the point where surgery was necessary sooner rather than later. Dr. Brooker's opinion that Petitioner's condition was acute was further buoyed by the fact that Petitioner's right hip condition was worse in comparison to his left hip, which did not show evidence of femoral collapse. Moreover, Dr. Psaradellis treated Petitioner on several occasions and also opined that the work injury aggravated his right hip condition, which was asymptomatic prior to the instant accident.

The Commission places little weight on Petitioner's initial complaints of a back injury to the exclusion of a hip injury. The Commission is not persuaded by Respondent's assertion that Petitioner offered medical providers inconsistent mechanisms of injury. A review of the records indicates Petitioner simply provided accounts of his accident to varying degrees of specificity. The Commission finds that none of Petitioner's accounts of injury conflict with one another. In each instance Petitioner detailed some combination of the work accident and pulling a heavy instrument leading to a snap or pop in his hip area. Accordingly, the totality of evidence negates Respondent's claims of inconsistencies rendering his accounts incredible.

Moreover, no evidence was presented to rebut Petitioner's claim about the occurrence or mechanism of injury through either witnesses or documentation. This is significant, as there were several individuals present at the time of the accident. Petitioner immediately informed his supervisor of the accident, who would have immediately documented the allegation occurring during OSHA-regulated haz-mat activity. To dismiss Petitioner's treatment for (what he believed to be) low back pain instead of hip pain occurring on the very date that the alleged injury occurred, the Commission would have to find Petitioner lacking in credibility despite an accident witnessed by several individuals without evidence adduced to the contrary.

It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill.2d 528, 533-34 (1981). The Commission infers from the totality of evidence that Petitioner was mistaken about his pain generator, assuming the source of his pain stemmed from his back rather than his right

hip. The Commission finds this mistake reasonable considering the proximity of the hip to the low back and the medical opinions of Dr. Brooker and Dr. Psaradellis. Accordingly, in consideration of the record as a whole, the Commission finds that Petitioner did prove by a preponderance of credible evidence that he suffered an accident affecting his right hip on the date in question.

B. Causal Connection

Having found that Petitioner sustained a compensable accident, the Commission turns to the issue of causal connection. The Arbitrator found no causal connection between Petitioner's current condition and any workplace accident. In so doing, the Arbitrator relied on the opinion of Respondent's Section 12 examiner, Dr. Thangamani.

In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205. It is well established that "[a] chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in a disability" may be sufficient to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

The weight of the evidence establishes that Petitioner's current right hip condition is causally related to the accident at work, which aggravated a degenerative condition that had been asymptomatic for years. Prior to the accident, Petitioner had no right hip issues that interfered with his ability to perform his full duties for Respondent. He had been doing so for nine months, working eight to ten hour shifts five to six days per week. Even on the date of accident itself, Petitioner had worked four hours prior to the incident. Afterward, he testified to an immediate onset of pain, which was ongoing and corroborated by the totality of the medical records. The foregoing is also corroborated by the causal connection opinions offered by treating Drs. Psaradellis and Brooker. Specifically, Dr. Brooker testified that the accident did not cause Petitioner's right hip condition, but it did cause this preexisting condition to become symptomatic and exacerbated it to the point where surgery was necessary sooner rather than later. Moreover, Respondent's own section 12 examiner Dr. Thangamani testified that the accident gave rise to the onset of pain that stopped Petitioner from working. He offered no other explanation for this new onset. Dr. Thangamani also acknowledged that pulling a six-inch diameter hose through two beams is not an activity of daily living.

Based on the foregoing, the Commission finds that the preponderance of evidence supports a reversal of the Arbitrator's ruling and finds that there is a causal connection between the accident and Petitioner's current right hip condition.

C. Medical Expenses

Regarding medical expenses, and having found that Petitioner established a compensable accident and causal connection, the Commission awards unpaid medical expenses found in Petitioner's Exhibit No. 6 of $241.64 to Midland Orthopedic Associates and $164.00 to Roseland Community Hospital pursuant to sections 8(a) and 8.2 of the Act. These expenses were the result of reasonable and necessary medical treatment to alleviate Petitioner of the effects of his injury at work.

D. Prospective Medical Care

Regarding Petitioner's claim for prospective medical treatment, the Commission notes that there is no dispute between the parties regarding his need for a right hip replacement surgery. The only issue is causal connection. Accordingly, having found accident and causal connection as explained herein, the Commission reverses the Arbitrator's ruling and awards the prospective surgery.

E. Temporary Total Disability

The Commission further awards Petitioner outstanding TTD benefits claimed. "To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). "The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Id.* The record reflects that Petitioner's condition has not stabilized and that he was unable to work. Accordingly, the Commission awards Petitioner TTD benefits from June 23, 2018 through October 29, 2019, totaling 70 and 4/7ths weeks. Respondent has paid benefits from June 23, 2018 through October 19, 2018, thus leaving an outstanding TTD period from October 20, 2018 through the arbitration date of October 29, 2019, totaling 53 and 4/7ths weeks.

F. Penalties and Fees

Despite reversing the Arbitrator's rulings on the above issues, the Commission nevertheless affirms the Arbitrator's denial of penalties and fees. Respondent's actions do not meet the threshold required for penalty imposition. Respondent paid benefits in good faith until the section 12 examination, which was scheduled within one month of Dr. Brooker's surgical recommendation. Respondent reasonably relied upon the opinions of Dr. Thangamani in terminating benefits and offered that reasonable basis on which to deny payment of benefits. Accordingly, the Commission affirms the Arbitrator's denial of penalties and fees.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has met his burden of proof regarding accident and causal connection in relation to the instant accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits from June 23, 2018 through the arbitration date of October 29, 2019, or $507.73 per week for 70 and 4/7ths weeks, totaling $35,831.23. Respondent shall receive credit for all previously paid temporary total disability benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay outstanding medical expenses of $241.64 to Midland Orthopedic Associates and $164.00 to Roseland Community Hospital pursuant to sections 8a and 8.2 of the Act. Respondent shall receive credit for medical expenses previously paid, including in the amount of $505.69 for "other benefits" paid.

It IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the recommended total right hip arthroplasty and all reasonable and necessary related charges stemming from the procedure.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for penalties and fees is hereby denied.

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

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

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.

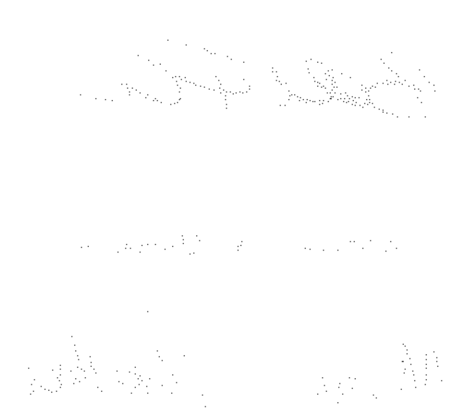
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 6 2020
o: 7/23/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker



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

OSEGUERRA, ALEJANDRO
Employee/Petitioner

Case# **18WC022306**

AQS SERVICES
Employer/Respondent

20IWCC0524

On 12/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
100 N RIVERSIDE PLZ SUITE 24TH
CHICAGO, IL 60606

5074 QUINTAIROS PRIETO WOOD & BOYER
KRISTIN LINDERMAN
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Alejandro Osequera
Employee/Petitioner
v.
AQS Services
Employer/Respondent

Case # 18 WC 22306

Consolidated cases: ____

20 I W CC 0524

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **October 29, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 22, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Preceding the injury, Petitioner's average weekly wage was $**761.22**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children

Respondent shall be given a credit of $**9715.19** for TTD, $**0** for TPD, $**0** for maintenance, and $**505.69** for other benefits, for a total credit of $**10,220.88**.

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

ORDER

Because Petitioner did not sustain accidental injuries that arose out of and in the course of employment; and Petitioner's current condition of ill-being is not causally connected to a work place injury, benefits are denied.

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

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

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

[signature]

Signature of Arbitrator

12/18/19

Date

ICArbDec19(b)

DEC 18 2019

Alejandro Oseguera, No. 18 WC 22306

Preface

The parties proceeded to hearing October 29, 2019, on a Request for Hearing and Petition for an Immediate Hearing under Section 19(b) of the Act, indicating the following disputed issues: whether Petitioner sustained accidental injuries that arose out of and in the course of his employment; whether Petitioner's current condition of ill-being is causally connected to the injury; whether Respondent is liable for unpaid medical bills; whether Petitioner is entitled to a period of temporary total disability; and whether Petitioner is entitled to penalties/attorney's fees under Sections 19(k), 19 (l), and 16 of the Act. Alejandro Oseguera v. AQS Services, No. 18 WC 22306 Transcript of Proceedings on Arbitration at 5; Arbitrator's Exhibit 1; Arbitrator's Exhibit 2. Three witnesses testified, Petitioner and, by evidence deposition, Dr. Jay Brooker and Dr. Vijay Bryan Thangamani. Prior to hearing, Petitioner voluntarily dismissed American Zink Recycling as a Respondent. Arbitrator's Exhibit 5.

Findings of Fact

Alejandro Oseguera (Petitioner), a 50 year old male, testified he worked for Respondent as a laborer, cleaning spills. He never testified precisely what business respondent was in or precisely what it was he did. What can be gleaned from his testimony is that Respondent was involved in the clean up of hazardous material by means of giant hoses, taking a team of men to operate. Petitioner testified that on June 22, 2018, his team was pulling a hose that got caught in a beam, he started pulling the hose over his shoulder, and he couldn't move. He said he crawled to a trailer where his supervisors were, and eventually they took him to the front gate. He said he was in agony, in pain, couldn't sit or stand was in massive pain, couldn't even walk and his first thought, said Petitioner, was to get a massage. Oseguera at 11, 17, 13, 15, 19-23, 24-25.

Petitioner testified he went to therapy. He thought the pain was in his back, and couldn't pinpoint it. The records of Liberty Physical Therapy indicate Petitioner was seen June 22, 2018, on a referral with a diagnosis of lower back pain. Petitioner did not testify he was referred there, nor that he was diagnosed elsewhere with back pain. The notes do not indicate who referred Petitioner. The pain, according to the notes, was in Petitioner's sacroiliac joint. There is no mention in the records of a work injury. The notes indicate mechanical lower back pain with treatment three times a week for four weeks of interferential current, heat, trigger point treatment, manual massage, home exercises and a stationary bicycle. Petitioner was seen twice more, June 25, 2018, and June 27, 2018, for treatment. He was not placed off work, not referred to other medical providers, and was given no medication. Oseguera at 20; Petitioner's Exhibit 1.

Petitioner testified he then went to his primary care physician at Chicago Family Health Center. The records of Chicago Family Health Center indicate Petitioner was seen almost a month after the alleged accident, July 12, 2018. He complained of pain in his right hip and was given a prescription for prednisone. Petitioner had diagnostic imaging of his right hip July 12, 2018, which indicated: evidence of multiple fracture fragments of the right femoral head which may represent pathological fractures secondary to aseptic necrosis. Imaging noted marked to

severe increased sclorosis of the right femoral head and portions of the neck. This was described as degenerative. Oseguera at 31; Petitioner's Exhibit 2. Petitioner's Exhibit 3.

Petitioner returned to Chicago Family on July 18, 2018. His x-ray was reviewed. Petitioner denied any immediate trauma and said he heard a snap. He indicated he had substantial improvement with the pain medication. Petitioner was assessed with a closed fracture of the head of his right femur and referred to an orthopedic surgeon. Petitioner's Exhibit 2.

Petitioner testified he was referred to an orthopedic surgeon and went to Midland Orthopedic Associates. We do not know how Midland was chosen. The records of Midland Orthopedic Associates indicate Petitioner was seen July 25, 2018, by Dr. Telly Psaradellis. Those notes indicate Petitioner told him this occurred a month ago while he was at work pulling a hose, he was not sure what happened, but felt and heard a pop in his right hip. If so, it is at odds with Petitioner's testimony at trial and his treatment at Liberty Physical. Psaradellis noted Petitioner's x-ray showed advanced bilateral avascular necrosis with femoral head collapse. Petitioner was placed off work. Oseguera at 35; Petitioner's Exhibit 4; Oseguera at 23-26.

Petitioner testified he was given Naproxen. He said he wanted to avoid surgery. Petitioner saw Psaradellis twice more. On August 10, 2018, he wanted to try anti-inflammatories and wanted to avoid surgery. By September 12, 2018, Psaradellis noted Petitioner had exhausted conservative treatment and felt surgery was indicated. Oseguera at 36, 37; Petitioner's Exhibit 4.

Petitioner was last seen at Midland by Dr. Jay Brooker on October 1, 2018. Brooker testified he saw Petitioner once. He described avascular necrosis as a loss of circulation to the ball of the hip joint and over time, the ball can collapse. During his direct examination, he testified the most common cause is taking steroids, commonly Prednisone, and alcohol abuse. For half of the people who have it, there is no known cause. Scuba divers are about one percent of people who have it. He did not testify that trauma was a cause. He testified Petitioner's x-ray indicated an acute component on chronic disease. This is not reflected anywhere else in the records and is at odds with the notes of Psaradellis indicating "advanced bilateral avascular necrosis." Brooker testified he thought Petitioner's injury exacerbated Petitioner's condition to the point where it led him to surgery sooner than he would have to have it. He did not address the mechanics of the injury, Petitioner pulling a hose over his shoulder, and how that supported his testimony. Brooker said he was not familiar with Petitioner's job. He admitted he never asked Petitioner for a history. No physical examination is noted in his records. On cross examination, Brooker said he forgot trauma may be a cause, but said it was not the cause of bilateral necrosis, that was something in a person's system. He said Petitioner's condition was severe, and regardless of Petitioner's work duties, at some point his replacement would be inevitable. Petitioner's Exhibit 4; Petitioner's Exhibit 5 at 8, 21, 22, 33, 26, 34, 43, 44, 46.

The Petitioner returned to Chicago Family Health Center October 9, 2018, eight days after his single visit with Dr. Brooker who testified his agreement with a hip replacement for Petitioner was based on Petitioner's pain. However, when Petitioner saw his primary care doctor at that October 9, 2018, visit, his pain scale was 0/10. Petitioner's Exhibit 2; Petitioner's Exhibit 5 at 42.

Petitioner testified his surgery was not authorized and he has no insurance. However, during an office visit to his primary care provider on November 14, 2018, the notes indicate Petitioner said his surgeon delayed surgery so Petitioner now wants to utilize his insurance to see another surgeon. His physician again noted a pain scale of 0/10, and indicated Petitioner has been a difficult historian and had suggested his anesthesiologist wanted further testing and diagnostic studies which delayed surgery, which angered Petitioner. Petitioner was diagnosed with bronchitis and referred to orthopedic surgery at Mt. Sinai Hospital. Petitioner testified he saw no other medical providers after October 14, 2018, for his right hip. Oseguera at 41 ; Petitioner's Exhibit 2.

Petitioner submitted to an independent medical examination by Dr. Vijay Bryan Thangamani, a board certified orthopedic surgeon in practice with the DuPage Medical Group on October 26, 2018. Unlike Brooker, he took a history from Petitioner, and reviewed his prior treatment. He diagnosed Petitioner with avascular necrosis of both hips based on medical records and imaging. Thangamani described the condition as where blood supply to the bone is disrupted, the bone slowly dies and is deformed and develops arthritis. He testified the causes are steroid use, alcoholism, severe trauma to the hip, but the majority of cases have no known cause. He testified he did not believe the work incident caused development of the condition because the process takes time to develop. If it's trauma, he said, it's pretty severe trauma, such as a car accident causing a fracture of the bone. He said such trauma takes years and years for deformity. He testified Petitioner's avascular necrosis was so advanced, the femoral head collapse was inevitable. Thangamani testified Petitioner's deformity and arthritis had been there long before the date of injury, and was so bad the need for hip replacement was inevitable because of the condition of the hips. Absent any injury, there was 100% chance Petitioner would require hip replacement. He testified the hip collapsed prior to the injury.

Conclusions of Law

The decision in this case begins and ends with disputed issues **C**, did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; and **F**, is Petitioner's current condition of ill-being causally related to the injury.

To prevail in a claim for benefits under the Act, a Petitioner most prove, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of his employment. Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 203 (2003). The "arising out of" component concerns the causal connection between a work related injury and the employee's condition of ill-being. National Freight Industries v. Illinois Workers' Compensation Commission, 2013 Ill. App. (5th) 12 0043 WC paragraph 25. To establish causation, a Petitioner must prove that some act or phase of employment was a causative factor in his ensuing injury. Land and Lakes Co. v. Industrial Commission, 359 Ill. App. 3d 582, 592 (2005).

I find as a conclusion of law, Petitioner failed to prove an accident occurred that arose out of and in the course of Petitioners employment by Respondent; and that Petitioner's current condition of ill-being is not related to any workplace accident or in any way connected to his employment. I rely on the following.

On July 18, 2018, during an office visit with his primary care physician, Petitioner denied any immediate trauma. Petitioner's Exhibit 2. The records of Liberty Physical Therapy indicate Petitioner complained of back pain. Petitioner's Exhibit 1. Petitioner's x-ray showed advanced bilateral avascular necrosis with femoral head collapse. Petitioner's Exhibit 3; Petitioner's Exhibit 4.

I place strong reliance on the testimony of Dr. Thangamani. He testified for trauma to cause this condition, it had to be severe and would take years to develop. Petitioner denied a trauma and testified he was holding a hose over his head. Thangamani said the condition was so advanced, collapse was inevitable, as was the need for his replacement. He is in a superior position to Brooker, who took no history from Petitioner, did not know about his job, and did not do a physical examination. Brooker also "forgot" trauma may be a cause of Petitioner's condition.

In view of the foregoing, Respondent is not liable for any medical bills, Petitioner is not entitled to any period of temporary total disability, and no penalties or attorney's fees are awarded Petitioner.

[signature] 12/18/19

Arbitrator Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RYAN STOCKE,

Petitioner,

vs. NO: 17 WC 36450

TAZEWELL COUNTY,

Respondent.

20 I W C C 0 5 2 5

DECISION AND OPINION ON REVIEW

Respondent timely filed a Petition for Review of the Decision of the Arbitrator finding Petitioner proved he sustained an accidental injury arising out of and in the course of his employment and his condition of ill-being is causally related to his work injury. Notice having been given to all parties, the Commission, after considering the issues of accident (arising out of), causal relationship, temporary total disability benefits, medical expenses, and permanent partial disability benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator. The Commission finds Petitioner failed to prove an accidental injury arising out of his employment on October 21, 2017. Therefore, all benefits are denied.

FINDINGS OF FACTS

The Commission affirms and adopts the Findings of Facts contained in the Arbitrator's Decision and fully incorporates the same herein.

CONCLUSIONS OF LAW

In finding Petitioner proved he sustained an injury which arose out of his employment on October 21, 2017, the Arbitrator and by extension, the Dissenting Commissioner made a favorable credibility determination; in particular, placing significant weight on Petitioner's testimony regarding his alleged need to hurry. The Commission views the evidence differently. See *R & D Thiel v. Ill. Workers' Comp. Comm'n*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870 (2010) ("[W]hether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence. A resolution of the question can only rest upon the reasons given by the Commission for the variance."). The Commission finds Petitioner not

credible based upon its review of the surveillance video documenting the occurrence as well as Petitioner's failure to advise anyone (supervisors and/or medical providers) as to his need to hurry.

The video documents Petitioner walking up the stairs, and when rounding the landing, Petitioner appears to be walking slightly faster but in no way appears to be hurried or rushed. RX1; PX5. Further, Petitioner testified his alleged hastened pace was due to a radio call advising of a new detainee being brought to booking. T. 21; 23. In viewing the video, there is no indication Petitioner in any way paused to listen to his radio. Moreover, and more importantly, no such radio call actually occurred as no detainee was brought to booking. T. 40.

Petitioner testified immediately following his fall, he reported the incident to his supervisor, Dave Harper. T. 27. Petitioner provided no testimony that he advised Mr. Harper regarding his need to hurry because of a detainee. Mr. Mike Harper is employed by Respondent as a Deputy Jail Superintendent and is Petitioner's supervisor. T. 45. Mr. Harper testified the first time he learned of Petitioner's alleged need to hurry was during Petitioner's trial testimony. T. 59. Moreover, Mr. Harper confirmed that to his knowledge no other supervisors of Petitioner were aware of his need to hurry. *Id.*

Petitioner testified within an hour of his accident, he sought treatment at Pekin Hospital Emergency Room. T. 27. The medical records evidence the following history of accident: "[Petitioner] reports that he fell down a couple concrete steps at work when he tripped." PX1. There is no mention of hurrying. On October 30, 2017, Petitioner presented to Dr. Tate for follow-up care from his emergency room visit due to "fall on stairs, lower back pain." PX2. There is no mention of hurrying.

On November 9, 2017, Dr. O'Leary evaluated Petitioner who provided the following history of accident: "[Petitioner] states that he was walking up the stairs and thinks that maybe his right foot caught the step and he fell forward." PX3. Again, no mention of hurrying. In fact, Petitioner provides Dr. O'Leary with a completely different explanation as to the cause of his fall- "his right foot caught the step." *Id.* On December 1, 2017, physical therapist, Mark Fabish, evaluated Petitioner who provided the following history of accident: "[Petitioner] was walking up some concrete steps at work and he slipped, twisted and scooted down 3-4 steps." *Id.* Again, no mention of hurrying.

The mere act of traversing stairs is not, in of itself, an employment risk but a neutral risk. See *Elliot v. Industrial Comm'n*, 153 Ill. App. 3d 238, 505 N.E.2d 1062 (1987). As such, there must be a showing of a qualitative or quantitative increase in the risk. Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Illinois Inst. of Tech. Research Inst. v. Industrial Comm'n*, 314 Ill. App. 3d 149, 163, 731 N.E.2d 795 (2000). Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Metro. Water Reclamation Dist. of Greater Chi. v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 1014, 944 N.E.2d 800 (2011). Petitioner failed to prove such increased risk. There is no evidence that the stairs were in any manner defective nor any credible evidence that the demands of Petitioner's job increased his risk of

tripping on the stairs (qualitative). Further, restrooms were provided on both the basement and the ground level, and Petitioner chose to use the basement level. Even if Petitioner was required to traverse the stairs twice a day to utilize the restroom, this would not rise to a quantitative increased risk.

The Commission finds Petitioner failed to prove he sustained an accident which arose out of his employment as Petitioner sustained an unexplained fall which is not compensable. See *Builders Square, Inc. v. Indus. Comm'n*, 339 Ill. App. 3d 1006, 1010, 791 N.E.2d 1308 (2003) ("a claimant must present evidence supporting a reasonable inference that the fall stemmed from an employment-related risk. After all, the 'arising out of' requirement contemplates 'a causal connection between the accidental injury and some risk incidental to or connected with the activity an employee must do to fulfill his duties.' [citation omitted]. Awarding compensation for a purely unexplained fall would eviscerate this requirement."). All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 1, 2019 is hereby reversed, and the award of benefits therein is vacated.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: SEP 1 6 2020

L. Elizabeth Coppoletti

O: 7/21/2020
068

Stephen J. Mathis

DISSENT

I respectfully dissent from the Majority's Decision, and would affirm and adopt the well-reasoned Decision of the Arbitrator. In reversing the Arbitrator's Decision, the Majority concludes that the video admitted into evidence shows the Petitioner "walking up the stairs, and when rounding the landing, Petitioner appears to be walking slightly faster but in no way appears to be hurried or rushed." However, the video does not reflect what the Majority purports to be so clearly evident, and I disagree with the interpretation. The video shows Petitioner jog up one set of stairs, round the landing, begin jogging up the next set of stairs and then fall. The Petitioner testified that he was in a hurry and the video corroborates his testimony. In my view, the Petitioner was, in fact, hurrying up the stairs to address what he believed was a detainee issue in the booking department. It is undisputed that there were usually three officers working in the booking department but only two on the day of the accident. I find that the risk of injury on those stairs was increased as a

20IWCC0525

consequence of Petitioner's work. Petitioner was exposed to a qualitative, neutral risk greater than that encountered by the general public.

The Arbitrator was also in the best position to judge the credibility of the witnesses in this case and I would affirm her Decision. Therefore, I respectfully dissent.

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STOCKE, RYAN
Employee/Petitioner

Case# **17WC036450**

TAZEWELL COUNTY
Employer/Respondent

20IWCC0525

On 10/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.79% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0708 JOHN LESAGANICH ATTY AT LAW
416 MAIN ST
SUITE 823
PEORIA, IL 61602

2337 INMAN & FITZGIBBONS LTD
MICHAEL BANTZ
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

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

Ryan Stocke
Employee/Petitioner

v.

Tazewell County
Employer/Respondent

Case # **17** WC **36450**

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 **Peoria**, on **August 15, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$52,624.00**; the average weekly wage was **$1,012.00**.

On the date of accident, Petitioner was **39** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,504.56** in non-occupational indemnity disability benefits, for a total credit of **$5,504.56.**

Respondent is entitled to a credit for medical bills paid in the amount of **$241.79** 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 **$674.67**/week for **12 4/7 weeks**, for the timeframe of **October 22, 2017 through January 17, 2018,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$607.20/week** for **15 weeks**, because the injuries sustained caused **3% loss of the person-as-a-whole**, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,504.56** in non-occupational indemnity disability benefits, for a total credit of **$5,504.56.**

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

9/26/19
Date

OCT 1 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ryan Stocke
Employee/Petitioner

Case # **17** WC **36450**

v.

Consolidated cases: N/A

Tazewell County
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he had been employed by Respondent as a Correctional Officer for more than 12 years. Petitioner described his job duties as managing detainees, taking in new arrest subjects, booking detainees into the computer system, transporting detainees, and performing watch tours. He testified that on October 21, 2017, he was assigned to booking-intake duties. He testified that the duties of booking-intake as consisting of going into the sally port and conducting searches of detainees, placing them into a transfer cell, and booking them into a computer system. He testified that intaking detainees from police agencies was different because it was more likely that they would be under the influence of drugs or alcohol, and that when they first arrived it was more likely that they might be combative.

Petitioner testified that just before the accident at issue, he had gone down to the bathroom in the basement and was returning from there. He testified that he was going back to the booking department on the first floor, when he entered the stairwell. He testified that he walked up the first set of stairs and stated that he, "thought that I heard on the radio that we have one in the sally port, so I started hurrying up to get back to the booking department because it was just me and another officer working back in the booking." Petitioner described the sally port as the area where the new detainees were brought in and stated that there normally were three employees working in booking, but that on October 21, 2017, besides himself, there was only one other employee working in booking. Petitioner testified that, while he was on the stairs he thought that he heard something on the radio so he started hurrying, which he described as "not running, but walking very quickly to get back to the booking area." He testified that he believed that his right foot got caught underneath the lip of a stair and that that was why he fell.

Petitioner admitted on direct examination that approximately one week before the date of accident at issue, he had fallen going down his basement steps at home and injured his buttocks, low back, and left leg. He testified that he called in for a shift and missed a day of work because of those injuries. He acknowledged that he probably had a conversation with a co-worker about his fall at home. He testified that he did not, however, seek any treatment between the fall at home and his fall at work on October 21, 2017.

Petitioner testified that at the time he arrived at work on October 21, 2017, he did not have any soreness or bruising, and that he had worked four or five days between that day and the day that he fell at home. Regarding his ongoing low back issues as of the time of trial, Petitioner testified that he now had a hard time getting up but acknowledged that that could be due to the fact that he was 41 years old.

On cross examination, Petitioner testified that he was not sure how many prior workers' compensation claims he had filed in Illinois. He testified that he had, however, injured his left shoulder while working for Respondent.

On cross examination, Petitioner agreed that he later learned that there was not, in fact, a detainee being brought in at the time of the fall at issue.

On cross examination, Petitioner agreed that in late 2017 he underwent nasal surgery.

Michael Harper was called as a witness on behalf of Respondent at the time of arbitration. Mr. Harper testified that he was the Deputy Jail Superintendent for Tazewell County and has been so for five years. He testified that he was a supervisor of Petitioner and was so through 2017, including September and October of 2017.

Mr. Harper testified that in September of 2017, Petitioner asked if he could build up "comp time" in preparation for a nasal surgery, because he did not have very much sick time or other benefit time built up as of that period. He testified that Petitioner typically did not keep a buffer of sick time available and would use up the benefit time as he accrued it. He testified that when an employee was working in booking, their employment duties were all on the first floor. He testified that there were bathrooms available on the first floor and that they were all functional in October of 2017.

Mr. Harper testified that he had reviewed the video of Petitioner's fall and that it appeared to him that Petitioner had planned the fall. He testified that the video showed that Petitioner's right arm appeared bent with his body instead of out in front of him, where most people who fell would put their hands out. He testified that he prepared Respondent's Exhibit 2 and that Petitioner and "Jeff" (another employee of Respondent Tazewell County) were speaking with each other about a party when Petitioner admitted that he had hurt his back at home, falling on his stairs.

On cross examination, Mr. Harper testified that he authored Respondent's Exhibit 2, and that it was his understanding that Petitioner fell at home on either October 14th or 15th. He testified that between that date and October 21, 2017, he did not observe Petitioner having any difficulties with his work duties. He testified that he was unaware of any medical treatment involving Petitioner between October 14th and the date of the accident at issue.

On redirect, Mr. Harper testified that the first time that he had ever heard of Petitioner's explanation regarding hurrying up the stairs was at trial during his testimony at arbitration.

On rebuttal, Petitioner testified before his fall, he tried to use a bathroom on the 1st floor but since it was locked the next nearest bathroom was down in the basement.

On cross examination, Petitioner testified that there were more than three bathrooms on the ground floor, but that he only checked the one bathroom to see if it was locked.

On redirect, Petitioner testified that he assumed that the closest bathroom to the first one that he had tried on the 1st floor was the bathroom in the basement.

The medical records of Pekin Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen in the emergency room on October 21, 2017, at which time it was noted that he fell down concrete stairs at work, that he was complaining of right-sided back, hip and arm pain, and that he denied hitting his head or loss of consciousness. It was noted that Petitioner reported that he fell down a couple of concrete steps at work when he tripped, that he reported that he was able to stop himself from hitting his head and landed on his right side, that he complained of

right hip, right lower back, right knee and right arm pain, and that he reported that the back and hip pain were the worst. It was noted that Petitioner's right arm just felt stiff, that he rated the pain in his back a 7/10, and that when pushing on his lower back, he reported that it made him feel like he needed to urinate. It was noted that the pain in Petitioner's hip intermittently shot down his calf, and that he was a police officer and had his work belt on and landed on his handcuffs and gun. Petitioner underwent x-rays of the right hip on that date, which were interpreted as revealing no fracture. Petitioner underwent x-rays of the right knee on that date, which were interpreted as revealing no acute abnormality. Petitioner also underwent x-rays of the lumbar spine, which were interpreted as revealing no acute abnormality. It was noted that Petitioner was recommended to rest and use ice, to take Tylenol and Ibuprofen for pain, and to follow-up with his primary care physician on Monday. (PX1).

The Progress Note of ProHealth Primary Care was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen by Dr. Tate on October 30, 2017, at which time it was noted that he presented for hospital follow-up for a recent admission for a fall on stairs with low back pain and right shoulder pain. It was noted that Petitioner was complaining of lumbar radiculopathy radiating down the bilateral lower extremities keeping him up at night and right shoulder impingement. The assessment was noted to be that of lumbar radiculopathy and right shoulder impingement syndrome. Petitioner was recommended to undergo an MRI of the lumbar spine and right shoulder x-rays. Petitioner was also given prescription for Ibuprofen and Flexeril, and was given a work note taking him off wok until re-evaluation on November 2, 2017. (PX2).

The Interpretive Report for an MRI of the lumbar spine dated November 1, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2(a). The records reflect that the MRI was interpreted as revealing (1) no acute fracture; (2) subtle left paracentral disc protrusion exerts minimal mass effect on the traversing left S1 nerve root but may be clinically relevant given patient's left lower extremity numbness; no central stenosis in the lumbar spine. (PX2a).

The Interpretive Report for x-rays of the right shoulder dated November 1, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2(b). The records reflect that the films were interpreted as revealing no acute bony abnormality seen on three-view study. (PX2b).

The medical records of Midwest Orthopaedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on November 9, 2017, at which time it was noted that he stated that he was on duty down in the basement returning from a break, that he stated that he was walking up the stairs and thinks that maybe his right foot caught the step and he fell forward, and that during the process he kind of turned and ended up landing on the right side of his body and kind of flipped onto his back and slid down about 3-5 stairs. It was noted that Petitioner was able to get up, that he walked back up the stairs, and that he then went to the emergency room due to a fairly significant amount of back pain. It was noted that Petitioner was complaining of pain in the middle of his lumbar area, that it seemed to be worse with lying down, that he mentioned that he occasionally felt some left leg tingling but stated that he had had that for years, and that mostly it was the back pain that was bothering him. It was noted that Petitioner wanted to get back to work, that he only had about 10% leg pain and that he initially had some right leg pain, but thought that it had gotten better. The impression was noted to be that of (1) low back pain, lumbar strain; (2) work-related injury. Petitioner was recommended to undergo physical therapy. Petitioner was also issued work restrictions and was told that he could take some over-the-counter Ibuprofen. Petitioner was further recommended to return in four weeks. (PX3).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen for physical therapy on December 1, 2017, at which time it was noted that his pain had subsided to 6/10 pain at the worst, that he actually had no pain with light walking/activity, that sitting was about 3/10 pain, and that laying down was the worst. It was noted that when Petitioner sat he did experience some numbness in the right buttock, so

when he stood he did not feel right for a few steps. It was noted that Petitioner was not taking any medications and that he had not had any other treatments to date. It was also noted that Petitioner was off work and had to be 100% to return, that he wore a utility/gun belt, and that his goal was also to start a program to get back into shape again. The assessment was noted to be that of low back pain and lumbar strain. It was noted that Petitioner's rehab potential was excellent, and that he was motivated to return to full duty ASAP. At the time of the December 5, 2017 visit with Dr. O'Leary, it was noted that Petitioner should just start physical therapy and that Dr. O'Leary was hopeful that it would help him. It was also noted that Dr. O'Leary did not have any surgery to offer, and that he was not sure an injection would be of benefit. It was noted that Petitioner had had a spinal injection which gave him no relief. Petitioner was returned to work with restrictions and was recommended to follow-up after physical therapy. (PX3).

The records of Midwest Orthopaedic Center reflect that Petitioner underwent physical therapy on December 15, 2017, at which time it was noted that he had no pain in his low back on that date. At the time of the December 18, 2017 physical therapy visit, it was noted that Petitioner reported that he felt a little bit of back pain, that he described it as feeling like he just tweaked his back but that it was much better overall, and that he said he felt pretty good over the weekend and did not have any incidents of increased pain. At the time of the December 20, 2017 physical therapy visit, it was noted that Petitioner reported no low back pain on that date, but that he felt some popping in his low back when he rolled over the night before and that he said that it felt good. At the time of the December 21, 2017 physical therapy visit, it was noted that Petitioner reported 2/10 pain in the middle of his low back, that he stated he was a little sore after yesterday's treatment but not too bad, and that he said he thought maybe a couple more weeks of physical therapy would be beneficial since he was more sore after the exercises yesterday. It was noted that Petitioner's physical therapy visit of December 26, 2017 was cancelled by Petitioner. (PX3).

The records of Midwest Orthopaedic Center reflect that Petitioner underwent physical therapy on January 2, 2018, at which time it was noted that he reported his low back was feeling pretty good lately and that he rated 1-2/10 constant pain in his low back. It was noted that Petitioner thought that he was ready to return to work and that he would be able to do all work duties at that point. At the time of the December 28, 2017 physical therapy visit, it was noted that Petitioner's back locked up on him the night before while he was standing and washing dishes, and that he had to sit down to relieve it. It was noted that Petitioner did not show for his physical therapy visit on January 4, 2018, as he saw Dr. O'Leary's physician's assistant that morning. At the time of the January 4, 2018 visit with Alesia Svymberky, PAC, it was noted that Petitioner was currently in physical therapy, that he had been going three times a week for about three weeks, that he felt like he still had some pain in his lower back, mostly kind of pressure, and that he stated that it was right in the middle of his lower back. It was noted that Petitioner did not really have any radicular-type pain, that he stated that he was able to get up but at times when he was walking he would start to feel pain and pressure in his lower back, and that he felt like otherwise he was doing better but just not completely 100%. It was noted that Petitioner thought that his symptoms were better, and that he really wanted to try a couple more weeks of physical therapy to see if he could get back to 100%. The impression was noted to be that of (1) lumbar strain; (2) work-related accident status post fall. Petitioner was recommended to finish out his six weeks of physical therapy and if he was not improved, he would be sent to IPMR to see if they could offer him work conditioning-type of activity. Petitioner was issued work restrictions and was recommended to return in two weeks. (PX3).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen for physical therapy on January 10, 2018, at which time it was noted that he reported his low back on the right side had been bothering him more since he was last seen, and that he stated that it felt like a muscle spasm that went down into his right hip. At the time of the January 12, 2018 physical therapy visit, it was noted that Petitioner reported that his low back was feeling much better, and that he had not had any episodes of his low back/hip hurting since his last treatment. At the time of the January 16, 2018 physical therapy visit, it was noted that Petitioner reported that his low back no longer felt like a sledgehammer hit it when he first came to therapy,

and that it now felt more like a charlie horse cramping at times when he was standing. It was noted that Petitioner felt like he would be ready to return to work after his last week of therapy. At the time of the January 18, 2018 physical therapy visit, it was noted that Petitioner reported that his low back was feeling good that morning with no complaints of pain, that he stated that he did not practice going through his upgraded home exercise program yet, and that he felt ready to return to work and would call Dr. O'Leary's physician's assistant and let her know. Included within the records of Midwest Orthopaedic Center was a Return to Work slip dated January 18, 2018, allowing Petitioner to return to work without restrictions as of that date. (PX3).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen in the emergency room on January 31, 2018, at which time it was noted that he complained of back pain. It was noted that Petitioner had fallen at work as a correctional officer in October 2017 and had been off work on physical therapy until January 20, 2018, that after working a long 16-hour shift he noticed his back was hurting again and had worsened, and that he felt some numbness into his medial thigh at times and stated that it hurt to stand up straight. The diagnosis was noted to be that of acute bilateral low back pain with left-sided sciatica. Petitioner was given prescriptions for Flexeril, Norco and Naprosyn, and was recommended to follow-up at Midwest Orthopaedics.

The Job Video was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The video demonstrates that the time was approximately 10:51 a.m. at which point Petitioner is seen going upstairs and falling on his right side, after which he starts to slide down the stairs and catch the handrail with his left hand. The Arbitrator notes that Petitioner then slowly climbed up the rest of the stairs one foot at a time, favoring his right leg. (PX5).

The Records Review Report of Dr. Lawrence Li dated February 1, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. When asked of his understanding of Petitioner's lumbosacral spine prior to October 21, 2017, the report reflects that Dr. Li indicated that there was no indication that he had any prior history of back pain. When asked of his understanding of the mechanics of the fall that Petitioner sustained while at work on October 21, 2017, the report reflects that Dr. Li indicated that he fell forward and onto his right side, that he then slid down several stairs, and then finally was able to catch himself with his left arm on the rail and stop the fall. When asked of his understanding of the radiological impression of the MRI of November 1, 2017, the report reflects that Dr. Li indicated that that the dominant findings were a subtle left paracentral disk protrusion that exerted minimal mass effect on the traversing left S1 nerve root, but could correlate with the symptoms that Petitioner had complained of. When asked to provide a summary of the care that Petitioner received at Midwest Orthopaedics between the day he was seen and January 18, 2018, the report reflects that Dr. Li indicated that he was basically provided physical therapy and that as of January 18, 2018, he reported that his low back was feeling good with no pain, that the plan was to discharge him from therapy, and that he would go on a home exercise program and follow-up as needed. When asked of his understanding of the period of time in which Petitioner was authorized off work and his understanding of when Dr. O'Leary first thought he was eligible for light duty and whether the records reviewed related to the necessity of his time missed from work and light duty to the effects of the fall he sustained on October 21, 2017, the report reflects that Dr. Li opined that all the off work and light duty work prescribed by Petitioner's providers was reasonable, necessary, and related to the injury that he suffered on October 21, 2017. (PX6).

Video Footage was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The exhibit was effectively duplicative of that as contained in Petitioner's Exhibit 5. (RX1; PX5).

The October 31, 2017 Memorandum of DJS Mike Harper was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that on October 16, 2017 DJS Harper was sitting

in the Second Floor Control with Petitioner and Jeff Stocke, and that he heard Jeff Stocke ask Petitioner if he had a "smores party" and did not invite him. It was noted that Petitioner stated that he did not have a party, and that Jeff Stocke asked Petitioner if that was why he called in yesterday because he ate too many "smores." It was noted that Petitioner stated that he should have never carpeted the stairs because he fell down the stairs and hurt his back. (RX2).

The Documentation of Disability Payments was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Documentation of Self-Insured Group Health Payments was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The IWCC Database Information on Prior Cases was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records reflect that 99 WC 30433 alleging injury to the whole body on June 22, 1997 was dismissed on July 5, 2001; that 11 WC 41582 alleging injury to the left arm and shoulder on September 25, 2010 had a settlement contract approved on January 16, 2014; that 11 WC 42139 alleging injury to "multiple parts" on January 10, 2009 had a settlement contract approved on January 16, 2014; and that 12 WC 18227 alleging injury to "multiple parts" on December 10, 2011 had a settlement contract approved on January 16, 2014. (RX6).

The Description of Petitioner's Job Duties was entered into evidence at the time of arbitration as Respondent's Exhibit 7.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on October 21, 2017.

Having observed his manner and demeanor while testifying at the time of arbitration and finding Petitioner to have been a credible witness, the Arbitrator places significant weight upon Petitioner's testimony that, as he ascended the stairwell from Respondent's basement bathroom, he believed that he heard that a new detainee had arrived at the sally port and he thereafter hurried up the steps, resulting in a fall on Respondent's premises. Finding the accident to have been factually analogous to the fact pattern as described in *William G. Ceas & Co. v. Industrial Comm'n*, 633 N.E.2d 994, 261 Ill.App.3d 630, 199 Ill. Dec. 198 (1st Dist. App. Ct. 1994), the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on October 21, 2017.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of October 21, 2017.

The Arbitrator notes that, at the request of counsel for Petitioner, Dr. Li authored a records review report dated February 1, 2019, in which he offered various medical opinions. (PX6). The Arbitrator further notes that there was no rebuttal evidence offered by Respondent so as to refute Dr. Li's opinions in this matter. As a result thereof, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of October 21, 2017.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator notes that the Request for Hearing Form indicated that Petitioner's medical bills had been discharged through bankruptcy. (AX1). The Arbitrator further notes that no medical bills exhibit was proffered by Petitioner at the time of arbitration. As a result thereof, the Arbitrator finds that the issue of

Respondent's liability for the payment of reasonable and necessary medical services pursuant to Section 8(a) of the Act is moot.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner claims that he is entitled to temporary total disability benefits for the timeframe of October 22, 2017 through January 17, 2018. (AX1). In light of the Arbitrator's findings as to both accident and causation, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframe of October 22, 2017 through January 17, 2018, a period of 12 4/7th weeks. The Arbitrator further finds that Respondent is entitled to a credit of $5,504.56 in non-occupational indemnity disability benefits paid. (AX1).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, 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 impairment. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he was a Correctional Officer for Respondent at the time of the accident at issue. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 39 years old on the date of the accident at issue. In light of Petitioner's release to full duty by his treating physician, 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 Petitioner testified that he returned to work as a Correctional Officer for Respondent upon the completion of his medical treatment. As there was no evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected his future earnings capacity, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he now had a hard time getting up but acknowledged that that could be due to the fact that he was 41 years old. At the time of the January 4, 2018 visit with Alesia Svymberky, PAC, it was noted that Petitioner was currently in physical therapy, that he had been going three times a week for about three weeks, that he felt like he still had some pain in his lower back, mostly kind of pressure, and that he stated that it was right in the middle of his lower back. It was noted that Petitioner did not really have any radicular-type pain, that he stated that he was able to get up but at times when he was walking he would start to feel pain and pressure in his lower back, and that he felt like otherwise he was doing better but just not completely 100%. It was noted that Petitioner thought that his symptoms were better, and that he really wanted to try a couple more weeks of physical therapy to see if he could get back to 100%. The impression was noted to be that of (1) lumbar strain; (2) work-related accident status post fall. Petitioner was recommended to finish out his six weeks of physical therapy and if he was not improved, he would be sent to IPMR to see if they could offer him work conditioning-type of activity. Petitioner was issued work restrictions and was recommended to return in two weeks. (PX3). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was corroborated by his treating records at the conclusion of his treatment. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **3% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA JORDAN,

Petitioner,

vs.

NO: 15 WC 10684

STATE OF ILLINOIS, C.M.S.,

20 I W C C 0 5 2 6

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Respondent's review of Arbitrator Pulia's order granting Petitioner's petition for reinstatement. Notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, affirms the Arbitrator's Order granting reinstatement, which is attached hereto and made a part hereof. The Commission further remands the matter to the Arbitrator for hearing on the merits.

CONCLUSIONS OF LAW

Generally an Arbitrator's order granting reinstatement is interlocutory and not subject to review. See, *Bechtel Group, Inc. v. Industrial Commission*, 305 Ill. App. 3d 769, 772, 713 N.E.2d 220 (1999) (When the matters herein proceed to trial on the merits, the arbitrator "will be required to make multiple findings, any one of which may lead to another appeal by one of the parties. Piecemeal appeals are to be discouraged.") In this case, however, Respondent contends the Arbitrator lacked jurisdiction to consider reinstatement of the claim as more than 60 days had lapsed since the case was dismissed. Given the jurisdictional question presented, the matter is ripe for our consideration.

Rule 9020.90 governs reinstatement and provides, in pertinent part:

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file

a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90*.

As such, the Commission is tasked with analyzing both the timeliness and the merits of Petitioner's petition for reinstatement.

A. Timeliness

Section (a) of Rule 9020.90 states a Notice of Dismissal "shall be sent to the parties" and it is the "receipt of the dismissal order" which triggers the 60-day filing period for a Petition to Reinstate. *50 Ill. Adm. Code 9020.90(a)*. The Commission observes the physical file does not contain a Notice of Dismissal. As such, there is no documentary evidence to establish the start date for the 60-day filing period.

Petitioner's Petition to Reinstate alleges she did not receive a dismissal order. During the reinstatement hearing, Petitioner confirmed her former attorney did not inform her the case had been dismissed. Petitioner further advised she learned of the dismissal in September 2019, and she filed the petition to reinstate on her own behalf on October 5, 2019. The Commission finds Petitioner's testimony regarding when she learned of the dismissal is credible.

The Commission finds Petitioner did not receive notice of the dismissal until September 17, 2019. As such, the October 5, 2019 petition to reinstate was timely and the Arbitrator had jurisdiction to consider the merits of the petition.

B. Merits of reinstatement

On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1140, 804 N.E.2d 629 (2004). "A party must exercise due diligence in pursuing his or her claim before the Commission." *Id.* at 1143. Respondent argues reinstatement was improper

because Petitioner failed to diligently pursue her claim. The Commission disagrees.

Petitioner credibly testified she relied on her former attorney to competently pursue the matter. However, upon learning of the state of her claim, Petitioner quickly and properly filed the necessary petition herself. The Commission further observes Petitioner has sought new representation to move the claim forward. The Commission finds Petitioner demonstrated sufficient justification for reinstatement

The Commission finds the Petition to Reinstate was properly granted, and we affirm and adopt the Arbitrator's order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order granting reinstatement is hereby affirmed and adopted.

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

DATED: SEP 1 6 2020

LEC/mck

D: 8/26/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

20IWCC0526

Chelsea

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

2019 NOV 13 PM 4:02
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR
FILED

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Case # WC: 15 WC 010684, 15 WC 010685, 15 WC 010686 & 15 WC 024313

Employee/Petitioner:

Norma Jean Jordan

v.

Employer/Respondent:

State of Illinois (SOI) / Central Management Services (CMS)

TO: Whom it may concern at the Illinois Workers' Compensation Commission

On [illegible], at 8:30 a.m., or as soon thereafter as possible, I shall appear before the Honorable Pulia, Nowak & Hemenway, or any arbitrator or commissioner appearing in his or her place at Springfield, Illinois, and present the attached motion for:

1. Dismissal of attorney (#3052) 2. Reinstatement of case (#3074) 3. Request for hearing (#R33)

Norma J. Jordan
Signature Petitioner

Norma J. Jordan
Print Name of Employee / Petitioner

Thomas A. Dorsey III IC code # on file	105 Amos Ave.	Springfield, IL 62704
Attorney's name and IC code # (please print)	Street address	City, State, Zip code

The Dorsey Law Office	(217) 546-7892	DorseyTA3@aol.com
Name of law firm, if applicable	Telephone number	E-mail address

ORDER

The motion is set for hearing on ____________

Signature of arbitrator or commissioner ____________ Date ____________

ORDER

Dismisses atty on 15WC10684, 15WC10685, 15WC10686 and also REIN on 15WC10684, 15WC10685, 15WC10686, 15WC 243

19 DEC -2 AM 10:26
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR
FILED

The motion is √ Granted ___ Withdrawn ___ Continued to ____________

___ Denied ___ Dismissed ___ Set for trial (date certain) on ____________

[signature]
Signature of arbitrator or commissioner

10/24/19
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA JORDAN,

Petitioner,

vs. NO: 15 WC 10685

STATE OF ILLINOIS, C.M.S.,

Respondent.

20IWCC0527

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Respondent's review of Arbitrator Pulia's order granting Petitioner's petition for reinstatement. Notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, affirms the Arbitrator's Order granting reinstatement, which is attached hereto and made a part hereof. The Commission further remands the matter to the Arbitrator for hearing on the merits.

CONCLUSIONS OF LAW

Generally an Arbitrator's order granting reinstatement is interlocutory and not subject to review. See, *Bechtel Group, Inc. v. Industrial Commission*, 305 Ill. App. 3d 769, 772, 713 N.E.2d 220 (1999) (When the matters herein proceed to trial on the merits, the arbitrator "will be required to make multiple findings, any one of which may lead to another appeal by one of the parties. Piecemeal appeals are to be discouraged.") In this case, however, Respondent contends the Arbitrator lacked jurisdiction to consider reinstatement of the claim as more than 60 days had lapsed since the case was dismissed. Given the jurisdictional question presented, the matter is ripe for our consideration.

Rule 9020.90 governs reinstatement and provides, in pertinent part:

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file

a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90.*

As such, the Commission is tasked with analyzing both the timeliness and the merits of Petitioner's petition for reinstatement.

A. Timeliness

Section (a) of Rule 9020.90 states a Notice of Dismissal "shall be sent to the parties" and it is the "receipt of the dismissal order" which triggers the 60-day filing period for a Petition to Reinstate. *50 Ill. Adm. Code 9020.90(a)*. The Commission observes the physical file does not contain a Notice of Dismissal. As such, there is no documentary evidence to establish the start date for the 60-day filing period.

Petitioner's Petition to Reinstate alleges she did not receive a dismissal order. During the reinstatement hearing, Petitioner confirmed her former attorney did not inform her the case had been dismissed. Petitioner further advised she learned of the dismissal in September 2019, and she filed the petition to reinstate on her own behalf on October 5, 2019. The Commission finds Petitioner's testimony regarding when she learned of the dismissal is credible.

The Commission finds Petitioner did not receive notice of the dismissal until September 17, 2019. As such, the October 5, 2019 petition to reinstate was timely and the Arbitrator had jurisdiction to consider the merits of the petition.

B. Merits of reinstatement

On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1140, 804 N.E.2d 629 (2004). "A party must exercise due diligence in pursuing his or her claim before the Commission." *Id.* at 1143. Respondent argues reinstatement was improper

because Petitioner failed to diligently pursue her claim. The Commission disagrees.

Petitioner credibly testified she relied on her former attorney to competently pursue the matter. However, upon learning of the state of her claim, Petitioner quickly and properly filed the necessary petition herself. The Commission further observes Petitioner has sought new representation to move the claim forward. The Commission finds Petitioner demonstrated sufficient justification for reinstatement

The Commission finds the Petition to Reinstate was properly granted, and we affirm and adopt the Arbitrator's order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order granting reinstatement is hereby affirmed and adopted.

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

DATED: SEP 1 6 2020

LEC/mck

D: 8/26/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

20IWCC0527

Chelsea

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

2019 NOV 13 PM 4:02 ILLINOIS WORKERS' COMPENSATION COMMISSION-TR FILED

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Case # WC: 15 WC 010684, 15 WC 010685, 15 WC 010686 & 15 WC 024313

Employee/Petitioner:

Norma Jean Jordan

v.

Employer/Respondent:

State of Illinois (SOI) / Central Management Services (CMS)

TO: Whom it may concern at the Illinois Workers' Compensation Commission

On [illegible], at 8:30 a.m., or as soon thereafter as possible, I shall appear before the Honorable Pulia, Nowak & Hemenway, or any arbitrator or commissioner appearing in his or her place at Springfield, Illinois, and present the attached motion for:

1. Dismissal of attorney (#3052) 2. Reinstatement of case (#3074) 3. Request for hearing (#R33)

Norma J. Jordan
Signature Petitioner

Norma J. Jordan
Print Name of Employee / Petitioner

Thomas A. Dorsey III IC code # on file
Attorney's name and IC code # (please print)

105 Amos Ave.
Street address

Springfield, IL 62704
City, State, Zip code

The Dorsey Law Office
Name of law firm, if applicable

(217) 546-7892
Telephone number

DorseyTA3@aol.com
E-mail address

ORDER

The motion is set for hearing on ____________

Signature of arbitrator or commissioner ____________ Date ____________

ORDER

Dismissals atty on 15WC10684 15WC10685 15WC10686 and also REIN on 15WC10684 15WC10685 15WC10686 15WC243

19 DEC -2 AM 10:26 ILLINOIS WORKERS' COMPENSATION COMMISSION-TR FILED

The motion is V Granted ___ Withdrawn ___ Continued to ____________

___ Denied ___ Dismissed ___ Set for trial (date certain) on ____________

[signature]
Signature of arbitrator or commissioner

10/24/19
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA JORDAN,

Petitioner,

vs. NO: 15 WC 10686

STATE OF ILLINOIS, C.M.S.,

Respondent.

20 I W C C 0 5 2 8

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Respondent's review of Arbitrator Pulia's order granting Petitioner's petition for reinstatement. Notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, affirms the Arbitrator's Order granting reinstatement, which is attached hereto and made a part hereof. The Commission further remands the matter to the Arbitrator for hearing on the merits.

CONCLUSIONS OF LAW

Generally an Arbitrator's order granting reinstatement is interlocutory and not subject to review. See, *Bechtel Group, Inc. v. Industrial Commission*, 305 Ill. App. 3d 769, 772, 713 N.E.2d 220 (1999) (When the matters herein proceed to trial on the merits, the arbitrator "will be required to make multiple findings, any one of which may lead to another appeal by one of the parties. Piecemeal appeals are to be discouraged.") In this case, however, Respondent contends the Arbitrator lacked jurisdiction to consider reinstatement of the claim as more than 60 days had lapsed since the case was dismissed. Given the jurisdictional question presented, the matter is ripe for our consideration.

Rule 9020.90 governs reinstatement and provides, in pertinent part:

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file

a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90.*

As such, the Commission is tasked with analyzing both the timeliness and the merits of Petitioner's petition for reinstatement.

A. Timeliness

Section (a) of Rule 9020.90 states a Notice of Dismissal "shall be sent to the parties" and it is the "receipt of the dismissal order" which triggers the 60-day filing period for a Petition to Reinstate. *50 Ill. Adm. Code 9020.90(a)*. The Commission observes the physical file does not contain a Notice of Dismissal. As such, there is no documentary evidence to establish the start date for the 60-day filing period.

Petitioner's Petition to Reinstate alleges she did not receive a dismissal order. During the reinstatement hearing, Petitioner confirmed her former attorney did not inform her the case had been dismissed. Petitioner further advised she learned of the dismissal in September 2019, and she filed the petition to reinstate on her own behalf on October 5, 2019. The Commission finds Petitioner's testimony regarding when she learned of the dismissal is credible.

The Commission finds Petitioner did not receive notice of the dismissal until September 17, 2019. As such, the October 5, 2019 petition to reinstate was timely and the Arbitrator had jurisdiction to consider the merits of the petition.

B. Merits of reinstatement

On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1140, 804 N.E.2d 629 (2004). "A party must exercise due diligence in pursuing his or her claim before the Commission." *Id.* at 1143. Respondent argues reinstatement was improper

because Petitioner failed to diligently pursue her claim. The Commission disagrees.

Petitioner credibly testified she relied on her former attorney to competently pursue the matter. However, upon learning of the state of her claim, Petitioner quickly and properly filed the necessary petition herself. The Commission further observes Petitioner has sought new representation to move the claim forward. The Commission finds Petitioner demonstrated sufficient justification for reinstatement

The Commission finds the Petition to Reinstate was properly granted, and we affirm and adopt the Arbitrator's order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order granting reinstatement is hereby affirmed and adopted.

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

DATED: SEP 1 6 2020

L. Elizabeth Coppoletti

LEC/mck

D: 8/26/2020

Stephen Mathis

43

D. Douglas McCarthy

20IWCC0528

Chelsea

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

2019 NOV 13 PM 4:02 ILLINOIS WORKERS' COMPENSATION COMMISSION-TR FILED

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Case # WC: 15 WC 010684, 15 WC 010685, 15 WC 010686 & 15 WC 024313

Employee/Petitioner:

Norma Jean Jordan

v.

Employer/Respondent:

State of Illinois (SOI) / Central Management Services (CMS)

TO: Whom it may concern at the Illinois Workers' Compensation Commission

On [redacted], at 8:30 a.m., or as soon thereafter as possible, I shall appear before the Honorable Pulia, Nowak & Hemenway, or any arbitrator or commissioner appearing in his or her place at Springfield, Illinois, and present the attached motion for:

1. Dismissal of attorney (#3052) 2. Reinstatement of case (#3074) 3. Request for hearing (#R33)

Norma J. Jordan
Signature Petitioner

Norma J. Jordan
Print Name of Employee / Petitioner

Thomas A. Dorsey III IC code # on file
Attorney's name and IC code # (please print)

105 Amos Ave.
Street address

Springfield, IL 62704
City, State, Zip code

The Dorsey Law Office
Name of law firm, if applicable

(217) 546-7892
Telephone number

DorseyTA3@aol.com
E-mail address

ORDER

The motion is set for hearing on ___________

Signature of arbitrator or commissioner ______ Date ______

ORDER

Dismissals atty on 15WC10684 15WC10685 15WC10686 and also REIN on 15WC10684 15WC10685 15WC10686 15WC 243

The motion is ✓ Granted ___ Withdrawn ___ Continued to ___________

___ Denied ___ Dismissed ___ Set for trial (date certain) on ___________

[signature]
Signature of arbitrator or commissioner

10/24/19
Date

19 DEC -2 AM 10:26 ILLINOIS WORKERS' COMPENSATION COMMISSION-TR FILED

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NORMA JORDAN,

Petitioner,

vs. NO: 15 WC 24313

STATE OF ILLINOIS, C.M.S.,

Respondent.

20IWCC0529

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Respondent's review of Arbitrator Pulia's order granting Petitioner's petition for reinstatement. Notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, affirms the Arbitrator's Order granting reinstatement, which is attached hereto and made a part hereof. The Commission further remands the matter to the Arbitrator for hearing on the merits.

CONCLUSIONS OF LAW

Generally an Arbitrator's order granting reinstatement is interlocutory and not subject to review. See, *Bechtel Group, Inc. v. Industrial Commission*, 305 Ill. App. 3d 769, 772, 713 N.E.2d 220 (1999) (When the matters herein proceed to trial on the merits, the arbitrator "will be required to make multiple findings, any one of which may lead to another appeal by one of the parties. Piecemeal appeals are to be discouraged.") In this case, however, Respondent contends the Arbitrator lacked jurisdiction to consider reinstatement of the claim as more than 60 days had lapsed since the case was dismissed. Given the jurisdictional question presented, the matter is ripe for our consideration.

Rule 9020.90 governs reinstatement and provides, in pertinent part:

a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file

a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.

b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.

c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90.*

As such, the Commission is tasked with analyzing both the timeliness and the merits of Petitioner's petition for reinstatement.

A. <u>Timeliness</u>

Section (a) of Rule 9020.90 states a Notice of Dismissal "shall be sent to the parties" and it is the "receipt of the dismissal order" which triggers the 60-day filing period for a Petition to Reinstate. *50 Ill. Adm. Code 9020.90(a).* The Commission observes the physical file does not contain a Notice of Dismissal. As such, there is no documentary evidence to establish the start date for the 60-day filing period.

Petitioner's Petition to Reinstate alleges she did not receive a dismissal order. During the reinstatement hearing, Petitioner confirmed her former attorney did not inform her the case had been dismissed. Petitioner further advised she learned of the dismissal in September 2019, and she filed the petition to reinstate on her own behalf on October 5, 2019. The Commission finds Petitioner's testimony regarding when she learned of the dismissal is credible.

The Commission finds Petitioner did not receive notice of the dismissal until September 17, 2019. As such, the October 5, 2019 petition to reinstate was timely and the Arbitrator had jurisdiction to consider the merits of the petition.

B. <u>Merits of reinstatement</u>

On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1140, 804 N.E.2d 629 (2004). "A party must exercise due diligence in pursuing his or her claim before the Commission." *Id.* at 1143. Respondent argues reinstatement was improper

because Petitioner failed to diligently pursue her claim. The Commission disagrees.

Petitioner credibly testified she relied on her former attorney to competently pursue the matter. However, upon learning of the state of her claim, Petitioner quickly and properly filed the necessary petition herself. The Commission further observes Petitioner has sought new representation to move the claim forward. The Commission finds Petitioner demonstrated sufficient justification for reinstatement

The Commission finds the Petition to Reinstate was properly granted, and we affirm and adopt the Arbitrator's order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order granting reinstatement is hereby affirmed and adopted.

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

DATED: SEP 16 2020

LEC/mck

D: 8/26/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

20IWCC0529

Chelsea

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

2019 NOV 13 PM 4:02
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR
FILED

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Case # WC: 15 WC 010684, 15 WC 010685, 15 WC 010686 & 15 WC 024313

Employee/Petitioner:

Norma Jean Jordan

v.

Employer/Respondent:

State of Illinois (SOI) / Central Management Services (CMS)

TO: Whom it may concern at the Illinois Workers' Compensation Commission

On [illegible], at 8:30 a.m., or as soon thereafter as possible, I shall appear before the Honorable Pulia, Nowak & Hemenway, or any arbitrator or commissioner appearing in his or her place at Springfield, Illinois, and present the attached motion for:

1. Dismissal of attorney (#3052) 2. Reinstatement of case (#3074) 3. Request for hearing (#R33)

Norma J. Jordan — Signature Petitioner

Norma J. Jordan — Print Name of Employee / Petitioner

Thomas A. Dorsey III IC code # on file — Attorney's name and IC code # (please print)

105 Amos Ave. — Street address

Springfield, IL 62704 — City, State, Zip code

The Dorsey Law Office — Name of law firm, if applicable

(217) 546-7892 — Telephone number

DorseyTA3@aol.com — E-mail address

ORDER

The motion is set for hearing on ____________

Signature of arbitrator or commissioner ____________ Date ____________

ORDER

Dismissal atty on 15WC10684, 15WC10685, 15WC10686 and also REIN on 15WC10684, 15WC10685, 15WC10686, 15WC 243[illegible]

The motion is ✓ Granted ___ Withdrawn ___ Continued to ____________

___ Denied ___ Dismissed ___ Set for trial (date certain) on ____________

[signature] — Signature of arbitrator or commissioner

10/24/19 — Date

19 DEC -2 AM 10:26
ILLINOIS WORKERS' COMPENSATION COMMISSION-TR
FILED

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

GEORGE KOENIG,

Petitioner,

vs. NO: 18 WC 553

STATE OF ILLINOIS,
DEPARTMENT OF TRANSPORTATION,

Respondent.

20IWCC0530

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, 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.

Correction

The Commission makes the following correction to accurately incorporate the parties' stipulations. Respondent stipulated Petitioner was entitled to Temporary Total Disability benefits from November 20, 2017 through July 4, 2018. Respondent further claimed a credit of $30,868.41 for TTD benefits paid, to which Petitioner stipulated. The Arbitrator's decision awarded Respondent's credit but failed to award Petitioner the associated TTD benefits. Therefore, the Commission corrects the decision to award the stipulated TTD benefits from November 20, 2017 through July 4, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 13, 2019 as corrected above is hereby affirmed and adopted.

20 I W CC0530

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $951.82 per week for the period of November 20, 2017 through July 4, 2018, that being the stipulated period of temporary total incapacity for work under §8(b). Respondent shall have credit for $30,868.41 in TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $790.64 per week for a period of 50.6 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused a 20% loss of use of the left arm.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: SEP 16 2020

LEC/mck

O: 9/15/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOENIG, GEORGE
Employee/Petitioner

Case# **18WC000553**

IDOT
Employer/Respondent

20 I W CC0530

On 11/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

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

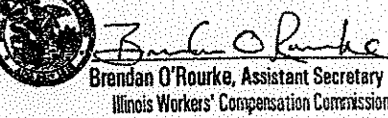
4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1430 CMSBUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 13 2019



Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

George Koenig
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # **18** WC **000553**

Consolidated cases: ____

20IWCC0530

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **9/17/19**. By stipulation, the parties agree:

On the date of accident, **11/9/17**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**72,241.96**, and the average weekly wage was $**1,427.73**.

At the time of injury, Petitioner was **66** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**30,868.41** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**30,868.41**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$790.64**/week for a further period of **50.6** weeks, as provided in Section **8(e)(10)** of the Act, because the injuries sustained caused **20% loss of use of the left arm**.

Respondent shall pay Petitioner compensation that has accrued from **6/14/19** through **9/17/19**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator | 11/13/19 Date

NOV 13 2019

STATEMENT OF FACTS

Petitioner, George Koenig, testified that he was at work for the Respondent, IDOT, as a Highway Maintainer on November 9, 2017. On that date, Petitioner was climbing up on a bed of a truck which he estimated that was raised to 20 or 25 degrees to grab a bucket. The Petitioner's foot slipped while he was grasping the bucket thereby causing his left arm to go into hyperflexion with his hand near his left shoulder. Petitioner felt an immediate and severe pain into the back of his left arm. Petitioner testified that he has never injured his left arm before.

Petitioner was initially seen by the Jerseyville Community Medical Group who referred him to Dr. Stirton who then referred him to Dr. Omotola. Petitioner first saw Dr. Omotola on 1/3/18. After taking a history and conducting a physical examination, Dr. Omotola diagnosed the Petitioner with a traumatic rupture of his left triceps tendon. (PX 3 at 30). Dr. Omotola recommended immediate surgery, as delay with this sort of injury was contraindicated. (Id.). Dr. Omotola performed surgery on January 11, 2018 which consisted of suturing and anchoring the Petitioner's left triceps. (PX 4 at 2). Dr. Omotola noted the triceps was completely ruptured. (Id.)

Petitioner performed his physical therapy at Jerseyville Community Hospital Physical Therapy. (PX 5). Petitioner underwent all 25 physical therapy visits that were authorized by TriStar (PX 7). Petitioner did not complete the physical therapy requested by his Physician as TriStar did not approve this treatment pending Utilization Review. (Id. at 1-3).

Petitioner was last seen by Dr. Omotola on 1/14/19. Dr. Omotola noted that Petitioner had a full range of motion with residual weakness and no pain. (PX 3 at 1).

By stipulations of the Parties, Petitioner missed work from November 20, 2017 through July 4, 2018, a period of 32 and 3/7 weeks. All of the Petitioner's TTD benefits were paid during this period of time.

Currently, the Petitioner has indicated that he has returned to work as a Highway Maintainer for IDOT. Petitioner complains that while he has a full range of motion, he will experience severe shooting pains slightly above his elbow every three or four days. Petitioner also testified to a reduction of strength in his arm. Specifically, he estimates that he has lost approximately 20% of his strength in his arm. This does cause Petitioner some difficulties in doing his job duties, such as lifting up tailgate covers. He could do activity this by himself before, but now requires assistance from co-workers.

THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF LAW:

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Highway Maintainer 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 specifically testified that he is planning on continuing his career until retirement. Because the Petitioner returned to his job with no anticipation of not being able to do his job in the future. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 66 years old at the time of the accident. Because Petitioner is an older worker who is less likely to make a good recovery from this injury than a younger worker, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner does not anticipate nor was any evidence introduced that would indicate the Petitioner would lose any future earning capacity. Because Petitioner will not likely have a loss of future earning capacity, 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 Dr. Omotola opined that Petitioner had a strength loss. Further, Respondent's IME Physician, Dr. Williams' opined that Petitioner had weakness into the left elbow triceps tendon even after being back to work for nearly 6 months. (RX 1) Because of the medical evidence by two different Doctors of Petitioner ongoing weakness into his left triceps' tendon, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the left arm pursuant to §8(e)(10) of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK JORDAN,

Petitioner,

vs. NO: 16 WC 35797

CITY OF PEORIA,

Respondent.

20 IWCC0531

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, prospective medical, and credit for missed §12 examination, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds Petitioner failed to prove a causal connection between his left shoulder condition of ill-being and the October 28, 2016 work accident. The Commission further remands the matter to the Arbitrator for proceedings consistent with this decision.

FINDINGS OF FACT:

The Commission adopts the Statement of Facts as set forth in the Decision of the Arbitrator and incorporates such facts herein with the following modifications:

1 - Page 5, Paragraph 9: The second sentence states, "The Petitioner testified that he did not inform Dr. Anane-Sefah of his left shoulder problems because Dr. Anane-Sefah was a wrist surgeon and did not specialize nor treat shoulder problems. (A.T. 60)" The Commission strikes that language and substitutes the following: "Petitioner testified he remembered telling Dr. Anane-Sefah about his left shoulder problems, but the doctor advised he does not treat shoulders and would not assess Petitioner's shoulder. T. 60."

2 - Page 12, Paragraph 3: The Commission strikes the third sentence and substitutes the following:

> Dr. Hoepfner testified Petitioner reported an onset of pain radiating up his wrists to his forearms and elbows following the fall. RX4, p. 13. As to current complaints, Dr. Hoepfner explained Petitioner reported ongoing left wrist pain as well as mild right wrist and elbow pain but denied bilateral shoulder complaints. RX4, p. 14. Dr. Hoepfner's report documents he examined Petitioner's bilateral shoulders and his examination findings were benign and provocative testing was negative. RX2.

CONCLUSIONS OF LAW:

I. Causation

The Arbitrator concluded Petitioner's left shoulder condition of ill-being is causally connected to the undisputed October 28, 2016 accident. The Commission views the evidence differently.

Petitioner indicated his left shoulder pain began after the October 28, 2016 fall, but his left wrist problem was more severe and demanded his focus. Petitioner nonetheless repeatedly testified that over the course of his care he advised multiple physicians of his left shoulder symptoms. We find the record is devoid of corroborating evidence.

The Commission observes that in the eight months between his October 28, 2016 accident and the June 20, 2017 evaluation with Dr. Garst, Petitioner had nine appointments with Dr. Anane-Sefah as well as five visits with Dr. Moody. The notes from those 14 visits do not include any mention of left shoulder complaints. The Commission finds it strains credulity to think the physicians failed to document Petitioner's complaints as voiced. This is particularly so for Dr. Anane-Sefah: on November 10, 2016, the doctor documented Petitioner voiced right upper extremity complaints, but he was not authorized to address those: "has questions regarding his right upper extremity as well, but as far as I am aware, we did not get authorization to treat or evaluate the right side" (PX2); given this notation, the Commission finds Dr. Anane-Sefah would have similarly memorialized any left shoulder complaints Petitioner made. Further, while Petitioner testified he completed intake/symptom status forms in work hardening and documented his left shoulder complaints thereon, the Commission observes no such forms are contained in the record. We also note there are no left shoulder complaints documented in the work hardening reports. Moreover, the Commission emphasizes the stiff-arm complaint purportedly memorialized by the physical therapist is in fact the name of a Job Specific exercise modality: "simulated fight with stiff arming a punching bag" PX2.

The Commission further finds the April 6, 2017 §12 examination is significant. Not only did Dr. Hoepfner memorialize Petitioner's denial of shoulder complaints, but the doctor performed a shoulder examination and the findings were normal: normal range of motion without pain; no scapular winging; no muscle wasting about the shoulder girdle;

acromioclavicular joint and long head of the biceps nontender to palpation bilaterally; rotator cuff strength 5/5 bilaterally; negative Hawkin's; negative Neer's; negative drop arm test; negative apprehension test; negative Speed's sign; negative O'Brien's; and negative liftoff sign. RX2. The Commission finds these objective physical examination findings and negative provocative maneuvers are incompatible with Petitioner's claim of ongoing left shoulder complaints stemming from the October 28, 2016 accident. The Commission is cognizant Dr. Garst opined Petitioner's left shoulder condition is causally related to the October 28, 2016 accident. We emphasize, however, Dr. Garst's opinion is predicated on the history provided by Petitioner. PX9, p. 35. As detailed above, that history is not corroborated by the treating medical records. Moreover, when presented with the fact Petitioner told a physician two months before the June 20, 2017 evaluation that he had no pain in either shoulder, Dr. Garst stated, "That statement in and of itself contradicts everything that I've done here. But if that's true, then, yeah, it would work against, you know, my opinion regarding causal relationship." PX8, p. 45. Therefore, the Commission finds Dr. Garst's causation opinion is entitled to little weight. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Given the lack of documentation of left shoulder complaints until June 20, 2017, the Commission finds Petitioner failed to prove a causal connection between his left shoulder condition and the work accident. Petitioner's request for prospective left shoulder treatment is denied.

II. <u>Credit for Section 12 examination "no-show" fee</u>

Respondent argues it is entitled to a $1,200 credit for a "no-show" fee for a missed February 23, 2017 §12 examination. Respondent posits Petitioner and Petitioner's attorney were faxed notice of the exam and a mileage check on February 16, 2017, yet Petitioner did not appear for the exam. Relying on *King v. Industrial Commission*, 189 Ill. 2d 167, 724 N.E.2d 896 (2000), and *R.D. Masonry v. Industrial Commission*, 215 Ill. 2d 397, 830 N.E.2d 584 (2005), Respondent claims Petitioner "unreasonably refused to comply with" its request for a §12 examination. The Commission disagrees.

The Commission finds Respondent's reliance on *King* and *R.D. Masonry* is misplaced. In both of those cases, the claimant acknowledged he was aware of the scheduled §12 examination yet made the deliberate choice not to attend, *i.e.*, refused. Here, Petitioner testified he did not receive notice of the §12 examination and knew nothing about it until the appointment date had already passed: "I was told when I was working light duty that I was supposed to go to an IME, my attorney informed me that your office told him that I missed an IME that I didn't know nothing about, I didn't get no notification or anything." T. 82. The Commission observes the February 16, 2017 notice is addressed to Petitioner and indicates the adjuster "enclosed a check for mileage"; a check voucher is included as a separate page however the fax confirmation shows only a single page ("1/1") was sent. Petitioner was not asked if he received the mileage expenses. The Commission finds there is nothing to evidence a deliberate "refusal" to comply with a §12 examination.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 25, 2019 is hereby reversed, and the award of benefits therein is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's request for credit for Section 12 "no-show" fee 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 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.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: SEP 16 2020

L. Elizabeth Coppoletti

LEC/mck

O: 7/21//2020

Stephen Mathis

43

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(A)

JORDAN, PATRICK
Employee/Petitioner

Case# **16WC035797**

CITYOF PEORIA
Employer/Respondent

20IWCC0531

On 9/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.86% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5354 STEPHEN P KELLY
ATTORNEY AT LAW LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0980 HASSELBERG GREBE SNODGRASS
BOYD ROBERTS
401 MAIN ST SUITE 1400
PEORIA, IL 61602

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
8(A)

Patrick Jordan
Employee/Petitioner

Case # **16** WC **35797**

v.

Consolidated cases:

City of Peoria
Employer/Respondent

20IWCC0531

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Peoria**, on **July 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Credit for failed section 12 examination**

FINDINGS

On the date of accident, **10/28/16**, 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 $**87,581.00**; the average weekly wage was $**1,684.25**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

- The Petitioner's condition of ill-being to his left shoulder is causally related to the October 28, 2016, accident.
- The Respondent is responsible for the medical care and treatment recommended by Dr. Garst to the left shoulder, including but not limited to surgery for same and follow-up care.
- Respondent's request for credit for failed section 12 examination 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

September 3, 2019
Date

ICArbDec19(b)

SEP 2 5 2019

STATEMENT OF FACTS:

Testimony of Patrick Jordan

The parties agree that the Petitioner sustained a work injury on October 28, 2016 that involved various other body parts aside from the left shoulder. (A.T. 7) The issue for trial is medical authorization for the left shoulder. (A.T. 7)

The Petitioner has been employed with the Respondent since August 1993. (A.T. 13) The Petitioner's job title was that of a police officer of the Respondent. (A.T. 13) The Petitioner's responsibilities involved patrolling, interacting with the public, providing security and well-being for the public, apprehending criminals. (A.T. 13)

Leading up to October 28, 2016, the Petitioner had not missed any off-work time for the left shoulder. (A.T. 15) The Petitioner had not received any medical care or treatment to the left shoulder prior to October 28, 2016. (A.T. 15) The Petitioner further testified that he had never received any type of diagnosis to the left shoulder pre-dating October 28, 2016. (A.T. 15)

On October 28, 2016, the Petitioner spotted a shooting suspect, went to stop, and the suspect pulled in front of him and the Petitioner tripped and fell and landed on both hands outstretched. (A.T. 16) The Petitioner goes into greater length regarding the accident, testifying that he asked the suspect for a name and the suspect did not respond. The suspect started to run, the Petitioner tripped and fell and landed on both hands. (A.T. 17)

The Petitioner testified that he fell over an uneven sidewalk. (A.T. 18) The Petitioner struck his right hand during the fall. (A.T. 19) The Petitioner informed Officer Cover, his sergeant, about the accident. (A.T. 19)

The Petitioner testified that he noticed pain in his left wrist, radiating up his arm and pain in his right wrist. (A.T. 19) Prior to this date, the Petitioner had no problems to his left arm. (A.T. 20)

The Petitioner testified that he went to OSF Hospital immediately after the occurrence. (A.T. 23) The Petitioner testified that OSF Hospital provided an X-Ray and medical care to his left wrist. (A.T. 24). The Petitioner testified that he was directed to go to OSF Occupational Health under the care of Dr. Moody at the direction of the Respondent. (A.T. 24)

The Petitioner testified that a week or two after the accident, he noticed having a lot of pain with his left hand, left wrist going up the arm, and right hand up to the right elbow. (A.T. 25) The Petitioner testified that, when he mentions the right arm, the pain was going up to his left shoulder. (A.T. 25)

In November 2016, OSF Occupational Health provided the Petitioner Norco for pain control. (A.T. 26) The Petitioner testified that, when taking Norco, he noticed feeling drowsy, pain was dissipating, and he did not feel like there was a lot of pain. (A.T. 26)

The Petitioner testified that he was referred to OSF Orthopedics. (A.T. 27) The Petitioner was referred to Dr. Anane-Sefah in November 2016. (A.T. 27) Petitioner testified that when he

saw Dr. Anane-Sefah, he was having a lot of pain in his left wrist and surgery was recommended by Dr. Anane-Sefah to the left wrist. (A.T. 28) The Petitioner testified that the surgery performed by Dr. Anane-Sefah was that of a TFCC tear repair. (A.T. 28)

The Petitioner testified that after surgery to his left wrist, Dr. Anane-Sefah put restrictions of no use of the left arm. (A.T. 29) The Petitioner testified that Dr. Anane-Sefah provided a sling for the Petitioner's left arm immediately following the surgery. (A.T. 29-30) The Petitioner's left arm use was limited by Dr. Anane-Sefah at that time. (A.T. 30)

The Petitioner testified that after 30 days from the surgery to the left wrist, he continued to have pain. The Petitioner testified that he was taking drugs and medication. Therefore, he was drowsy for a lot of that time period. (A.T. 30)

The Petitioner testified that he was progressing under the care of Dr. Anane-Sefah and eventually physical therapy was ordered for the recovery of the wrist surgery. (A.T. 31) The Petitioner testified that during physical therapy he started noticing pain in his left shoulder and that was pain that never went away. The Petitioner testified that the pain in his left shoulder became more pronounced during physical therapy. (A.T. 32) The Petitioner testified that he noticed more pain in his left shoulder with more activity in physical therapy, such as working with bags and punching bags. (A.T. 32)

The Petitioner testified that pain in his arm never really went away after the work accident. (A.T. 33) The Petitioner testified that the left shoulder pain was getting worse in physical therapy. (A.T. 33) The Petitioner testified that, while undergoing physical therapy through May 2017, he never had been released to full duty for use of his left arm. (A.T. 33)

The parties agree that the Petitioner sustained a tear to the right shoulder, rotator cuff when undergoing work hardening in recovery for the left wrist. (A.T. 34) The Petitioner was sent for an examination under section 12 of the Act for his right shoulder by the Respondent. (A.T. 43) The Petitioner eventually underwent surgery to the right shoulder in September 2017, by Dr. Garst. (A.T. 35)

The Petitioner testified that, during the timeframe from May 2017, to September 2017, he noticed that his left shoulder had pain that never went away. (A.T. 35) The Petitioner further testified that from May 2017, to September 2017, he was on pain medication for his right shoulder. (A.T. 35) The Petitioner further testified that during this timeframe, he was limited from work because of the right shoulder surgery. (A.T. 36) The Petitioner testified that from May 2017 to September 2017, he never used his left arm on a regular basis or above his head. (A.T. 36) Petitioner further testified that the pain in his left shoulder never completely went away from May 2017, to September 2017. (A.T. 36)

The Petitioner testified that in February 2018, Dr. Garst recommended the Petitioner undergo another surgery, but to his left shoulder. (A.T. 38) The Petitioner testified that he underwent an MRI to the left shoulder, and after that, surgery was recommended by Dr. Garst. (A.T. 38).

The Petitioner testified that from February 12, 2018, until February 2019, the MRI of the left shoulder was not authorized by workers' compensation. (A.T. 39) The Petitioner testified that in February 2019, Dr. Garst provided a surgical recommendation after reviewing the MRI. (A.T. 40)

The Petitioner testified that he wants to have the surgery to the left shoulder, but the Respondent has not authorized same. (A.T. 40-41)

The Petitioner testified that he did return to work full duty for the Respondent in April 2018. (A.T. 41) The Petitioner testified that, since his return to work as a police officer, he sustained an injury to his knee in March 2019. (A.T. 42) Since March 2019, the Petitioner has been working in a light duty capacity due to the work injury to the left knee. (A.T. 42)

The Petitioner testified that, at the time of hearing, he had throbbing pain that shoots across his left shoulder and has certain pains with movements. (A.T. 43) Petitioner testified that he can't do all the activities that he used to be able to do prior to the work injury. (A.T. 43) The Petitioner once again confirmed that, prior to October 28, 2016, he never had pain to his left shoulder. (A.T. 43)

The Petitioner testified that when the fall on October 28, 2016, occurred, he fell with his hands flat on the ground. (A.T. 45) The Petitioner confirmed that, initially after the fall, his major complaints to his medical providers were to his left wrist. (A.T. 45)

The Petitioner denies the allegation that he had no complaints to either shoulder while receiving treatment from Dr. Anane-Sefah in November 2016. The Petitioner testified that he informed Dr. Anane-Sefah of the left shoulder pain at that time. (A.T. 49)

During the timeframe of November 2016, to March 2017, the Petitioner testified that he mentioned to Dr. Moody, the company doctor, his left shoulder pain. (A.T. 50-51) The Petitioner further testified that he informed Dr. Garst of left shoulder pain and the section 12 examiner of same during that time period. (A.T. 51)

The Petitioner confirmed that in March 2017, while in work hardening at OSF, he started noticing his left shoulder pain becoming more pronounced. The Petitioner associated this with lifting boxes and having to work more with his left arm in recovery. (A.T. 52-53) The Petitioner confirmed that when he injured his right shoulder in work hardening on or about May 30, 2017, he did not mention his left shoulder to Dr. Braun, the company doctor, because his right shoulder pain was more prominent, and he couldn't lift it. (A.T. 56-57)

The Petitioner testified that, when he reported his left shoulder complaints to both the company doctor and the section 12 examiner, there were times that neither doctor wrote down his complaints. (A.T. 59) The Petitioner testified that he did not inform Dr. Anane-Sefah of his left shoulder problems because Dr. Anane-Sefah was a wrist surgeon and did not specialize nor treat shoulder problems. (A.T. 60) The Petitioner testified that June 29, 2017, is the first time that he mentioned to Dr. Moody at OSF Occupational Health having left shoulder issues. (A.T. 65-66)

The Petitioner testified that between October 28, 2016, and June 20, 2017, he did inform physicians at OSF Occupational Health of having problems with his left shoulder. (A.T. 70)

The Petitioner testified that, while taking medications, his left shoulder pain would decrease. The Petitioner testified that, when he stopped taking medications in order to return to work, his.left shoulder complaints became more prominent. (A.T. 72) The Petitioner testified that he was unaware of the section 12 examination set up by the respondent for which they are requesting reimbursement for charges for missed appointment. (A.T. 82)

The Petitioner testified that, when he informed Dr. Anane-Sefah of his left shoulder problems, Dr. Anane-Sefah informed him that he did not treat shoulders and referred him to Dr. Garst, a partner in his office. (A.T. 85) The Petitioner testified that, from October 2016, to March 2017, he was on pain medication for his left wrist. Additionally, the Petitioner's left arm was limited in use. The Petitioner did notice problems to the left shoulder during this timeframe (A.T. 86).

The Petitioner testified that from March 2017 to June 2017, he did inform the physical therapists of left shoulder problems during that timeframe (A.T. 87). The Petitioner testified that from May 2017 until he injured his right shoulder, he was still having left shoulder problems (A.T. 87).

Accident Report

On October 28, 2016, the Respondent prepared a Form 45. (Respondent's Ex. 9) This report was filed out by Sergeant Steven Cover. (Respondent's Ex. 9) The Form 45 provided a description of history of the Petitioner hurting his left wrist when he fell. The description of the accident specifically states that **Officer Jordan held out his hands/arms to break his fall.** (Respondent's Ex. 9)

Amended Application for Adjustment of Claim

The Petitioner filed an Amended Application for Adjustment of Claim with the Illinois Workers' Compensation Commission. The Amended Application for Adjustment of Claim notes an accident date of October 28, 2016. This Application indicates that the Petitioner was in an altercation with a suspect and injured his right wrist, hand, left wrist, left hand, right forearm, left forearm, right elbow, and right and left shoulders. (Petitioner's Ex. 1)

Medical Treatment

On October 28, 2016, the Petitioner went to the emergency room at OSF St. Francis. (Petitioner's Ex. 4) The Arbitrator notes that the records of OSF emergency room department do not provide a specific work injury. The chief complaint was right wrist pain. (Petitioner's Ex. 4) The Arbitrator notes that the Petitioner was provided with pain medication and x-rays were provided to the Petitioner's right forearm and right wrist. The Petitioner was referred to Dr. Anane-Sefah. (Petitioner's Ex. 4)

On October 31, 2016, the Petitioner was seen by Dr. Anane-Sefah at OSF Orthopedics. An MRI was performed to the Petitioner's left wrist on this date. The assessment of his left wrist injury was a fracture and quite a bit of swelling around the dorsal aspect of the left wrist and distal ulna. (Petitioner's Ex. 2) On October 31, 2016, the Petitioner provided a history of sustained an on-the-job injury and he fell onto his wrists. The impression was no acute fracture or dislocation of the left wrist. There is suspicion the Petitioner may have a TFCC tear. An MRI was ordered at that time. (Petitioner's Ex. 2)

On November 8, 2016, the Petitioner was seen by the company doctor at OSF Occupational Health. The history was that the Petitioner fell on **bilateral** outstretched hands while running after suspect. (Petitioner's Ex. 3) Petitioner has provided a history that he was provided narcotics and taking them around the clock to control the pain. (Petitioner's Ex. 3) The Petitioner had an MRI to the left wrist, which showed bruising and potential tear of the TFCC. (Petitioner's Ex. 3) The Petitioner has provided complaints of both extremities, including the left wrist and right elbow and right hand. (Petitioner's Ex. 3) The Petitioner continued on pain medication and was provided a 1 lb. weight restriction regarding the left wrist. The Petitioner is to see an orthopedic consultant. (Petitioner's Ex. 3)

On November 10, 2016, the Petitioner was seen by Dr. Anane-Sefah for a follow-up. At that time, the MRI was reviewed to confirm the TFCC tear to the left wrist. Dr. Anane-Sefah recommended a surgical repair to the TFCC tear to the left wrist. (Petitioner's Ex. 2)

On November 16, 2016, the Petitioner underwent surgery under the care of Dr. Anane-Sefah. The surgery was to the left wrist. The surgery was a TFCC repair. (Petitioner's Ex. 2)

The Arbitrator notes that leading up to the surgery of Dr. Anane-Sefah of November 16, 2016, the Petitioner was on constant pain medication and had limited use of the left upper extremity.

On January 10, 2017, the Petitioner was seen at OSF Occupational Health. This visit was a follow-up to the surgical procedure performed by Dr. Anane-Sefah. It is noted in his records that the Petitioner had limited use of the left upper extremity and was provided pain medication for the same. (Petitioner's Ex. 3)

On February 6, 2017, the Petitioner was seen for a follow-up at OSF Occupational Health. The doctor noted this was 2 1/2 months post-surgery. As of February 6, 2017, no physical therapy had been ordered yet. It was noted that the Petitioner was continuing the use of Norco, pain medication twice a day. Additionally, the restrictions of no use of the left upper extremity. (Petitioner's Ex. 2)

On February 27, 2017, the Petitioner was seen for a follow-up at OSF Occupational Health. Those records indicate that the Petitioner was still on pain medication and was instructed to have limited use of the left upper extremity. (Petitioner's Ex. 3)

The Petitioner was eventually referred by his physicians to start physical therapy for recovery of the surgery to the left wrist. The Petitioner's physical therapy started in late February 2017. On February 27, 2017, the Petitioner was in physical therapy but still provided limited use of the left upper extremity while performing this activity. (Petitioner's Ex. 3)

The Petitioner's physical therapy continued from February to April 2017. It is noted that in April 2017, **the Petitioner provided a history to the physical therapist of his left arm being stiff.** In fact, it is noted that on April 3, 2017, the Petitioner had pain to both extremities. (Petitioner's Ex. 3) On May 3, 2017, the Petitioner continued physical therapy. The records indicate that the Petitioner still had complaints of pain and stiffness to his left upper extremity. (Petitioner's Ex. 3)

On May 5, 2017, the Petitioner was seen in physical therapy and the Occupational Health facility indicated that the Petitioner had restricted use of the left upper extremity and left wrist. (Petitioner's Ex. 3) On May 25, 2017, the Petitioner was performing physical therapy and provided a history of the left arm being sore and stiff. The Petitioner had a stiff left arm while pushing in physical therapy. (Petitioner's Ex. 3)

On May 30, 2017, while the Petitioner was participating in work hardening, he sustained another work injury to his right shoulder while performing activities. (Petitioner's Ex. 3) This accident is not in dispute and was accepted as compensable by the Respondent.

The Petitioner's recovery for the left wrist ceased and treatment was concentrated on the right shoulder. On June 2, 2017, an MRI was performed to the Petitioner's right shoulder and showed a rotator cuff tear. (Petitioner's Ex. 2) On June 5, 2017, the Petitioner was seen for the MRI and the diagnosis was a tear to the right shoulder. (Petitioner's Ex. 3)

The Petitioner was referred to Dr. Garst for treatment to his right shoulder after sustaining a rotator cuff tear. On September 14, 2017, the Petitioner underwent a surgical repair by Dr. Garst to repair the tear in the shoulder. (Petitioner's Ex. 2)

After the surgery to the Petitioner's right shoulder on September 14, 2017, he was given pain medication and was instructed to be on limited work activities. In fact, the Petitioner's complete physical activities were limited by the physicians in this case. (Petitioner's Ex. 2)

The Petitioner started progressing in his recovery from right shoulder surgery. On February 12, 2018, in Dr. Garst's records, the Petitioner provided complaints to his left shoulder. Specifically, in rehabilitation, the Petitioner provided complaints of pain in his left shoulder and it limited his full rehabilitation and exercises during recovery in physical therapy. (Petitioner's Ex. 2)

Testimony of Dr. Garst – 3/21/18

Dr. Garst is a board-certified orthopedic surgeon. (Petitioner's Ex. 8, pg. 9) Dr. Garst has hospital affiliations with OSF St. Francis and Proctor Hospital. (Id. pg. 10). Dr. Garst treats patients and performs no independent medical examinations. (pg. 10)

Dr. Garst is the treating physician of the Petitioner in this case. On June 20, 2017, Dr. Garst first saw the Petitioner. (Id. pg. 13) The history provided to Dr. Garst on that date is that in October 2016, the Petitioner fell, **injuring both shoulders**, right worse than the left, and his wrist and right elbow. Dr. Garst noted the surgery performed by Dr. Anane-Sefah prior to the Petitioner seeing him. The Petitioner provided a history of right shoulder, elbow, **and left shoulder pain.** (Id. pg. 13) After an examination and MRI, Dr. Garst diagnosed the Petitioner suffering from a right small full thickness tear and changes at the greater tuberosity, showing a possible impact fracture to the right shoulder. (Id. pg. 15)

Dr. Garst testified that the Petitioner did indeed provide complaints not only regarding the right shoulder, but also left shoulder pain when he first saw the Petitioner in June 2017. (Id. pg. 16)

On August 15, 2017, the Petitioner was seen by Dr. Garst for a second time. The recommendation at that time was a right shoulder surgery for the rotator cuff tear. (Id. pg. 17)

On September 1, 2017, the Petitioner was seen for a pre-operative visit. The pre-operative visit was for the right shoulder surgical repair. (Id. pg.19-20) On September 14, 2017, Dr. Garst performed a right shoulder arthroscopy with acromioplasty, distal clavicle incision and rotator cuff repair. The post-operative diagnosis was right shoulder complete rotator cuff repair with impingement and acromial clavicle joint arthritis. (Id. pg. 20)

Dr. Garst testified that the work hardening accident while the Petitioner was bench pressing, when the right injury to his right shoulder occurred, is consistent with what he found in the surgical findings. (Id. pg. 21)

On September 26, 2017, the Petitioner was seen by Dr. Garst for a 12-day follow-up after the surgery. **The Petitioner was provided pain medication and was complaining a little more regarding his left shoulder.** (Id. pg. 22) As of this visit, Dr. Garst kept the Petitioner off work completely and limited his use of the left and right upper extremities. (Id. pg. 23)

On October 31, 2017, the Petitioner was seen by Dr. Garst for a 6-week follow-up after the surgery. The Petitioner was still complaining of left shoulder pain more during this visit. (Id. pg. 23-24)

On December 5, 2017, the Petitioner was seen by Dr. Garst. His right shoulder was improving – but, he still had left shoulder complaints. The Petitioner was still on restricted

work as of December 11, 2017, of no lifting over 5 lbs. Dr. Garst ordered an MRI of the Petitioner's left shoulder at this visit. (Id. pg. 24-25)

On January 9, 2018, the Petitioner was seen by Dr. Garst 3 1/2 months post right shoulder surgery. **The Petitioner still had left shoulder pain.** (Id. pg. 25) The right shoulder was improving. Dr. Garst kept a restriction on the Petitioner for his work activities. (Id. pg. 25-26)

On February 13, 2018, the Petitioner was seen by Dr. Garst. The Petitioner was still recommended to have an MRI of the left shoulder. The Petitioner still had complaints to the left shoulder during this visit. (Id. pg. 26-27)

Dr. Garst testified that the described mechanism of injury that the Petitioner sustained on October 28, 2016, was consistent with causing an injury to the Petitioner's left shoulder. (Id. pg. 27-28)

Testimony of Dr. Garst – 6/12/19

Dr. Garst testified a second time on June 12, 2019. This deposition took place after the MRI was authorized by the Respondent to the Petitioner's left shoulder. On March 27, 2018, the Petitioner was seen and had better strength in his right shoulder post-surgery. The second diagnosis of Dr. Garst was continued left shoulder pain. Petitioner was released back to work full duty without any restrictions. The Petitioner was to be seen as needed. At that point, an MRI was still recommended to the Petitioner's left shoulder. (Petitioner's Ex. 9, pg. 9) The MRI of the left shoulder was finally authorized and performed. (Id. pg. 10) **Dr. Garst interpreted the MRI of the left shoulder in that it revealed a clavicle joint separation at the left shoulder that looked post-traumatic and probably long-standing since the injury.** The Petitioner had long head bicep tenosynovitis and partial rotator cuff tear at the supraspinatus insertion. (Id. pg. 10)

On February 18, 2019, the Petitioner was recommended for surgery by Dr. Garst for the left shoulder. The surgery would be a left shoulder arthroscopy with acromioplasty and debridement v. repair of the left rotator cuff and debridement tenotomy and long head biceps. (Id. pg. 12) Aside from the surgery, the Petitioner would have an extended therapy and return to work depending on the Petitioner's progress through therapy.

Dr. Garst testified that patients were described Norco as medical protocol and that the medication would affect the pain across the individual's whole body. (Id. pg. 15) Dr. Garst further indicated that the Petitioner's left shoulder was limited due to surgery to the left wrist, including a sling. (Id. pg. 15) Dr. Garst was asked a hypothetical:

"Q. Doctor, let me ask you a couple
more questions and I'll be done here. When
someone is prescribed Norco in the medical
protocol and they're given that medication,
does that medication go to one certain part of
the body or does it affect pain across the

whole body; do you understand the question?

A. Yes. It's -- Norco is a pain
reliever, and if you take it for one thing, it
will often help with others.

Q. Also if the upper extremity like
the left shoulder is limited by a surgery to
the left wrist, sling, slowly progressing,
would that be the type of scenario that could soften
or lessen someone's complaints to the
left shoulder, the condition my client has?

A. That's reasonable.

Q. So in this case, you know, my
client had a left wrist surgery initially
following the accident, he was given Norco, he
then was put in a sling, left shoulder, left
upper extremity. Then while recuperating and
going to physical therapy for that surgery he
injured his right shoulder as the records
show. Once again, given pain medication,
limited activity until the point you had
surgery in September 2017. While he's getting
back to physical therapy and doing more
activity, recovering from the right shoulder
surgery, his left shoulder complaints remain
the same and became more apparent. Is that a
normal scenario that you would expect in this
situation if someone suffers this kind of
condition of ill-being?

A. I don't know if it's completely
normal, but it's reasonable. Most patients
focus on their worst injuries and tend to shy
away from their lesser injuries so they can
get treatment for the worst things.

Q. The treatment you've recommended in
this case from your last deposition to today,
the surgery to the left shoulder, it is your
opinion that's related to the initial work
injury in October 2016?

A. Yes." (Id. pg. 15-17)

Testimony of Dr. Hoepfner

The Respondent exercised their rights under Section 12 of the Illinois Workers' Compensation Act. In fact, the Respondent had the Petitioner examined on two separate occasions by Dr. Hoepfner. On one occasion, the independent medical examination was directly solely to the Petitioner's left shoulder complaints. Dr. Hoepfner has testified in this case.

Dr. Hoepfner examined the Petitioner on April 6, 2017, and July 20, 2017. Dr. Hoepfner testified on September 25, 2018.

The history obtained from the Petitioner on the first examination was that the Petitioner sustained a work injury on October 28, 2016, while chasing a suspect. (Respondent's Ex. 4, pg. 13) **The Petitioner's history of injury was that he tripped, fell forward, landing onto the palmer aspect of both hands.** (Id. pg. 13) **The Petitioner had pain radiating up to his wrists and forearms and elbows.** (Id. pg. 13)

Dr. Hoepfner opined that the treatment provided to the Petitioner as of the date of the examination was reasonable and necessary to the Petitioner's right and left wrist and right elbow (Id. pg. 17). Dr. Hoepfner believed that the treatment was causally related to the October 28, 2016, incident. (Id. pg. 17) Dr. Hoepfner also believed that there was a causal relationship between the Petitioner's diagnosis to the right and left wrists and the described work injury. (Id. pg. 17-18) Dr. Hoepfner did not believe the Petitioner was at maximum medical improvement at the date of his examination. (Id. pg. 18) Dr. Hoepfner agreed with the restrictions placed on the Petitioner at the time of the examination. (Id. pg. 19)

On July 20, 2017, Dr. Hoepfner saw the Petitioner on a second occasion. The Petitioner provided a history that he had complaints to his right shoulder and left shoulder. **The Petitioner provided a history of having left shoulder pain that was 3/10 at best and 5/10 at worst.** (Id. pg. 23) After physical examination, Dr. Hoepfner felt the Petitioner needed no more medical treatment to his right or left wrist. (Id. pg. 27) Dr. Hoepfner did provide an opinion that the Petitioner's right shoulder complaints and diagnosis was related to the work hardening incident that occurred while recovering from the initial surgery to the left wrist. (Id. pg. 28)

Dr. Hoepfner felt that the Petitioner's left shoulder complaints were not related to the described work injury of October 28, 2016. Id. (pg. 29) Dr. Hoepfner was of the opinion that the work hardening incident of May 30, 2017, did not contribute to the Petitioner's left shoulder complaints. (Id. pg. 29) **On cross-examination, Dr. Hoepfner opined that the described work injury of October 28, 2016 the Petitioner sustained, was the type of injury that could cause injuries to a shoulder area and rotator cuff** (Id pg. 39)

Dr. Hoepfner agreed that the Respondent has given no other evidence of any other accident occurring to the Petitioner's right or left shoulder aside from the October 28, 2016, incident or May 30, 2017. (Id. pg. 41) Dr. Hoepfner has also testified that he is not

aware of any outside accidents to the Petitioner's right or left shoulders outside of work. (Id pg. 41)

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is stipulated by the parties that the Petitioner sustained an injury on October 28, 2016. The described injury is the Petitioner falling on outstretched arms. There is no dispute to the description of the injury by the Petitioner.

The Respondent's own section 12 examiner, Dr. Hoepfner, testified that the described mechanism of injury of October 28, 2016, is the type of injury that could cause an injury to a shoulder area.

The records show that the Petitioner did have multiple complaints from this work accident. The Petitioner was placed immediately under pain medication and placed with a restriction by the company doctor of limited use of the left wrist, arm and shoulder.

Leading up to the surgery of the Petitioner's left wrist, the Petitioner was put on limited duty and pain medication. After the surgery to the Petitioner's left wrist by Dr. Anane-Sefah, the Petitioner was put in a sling and kept on limited duty.

The treating physician, Dr. Garst, testified that the pain medication the Petitioner was on could have masked/subsided the Petitioner's left shoulder complaints. Additionally, the Petitioner was not asked to use the left upper extremity immediately following the left wrist surgery. The Petitioner's left shoulder complaints clearly started to be consistent and rise through the treatment and recovery after the right shoulder surgery.

Dr. Garst testified, as a treating physician, that the Petitioner's left shoulder conditions was clearly related to the described mechanism of injury of October 28, 2016. Dr. Garst testified that the described mechanism of injury caused the findings on the MRI of the left shoulder. Dr. Garst further testified that it is not unusual for someone who is on pain medication for those type of complaints to be subsided and then rise as he is being pulled off medication and recovering from other conditions.

Based on all of the above, and the entirety of the evidence of record, the Arbitrator finds that the Petitioner's left shoulder diagnosis of a rotator cuff tear is related to the October 28, 2016, accident.

J. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

The Arbitrator finds that the Respondent is responsible for the recommended surgery of Dr. Garst to the left shoulder and that the care and treatment provided to the Petitioner recovering from that surgery will also be the responsibility of the Respondent.

O. REQUEST FOR REIMBURSEMENT FOR FAILED APPOINTMENT UNDER SECTION 12 OF THE ACT

The Arbitrator denies the respondent's request.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHRYN McCORMICK,

Petitioner,

20IWCC0515

vs. NO: 17 WC 37946

FRANCIS P. O'MEARA, D.D.S., P.C.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of accident but attaches the Decision of the Arbitrator, which is made a part hereof, for the Findings of Fact with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner slipped and fell in a bathroom located in a common area of an "arcade building" where Respondent, a dentist, had an office. The Arbitrator found that Petitioner's accident occurred in the course of her employment but that she failed to prove that it arose out of her employment. The Arbitrator applied a neutral risk analysis and found that Petitioner "did not meet her burden of showing that she was exposed to the risk of slipping and falling to a greater degree than the general public." *Dec. at 4 (unnumbered).* The Arbitrator also found that "Petitioner's testimony only surmised that it was lotion or cream that she must have slipped [on]." *Id.*

Regarding whether Petitioner faced any increased risk, there is no dispute that the bathroom was not part of Respondent's premises. However, a key was required to enter the bathroom. *T.11.* Even though other tenants in the building and their clients/customers/guests were able to use the bathroom with a key (*T.37*), we find that these people are not synonymous

with the "general public" because it is illogical to conclude that the "general public" is exposed to an area that requires a key to gain access.

Furthermore, due to Petitioner's employment with Respondent, that first-floor bathroom was the only reasonable option for her. Petitioner testified that there was one bathroom on the first floor (where Respondent was located) and another bathroom on the second floor (where another dentist office and other offices were located). *T.40.* Petitioner testified that she did have access to the second-floor bathroom "but I never used them" because they were for the second-floor offices. *Id.* Petitioner also did not know if the key for the first-floor bathroom was even the same as the one for the second floor. *T.41.*

This is not a situation where a claimant slipped near one of the ten entrances to a large shopping mall and her employer (a tenant in the mall) had no control over the common areas. *See Illinois Bell Telephone Co. v. IC, 131 Ill. 2d 478 (1989).* We find this case to be more similar to *Bommarito v. IC*, 82 Ill.2d 191 (1980), which involved a claimant who stepped into a hole in an alley when she was eight feet from the back door that the employer required its employees to use. The Supreme Court found that, under these circumstances, "the special risks or hazards encountered by the claimant, as a result of the respondent's order to enter through the rear door only, must be deemed to arise out of her employment." *Id.* at 197. However, a distinction was made between a situation where an employee "freely chooses to use a certain route and is injured in doing so." *Id.* at 197.

Here, Petitioner really had only one choice of bathroom: the one on the first floor nearest to her employment. She had worked for Respondent for 17 years (*T.30*) but never used the second-floor bathroom and didn't know if the same key would work (*T.40*). In our view, when an employer does not provide a bathroom which it controls and is responsible to maintain, but, instead, requires an employee to use a "common area bathroom," the risk should be considered a risk distinctly associated with the employment. After all, the only reason the employee is at that location is because she is doing her job.

Even if this did not represent a risk distinctly associated with employment, we find it would also be compensable under a neutral-risk analysis because it is clear that Petitioner faced a neutral risk to a greater degree, both quantitatively and qualitatively, than the general public. We wonder what else an employee in these situations is supposed to do? Having to provide one's own receptacle when nature calls does not seem like a reasonable option.

Although not precedential, the Commission decision in *Pearson v. Denny's* found that injuries sustained in a common-area bathroom did arise out of employment. 16 WC 13523, 2018 Ill. Wrk. Comp. LEXIS 85 (1/30/18). Claimant, a waitress at a Denny's restaurant located in a truck stop was injured when a large, industrial-size roll of toilet paper fell on her head in a common-area bathroom. The Denny's restaurant did not have its own bathroom for its employees and the claimant had her choice of two common-area bathrooms. She regularly chose the one closest to Denny's. The Commission found that her accident arose out of employment because she faced both a qualitatively and quantitatively increased risk and wrote:

> The Commission finds elements of both in the present situation. Indeed, Petitioner's employment increased the risk of injury qualitatively by way of Respondent's failure to provide bathroom facilities for its employees, forcing Petitioner and her fellow workers to leave their place of employ to go off site to seek personal comfort in the form of a busy

 20IWCC0515

> public restroom. As a result, Petitioner's choices were severely limited, and any safeguards with respect to the safety and cleanliness of any such facility were effectively outsourced by Respondent. Thus, the employment and its lack of basic bathroom accommodations had a very real effect on the circumstances leading up to the injury, and as such exposed Petitioner to a greater risk of injury than members of the general public. Likewise, from a quantitative standpoint, Petitioner was exposed to a greater risk of injury due to her employment given the frequency with which she was forced to utilize these public facilities compared to members of the general public, who no doubt would have visited the facilities in question on a decidedly less frequent basis. *Pearson at 7.*

We agree with the rationale in *Pearson* and finds that it also applies to the case at bar. Petitioner was forced to expose herself to the increased risk of this common bathroom. Additionally, Petitioner testified that she hit her head on the back of the bathroom door when she slipped because:

> The doors that closed to the ladies' room had an automatic closer on it. The building owner had it set to close very quickly because he didn't want any transients or anybody getting into the bathrooms, you know, behind somebody that had a key. *T.38.*

In other words, unlike the "general public" common area in *Pearson* (and many other cases), the building owner in this case purposely set the bathroom doors to close very quickly to keep out transients or anyone who did not have a key.

Petitioner's testimony was that she believes she got to work around 7:00 to 7:30 a.m. but she knows that she was there before 8:00 a.m. *T.35.* This is consistent with Dr. O'Meara's testimony that Petitioner would come in early and get the place set up. *T.47.* Petitioner testified that she went to the bathroom after she set up the office for the day. *T.11.* There is no evidence that Petitioner was actually the "first person exposed to the hand cream on the floor," as her brief claims but the argument is still worthy of consideration because she, more likely than not, entered the bathroom earlier than any members of the "general public" would have been in the building. We also note that Petitioner testified she had to turn on the light in the bathroom after she entered because it was not already on. *T.11.*

Based on the above and a review of all the evidence, we find that Petitioner was exposed to a greater risk than the general public. However, the Arbitrator also found that Petitioner failed to prove that she slipped on hand lotion or cream. The Arbitrator wrote: "there was also no testimony directly connecting her fall to the substance on the ground." *Dec. at 4 (unnumbered).* Without doing a sentence-by-sentence analysis of the paragraph regarding this issue, we believe the Arbitrator's analysis is inaccurate. Several times, the Arbitrator wrote that Petitioner "assumed" that there was lotion or cream on the floor. However, Petitioner never used the word "assumed." Instead, she specifically testified, "I believe it was hand cream. It could have been something else. But there was a substance on the floor, which caused my foot to go out from underneath me." *T.11.* She believed it was hand cream because:

> there was a bottle of hand cream on the floor that after the light when on that I saw. I mean, I saw an empty bottle and cream all over the floor. So I think it was hand cream. It could have been something else, but I believe it to be hand cream. *T.13.*

Based on her testimony, Petitioner has met her burden. The Arbitrator's decision attempts to turn

a slip and fall on *some* foreign substance (whether lotion or some other cream like substance) into an idiopathic or unexplained fall. We note that the Arbitrator made a specific finding that Petitioner was "credible and candid in her recollection of her work accident" (*Dec. at 4*) but then focused on the fact that "it was only after she had already fallen that she noticed what she thought was lotion or cream nearby – she never identified the substance as being on her shoe or as making contact with her shoe or any other part of her body." We find that this is an unreasonable basis to deny accident. The credible evidence shows that Petitioner slipped, hit her head on the door, and fell to the floor because "there was a substance on the floor, which caused my foot to go out from underneath me," which she believed to be hand cream.

Apparently because of the Arbitrator's belief that Petitioner's testimony regarding the lotion was lacking enough detail, she concluded that Dr. Kastanes' September 14, 2017 record, which "noted that she slipped on some kind of cream is given less weight in light of her trial testimony." We disagree. Petitioner's intake form on that date states, "I slipped on some kind of cream that was on the floor. I hit the back of my head and chipped my front tooth." We find this is consistent with Petitioner's testimony that some substance, believed to be hand cream, caused her foot to go out from underneath her. We disagree with the Arbitrator's analysis of the medical records as well. The fact that Petitioner's dental record "did not mention any substance as the cause of her fall" is unpersuasive. . Petitioner testified that she reported the accident to Dr. O'Meara who smoothed down where the porcelain had chipped off of her crown. *T.13-14.* Petitioner was also told by Dr. O'Meara to contact building maintenance and also his lawyer, Chris Daniels, who told Petitioner to take pictures. *T.13-14.* Dr. O'Meara testified that Petitioner reported to him that she had slipped and fallen in the bathroom, but he did not report it to his workers' compensation insurance company because "whatever had happened, it wasn't in my office. So I assumed that I had no liability. I am not responsible for the maintenance of the bathroom or anything else. I have nothing to do with that." *T.52.* Likewise, the fact that Petitioner's first record with Dr. Chunduri, on January 18, 2018, states that Petitioner "slipped on something on the floor" and did not specifically identify it as cream or lotion is a very weak basis for finding that Petitioner's medical records are not supportive of her testimony.

In summary, we find that Petitioner has proven that her accident arose out of her employment and also that she slipped and fell on hand cream. We also find that her lumbar and cervical conditions of ill-being are causally related to her work accident as explained below.

Respondent's §12 examiner, Dr. Butler, opined that Petitioner's conditions are not causally related to the accident because she only had two chiropractic visits on September 14th and 16th, 2017, and did not seek any additional medical treatment for her back or neck until January 2018. However, Petitioner testified that she received two visits of free chiropractic treatments from Dr. Kastanes who was a dental patient of Dr. O'Meara. *T.16-17.* She testified that, after these visits, she was in more pain and she "was afraid it was doing me more damage than good." *T.17.* She also did not have money to continue seeing him. *T.18.* Petitioner testified that Respondent never provided health insurance and that she had applied for Affordable Care Act insurance but never used it. *T.30, 18.* She was told by her primary care physician that she need her workers' compensation information, but Petitioner did not have it and, by that time, Dr. O'Meara's practice had closed and the building had been torn down. *T.19-20.*

After her accident, Petitioner kept working until the end of October when Dr. O'Meara closed his practice. This had been planned since the beginning of 2017 when the office building was sold to a new owner. *T.20.* Regarding how she felt while she was going about her work

between September 18, 2017, and the closure of the building, Petitioner testified:

> Oh, it was rough. It was hard just to make it to work. You know, I had family and friends, my daughter, my niece, that would come and help me do the work that I had to do, sweeping, mopping, vacuuming, filing. I needed to get help for the things that I normally did. *T.21.*

Although Respondent's witness, Kathryn Sullivan (Dr. O'Meara's sister and dental hygienist) testified that she did not notice anything different about how Petitioner moved or performed her job duties after the September 1, 2017 accident (*T.67*), Petitioner did tell her about the accident and that she hit her head. *T.64-65.*

Similarly, Dr. O'Meara testified that Petitioner worked her normal job until his practice closed and he did not notice anything different about Petitioner physically such as walking differently after the injury. *T.53-55.* However, Petitioner did inform him about the accident and that she was "quite sore." T.48. He testified that he smoothed off a fractured piece of porcelain from her tooth. *Id.*

Petitioner's September 1, 2017 dental record indicates that Dr. O'Meara "smoothed down porcelain fx" but that "Pt to [sic] sore [from] fall to treat." The dental record from over two weeks later, on September 18, 2017, states "Pt still sore from fall on 9/1/17." The records of Dr. Kastanes on September 14th and September 16th also reflect Petitioner was having continuing symptoms.

We are mindful that one could question Petitioner's motives because her job of 17 years was coming to an end and she sustained an unwitnessed accident. However, as pointed out previously, the Arbitrator found Petitioner's testimony credible and so do we. She testified that she had a conversation on the date of accident with Dr. O'Meara's attorney about a potential premises liability action against the building. She testified that she thought she would heal, and she was never provided with any insurance company information or referred anywhere for treatment. *T.71.* Petitioner had two free chiropractic treatments with Dr. Kastanes which did not help. Respondent's dental office then closed at the end of October 2017.

Petitioner testified that she continued to have symptoms and that she filed her *pro se* Application for Adjustment of Claim on December 19, 2017, because "I thought that by coming down here it would get me the insurance information and the medical treatment. I knew there was something wrong." *T.21-22.* She testified that she eventually saw Dr. Chunduri on January 18, 2018, because "after coming down here and finding out a little bit more on how things worked, I sought legal counsel. I asked your office, lawyer's office that I hired, how to get medical treatment. They were able to provide me with the Workers' Compensation information. They referred me over to Dr. Chunduri who treated me." *T.22.*

We find that Petitioner credibly testified that she never had any prior problems with or treatment to her neck or back. *T.27.* Although there was a short gap in treatment, we find it credible that this was because she thought she would get better and also that she did not know how to get treatment. She eventually filed a *pro se* Application for Adjustment and then retained an attorney, which led to her treatment with Dr. Chunduri. Dr. O'Meara's testimony, his treating records, and those of Dr. Kastanes provide contemporaneous evidence of the fall and Petitioner's post-accident symptoms. There is objective MRI evidence of cervical and lumbar pathology and

even Dr. Butler believes surgery may be necessary. In this case, we find the few-month gap in treatment reasonable and, therefore, do not find Dr. Butler's causation opinion persuasive.

Petitioner's continued post-accident complaints are supported by the records of Dr. Chunduri and Dr. Templin, who gave an affirmative causation opinion in his October 19, 2018 record when he reviewed Dr. Butler's report and countered:

> Clearly this patient has had continued back, neck and radicular symptoms since the time of the injury, but as noted, was unable to access care for these issues, given her lack of medical insurance or otherwise. That being said, I continue to recommend surgical intervention first in the lumbar spine of L4-S1 fusion followed by the cervical spine in the form or [sic] potential C4-C7 ACDF. **Her injuries are causally related. Her time frame of delay in treatment was solely due to the fact that she was not afforded medical care and we will see her for preop discussion when surgical approval is met.** *Px1 (emphasis added).*

Based on the above and a thorough review of the evidence, we find that Petitioner's current cervical and lumbar conditions of ill-being remain causally related to her work accident.

Having found that Petitioner has proven accident and causation, the Commission finds that Petitioner is entitled to 48 weeks of temporary total disability (TTD) benefits from January 18, 2018, when Dr. Chunduri took her off work, through the date the hearing was held on December 19, 2018. This period is supported by off work notes from Dr. Chunduri and Dr. Templin. Based on Petitioner's stipulated average weekly wage of $322.28, her weekly TTD benefit rate is $220.00, which is the minimum TTD rate for a single person with no dependents, pursuant to §8(b)1 of the Act.

Petitioner is also entitled to the medical expenses contained in Petitioner's Exhibits 1 through 8, subject to the fee schedule in §8.2 of the Act, which we hereby find are reasonable, necessary and causally related to her work injury. We also award the prospective lumbar and cervical fusion surgeries recommended by Dr. Templin and note that even Respondent's §12 examiner, Dr. Butler, agreed that Petitioner may be a candidate for those procedures despite his belief that they would be unrelated to her work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $220.00 per week for a period of 48 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 medical bills contained in Petitioner's Exhibits 1 through 8 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for the lumbar and cervical fusion surgeries recommended by Dr. Templin for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 15 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

SE/
O: 7/28/20
49

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

McCORMICK, KATHRYN
Employee/Petitioner

Case# **17WC037946**

20IWCC0515

FRANK P O'MEARA DDS PC
Employer/Respondent

On 2/27/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
BRENT M SCHMITZ
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

2837 LAW OFFICE OF JOSEPH MARCINIAK
NICOLE S McNAIR
200 W MADISON ST SUITE 501
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)

KATHRYN MCCORMICK
Employee/Petitioner

Case # **17** WC **37946**

v.

Consolidated cases: **N/A**

FRANCIS P. O'MEARA, DDS, PC
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 **DECEMBER 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **9/1/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$16,758.56**; the average weekly wage was **$322.28**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$6,097.12** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,097.12**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

Having found no accident occurred, the remaining disputed issues, causal connection, liability for unpaid medical bills, temporary total disability and prospective medical care are **MOOT**.

ORDER

Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment. All other claims for compensation are hereby 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

2/27/2019
Date

FEB 27 2019

FINDINGS OF FACT

Petitioner, Kathryn McCormick, testified that on September 1, 2017, she was employed by the Respondent, Francis P. O'Meara, D.D.S., P.C. This is a dental office consisting of three individuals – Petitioner was the office manager, Dr. O'Meara was the owner and dentist, and Dr. O'Meara's sister, Catherine Sullivan, was employed as a dental hygienist. Petitioner began working for Dr. O'Meara in January 2000. She began as his assistant, and as of 2017 was the office manager, receptionist, and dental assistant. She performed reception services, billing and scheduling, as well as working as a chairside dental assistant, with duties such as providing suction during dental procedures. Her job was relatively light in nature, with lifting and carrying limited to putting stock away, at ten or fifteen pounds.

On September 1, 2017, Petitioner was the first person to arrive at work. She entered the dental office, then went out a back door into the hallway to use the ladies' room. The hallway and restroom were not a part of Dr. O'Meara's rented suite, but were instead available to all the tenants of the building. She used a key to access the locked restroom. Upon entering, the lights were off, and the entry door closed behind Petitioner. As she went to turn on the lights, she slipped and fell, striking the back of her head against the closed door, and then striking her buttocks on the ground. After she fell, she rolled to the right and ended up on her right side. Petitioner got up, and felt pain from head to toe. She noticed broken porcelain in her mouth from a fractured tooth. She noticed an empty bottle of hand cream on the floor of the bathroom, and what appeared to be spilled hand cream on the floor. Petitioner believed that she had slipped on this spilled hand cream. She testified that she called Dr. O'Meara, advised him of what had happened. When Dr. O'Meara arrived, he smoothed down the fractured tooth.

Petitioner was scheduled to be off for the weekend of September 2-4 (Labor Day.) She spent the weekend in bed, with significant pain in her neck and back. She was off work until September 18, 2017, which was her own decision, and not on the advice of any physician. She went to the office a few times during this period to check for mail and contact patients. She believes that the office was largely closed during this time, because she was not there to perform her job duties. Petitioner did not see a physician until September 14, 2017, when she saw Dr. William Kastanes, DC of the Niles Chiropractic Center.

On September 14, 2017, Petitioner presented to Niles Chiropractic. Px4. In part, Petitioner related she slipped and fell on some kind of cream that was on the floor and hit the back of her head and chipped her front tooth. A diagram showed the neck, low back and hands circled. Additional hand-written notes indicated Petitioner was at work, ran to the bathroom and slipped on something on the floor. She hit her head, chipped her tooth, had TMJ clicking and back clicking. She felt as if there was a hot poker in her back. Her right hand was going numb. Her numbness started in her fingers and moved up the arms to the biceps. She was also sore in the neck. She didn't feel she had full motion. On September 16, 2017, Petitioner followed up with Dr. Kastanes. Px4. Symptoms continued. Therapy was administered to the neck, back and areas.

Petitioner testified she not see Dr. Kastanes again after September 16, as she had no way to pay for his bills. She had health insurance through the Affordable Care Act, but when she contacted her carrier, she was told that she would personally be responsible for any medical charges, as the incident had occurred at work, and the health insurance carrier would not pay. Petitioner returned to work on September 18, 2017, and continued working until the office permanently closed in October 2017. The building had been purchased, and Dr. O'Meara elected to retire rather than move his practice. During this period of September and October, Petitioner testified she worked through her pain, hoping that she would be able to heal once she had some time off when the office closed. She was using over-the-counter pain medication. After the office closed, Petitioner said she was off work and not improving.

On January 18, 2018, Petitioner presented to Dr. Chunduri with pain in the neck radiating down the right upper extremity with numbness in tingling. She also had lower back pain that occasionally radiated down the right leg. The doctor noted Petitioner was injured on September 1, 2017 while at work as a manager of a dental office. She slipped on the bathroom floor and fell backwards hitting her head and shipping two teeth. Recommendations were made.

On January 24, 2018, Petitioner presented to ATI physical therapy for initial evaluation. She presented with decreased cervical and lumbar range of motion, upper and lower extremity strength, flexibility, soft tissue mobility and increased pain. Her position as office manager/dental assistant required physical demand level of light. Therapy was recommended.

On January 25, 2018, Petitioner followed up with Dr. Chunduri with continued neck pain radiating down the right upper extremity and ongoing lower back pain with numbness, tingling and weakness radiating down the right leg to the feet. MRI results were reviewed. The plan was for cervical epidural injections at C6-7. She was to continue therapy and medications. On February 1, 2018, Dr. Chunduri administered a C6-7 injection.

On March 1, 2018, Petitioner followed up with Dr. Chunduri and reported she had significant improvement and the intensity of pain was down about 30%. She rated neck pain 6 out of 10. The low back pain was rated 8 out of 10 with continued radiation down the right leg. Exam revealed no new findings. The plan was for a repeat cervical epidural injection. Medications were adjusted.

On April 4, 2018, Petitioner followed up with Dr. Chunduri. History noted Petitioner slipped and fell in the bathroom, fell backwards, hitting the back of her head which caused her to head to snap forward and the chipped her tooth as she came forward and hit her face. A second cervical injection was recommended. Petitioner was to continue therapy and medications.

On April 9, 2018, Petitioner followed up with Dr. Chunduri and reported 100% relief of symptoms for three weeks after the first injection. She had about 80% relief for another three weeks. A repeat injection was recommended. She was to continue therapy and medication. On April 12, 2018, Dr. Chunduri repeated the epidural steroid injection at C6-7.

On May 3, 2018, Petitioner followed up with Dr. Chunduri. She was unchanged. The plan was for lumbar transforaminal epidural steroid injection on the right at L5 and S1. On May 4, 2018, Petitioner was discharged from physical therapy after 28 visits. She made objective improvements with cervical rotation range of motion, strength, soft tissue mobility and flexibility. She had significant improvement with pain after the injection. She reported significant pain in the right lower extremity. She continued with impairments in range of motion, strength, gait and pain. She plateaued and was discharged. On May 10, 2018, Petitioner underwent lumbar injections.

On June 1, 2018, Petitioner followed up with Dr. Chunduri. Px1. He noted her right foot stepped on some cream in the bathroom. She went onto her back, hit her head, chipped her tooth and has had lower back pain. The doctor assessed cervical spondylosis and radicular complaints to the right. Lumbar x-rays were recommended.

On June 27, 2018, Petitioner presented to ATI physical therapy for initial evaluation. Px8. Under nature of injury, Petitioner disclosed that she slipped and fell on hand cream or something on the floor of the bathroom at work. She reported she hit her head and chipped her tooth. She reported immediate pain in her head and neck. Within a few weeks of the fall, she began having numbness and pain in the left arm. Petitioner continued with therapies for the spine.

On July 17, 2018, Petitioner presented for a section 12 evaluation with Dr. Jesse Butler. Rx1. Petitioner related she slipped and fell in the bathroom at work. She struck her head and chipped her tooth. She reported pain in the neck and lower back. She had two sessions of chiropractic care in the new care until January 2018. She continued working until the practice closed. She denied any prior history of neck and back pain. Dr. Butler assessed cervical spinal stenosis, lumbar stenosis without neurogenic claudication and lumbar spondylolisthesis. Dr. Butler noted that Petitioner may require additional treatment. She may be a candidate for interior cervical discectomy and fusion from C4 through C7. Petitioner may also be a candidate for lumbar spinal fusion from L4 to the sacrum. However, the doctor opined that such treatment was not causally related to the work accident . The doctor noted Petitioner had two visits of chiropractic care and then did not seek any additional medical treatment for her back or neck until January 2018. The doctor further opined that Petitioner did not have any work restrictions at that time that would be related to the work accident. Finally, while the treatment had been reasonable and necessary, it was ultimately unrelated to the work event. The doctor concluded that Petitioner had reached maximum medical improvement after September 16, 2017 as she did not seek any additional medical care until three months later.

On August 3, 2018, Petitioner presented to Dr. Templin. Px1. She related she slipped on some substance at on the floor, fell back, hit her head and landed on her back. The doctor diagnosed degenerative spondylolisthesis at L4-5 with lateral recess stenosis and degenerative change at L5-S1, resulting in foraminal stenosis. The doctor felt this was aggravated by the work injury and rendered symptomatic. Lumbar fusion was recommended. On August 8, 2018, Petitioner underwent EMG/NCV. Px1. History noted Petitioner had back pain since her fall.

Petitioner testified at trial that she wishes to undergo the surgeries being recommended by Dr. Templin and Dr. Butler. She is currently taking multiple medications. She is unable to work, and has not worked since Dr. O'Meara's office closed in October 2017. She is living with her daughter. Her family takes care of chores around the house, as she is unable to do them. She testified she has had no problems with her back or her neck prior to this incident.

On cross-examination, Petitioner acknowledged that she was aware of the impending closure of Dr. O'Meara's office maybe a year prior to her accident. She acknowledged she had been involved in a motor vehicle accident in approximately 2001. Petitioner's daughter suffered minor injuries, including a lost tooth and some stitches for cuts. Petitioner does not believe she herself was injured in the incident. Petitioner also acknowledged that she was previously married to an abusive husband approximately thirty years ago.

Respondent then called Dr. Francis O'Meara. Dr. O'Meara testified consistently with Petitioner's testimony respecting her job duties. He stated that on the date of the accident, she told him about the accident. He was unsure if she called him, or if she told him about it when he came into the office that day. He did smooth down a chipped tooth, probably #8 based on his charted records. Dr. O'Meara did not report this incident to his workers' compensation insurance carrier, stating that Petitioner did not ask him to do so. He does not believe the office was closed from September 5 to September 17, 2017. He does not recall noticing any physical differences about the Petitioner between the accident date and the closure of the office.

Respondent next called Ms. Catherine Sullivan, the dental hygienist. Ms. Sullivan testified she had worked with her brother, Dr. O'Meara from 1982 until the closure of the office. She would not have been present on the date of accident, as she did not work on Fridays. She recalled a conversation in which Petitioner told her about the accident, and mentioned that she hit her head. Ms. Sullivan believed this conversation would have been sometime the week after the injury. Ms. Sullivan did not notice any physical differences about the Petitioner between the accident date and the closure of the office.

Petitioner was then recalled to the stand in rebuttal. She testified that on the date of accident, Dr. O'Meara instructed her to call Chris Daniels, Dr. O'Meara's attorney, about a possible premises liability claim.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner testified at trial. The Arbitrator had an opportunity to observe her demeanor and found her testimony to be credible and candid in her recollection of her work accident and her course of treatment. O'Meara and Sullivan also testified and the Arbitrator likewise found their testimony to be candid and straightforward.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Here, there can be no dispute that Petitioner's accident occurred in the course of her employment. The issue is whether the accident arose out of that employment. Having reviewed all credible evidence and applicable caselaw, the Arbitrator must conclude that Petitioner failed to meet her burden of proof on this issue.

An accident arises out of one's employment when it connected to an employment risk. Neutral and personal risks are generally not compensable unless a claimant can show she was exposed to either risk to a greater degree than the general public. This analysis can be qualitative or quantitative. In Illinois, slip and falls are generally considered neutral risks unless Petitioner can show it is connected to her employment or that she was exposed to the risk of slipping and falling to a greater degree than the general public. Weighing the facts of this case, Petitioner has not met her burden.

Here, Petitioner testified that this was a shared bathroom located in the arcade. Petitioner did not testify the bathroom was only available to Respondent's business or employees. Rather, she explained that the restroom was not part of Dr. O'Meara's suite but was instead available to all the tenants. Further, although she used a key that morning, she admitted the bathroom was open to the public. Petitioner did not give testimony establishing that the other tenants and their customers did or did not have access to this bathroom at the time she fell or anything other time. Based on Petitioner's unrebutted testimony, the evidence established that the bathroom was open to the general public. Petitioner also did not meet her burden of showing that she was exposed to the risk of slipping and falling to a greater degree than the general public. Petitioner did not state how many times she frequented this bathroom. Petitioner also did not give testimony as to the condition of this bathroom compared to the date of her fall, which may or may not have established whether substances were regularly on the ground or that the bathroom was unkept.

Finally, even if Petitioner overcame the neutral risk analysis required, Petitioner's testimony only surmised that it was lotion or cream that she must have slipped. The credible sequence of events established that Petitioner opened the door, turned the light on, stepped inside and slipped and fell. She said she did not know how she got to the ground. She then testified she saw lotion on the floor but that it could have been something else but she assumed it was that. Based on these facts, the Arbitrator infers that when Petitioner turned the light on and entered, she did not visualize any substance on the floor. It was only after she had already fallen that she noticed what she thought was lotion or cream nearby – she never identified the substance as being on her shoe or as making contact with her shoe or any other part of her body. Her candid testimony was that she assumed "it was that," without affirmatively clarifying whether she meant she assumed "it" was

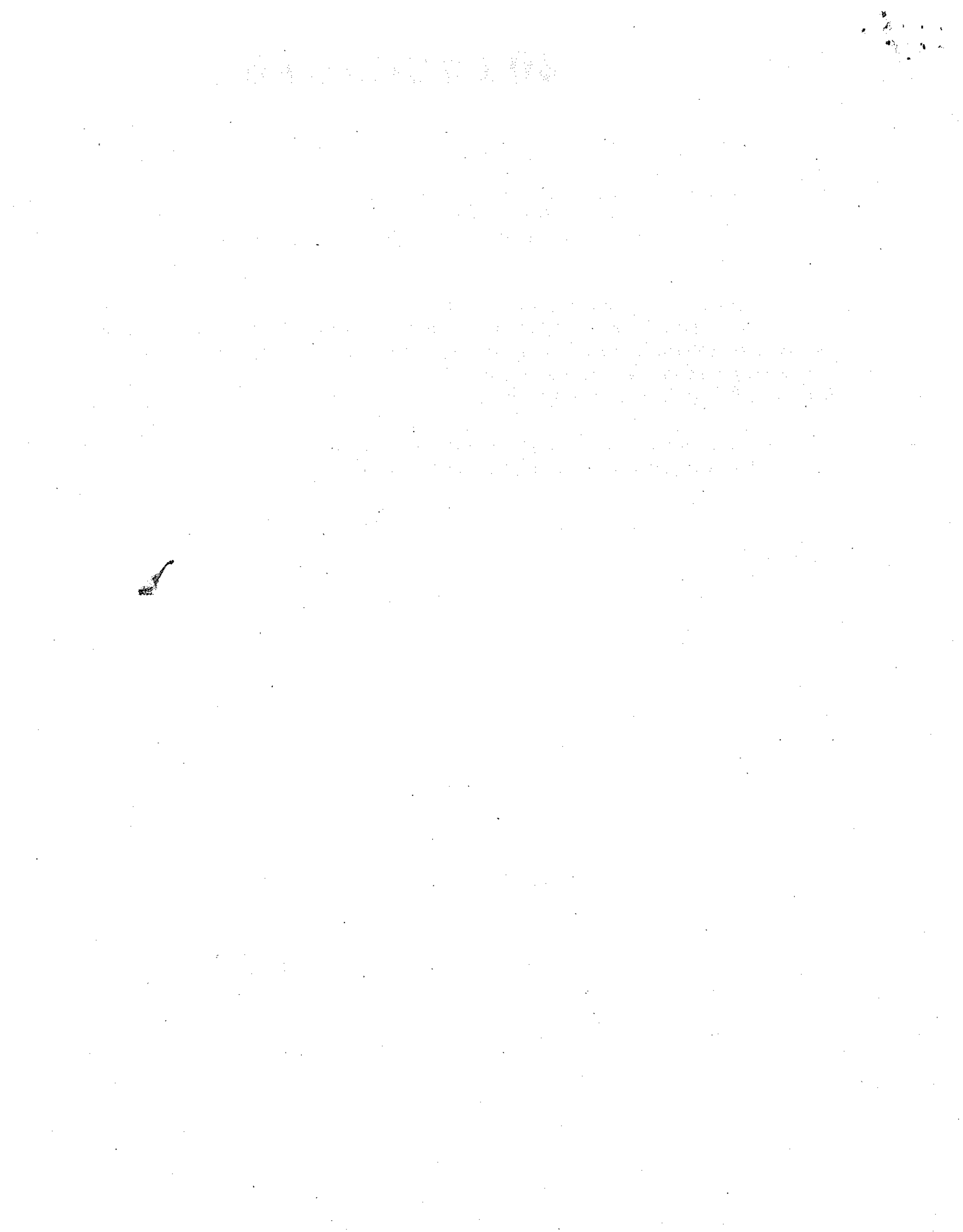
lotion on the ground or that "it," being the lotion, was the cause of her slip and fall. Therefore, there was also no testimony directly connecting her fall to the substance on the ground. In looking to the medical records submitted, Petitioner's dental record did not mention any substance as the cause of her fall. Px9. Petitioner's initial visit with Dr. Kastanes noted that she slipped on some kind of cream is given less weight in light of her trial testimony. Px4. Petitioner's initial treating record with Dr. Chunduri fails to note what, if anything, Petitioner slipped on. Px1. It was not until June 2018 that Dr. Chunduri and ATI first noted Petitioner stepped on cream. Px1, Px8.

ISSUE (F) Is Petitioner's current condition of ill-being causally related to the injury?
ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
ISSUE (L) What temporary benefits are in dispute?
ISSUE (K) Is Petitioner entitled to prospective medical?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found no accident, all other issues are moot.

Signature of Arbitrator

2/27/2019
Date



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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DYLAN JUNIOR,

Petitioner,

vs. NO: 17 WC 24222

EXPRESS EMPLOYMENT PROFESSIONALS,

Respondent.

20 I W CC0521

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 20, 2019, is hereby affirmed and adopted.

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

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

20 I W C C 0 5 2 1

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: SEP 1 6 2020
o090320
MP/jrc
068

Marc Parker

Barbara N. Flores

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JUNIOR, DYLAN
Employee/Petitioner

Case# **17WC024222**

EXPRESS EMPLOYMENT PROFESSIONALS
Employer/Respondent

20IWCC0521

On 11/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.54% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1189 WOLTER BEEMAN LYNCH & ET AL
BRENT A BEEMAN
1001 S 6TH ST
SPRINGFIELD, IL 62703

2623 McANDREWS & NORGLE LLC
EDWARD JORDAN
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DYLAN JUNIOR,
Employee/Petitioner

Case # **17** WC **24222**

v.

Consolidated cases: ____

EXPRESS EMPLOYMENT PROFESSIONALS,
Employer/Respondent

20IWCC0521

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/24/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ 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 ____

20 I W C C 0 5 2 1

FINDINGS

On **7/12/17**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**1,940.00**; the average weekly wage was $**242.50**.

On the date of accident, Petitioner was **19** years of age, ***single*** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/12/17. Petitioner's claim for compensation is denied.

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

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

Maureen H Pulia

Signature of Arbitrator

11/11/19
Date

ICArbDec p. 2

NOV 2 0 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 19 year old employee for respondent, alleges he sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/12/17, while working for the City of Decatur at the Williams Street Reservoir. Petitioner began working for respondent on 5/25/17. Petitioner was in the Army Reserves at the time of the accident. Petitioner is right hand dominant.

On 7/12/17 petitioner was working for the City of Decatur and was instructed to clean up branches on 7/11/17 and 7/12/17, and mow the lawn. Petitioner testified that he was not supplied any safety equipment to wear at the time of the accident.

Petitioner testified that on 7/11/17 he used a chainsaw to cut branches off pine trees that lined the fence around the reservoir. He testified that they were not able to clean them up on 7/11/17 because it began raining. He testified that he did see bottle rocket trash that day. It rained about 1.5 inches on 7/11/17. Petitioner testified that 7/12/17 was a humid and hot day, with the temperature in the 80's by 9 am. On 7/12/17 petitioner stated that he was picking up the tree limbs. Just before the accident he stated that he was picking up tiny branches and moved them from his right hand to his left hand. He then picked up a baseball size object, and within a split second it exploded, and he was knocked out. He testified that he did not see any wick, or any other baseball sized items on the ground. He testified that when he came to, his right hand was a mess and he freaked out running around until the firefighters came.

Petitioner testified that he lights his cigarettes with his right hand using his lighter. Petitioner denied lighting the firework with his lighter.

Petitioner testified that he was bent over at the waist when the explosion occurred, and that the explosion occurred a few inches off the ground. Petitioner then testified that he could not remember if he was bent at the knees or the waist. He also testified that his left hand was shoulder width (2 feet) from his right hand at the time of the explosion. Petitioner denied having any burns to his shins above his boots to his knees. He stated that the burns to his chest and waist level stopped at the top of his jeans. Petitioner testified that his right leg was closer to the explosion than his left hand. On cross examination petitioner stated that when he bent down to pick up the object his face was an arm's length from the explosion. He testified that the explosion went off immediately after he picked it up. He did not have a strong recollection as to how far off the ground the object was when it exploded.

Dustin Kawaski, a co-worker of petitioner for a few months prior to 7/12/17, was working with petitioner at the reservoir, near the firehouse in Decatur, at the time of the injury. Kawaski got to know petitioner by

working with him every day for about three months. On 7/12/17 there were tree branches from pine trees along the fences around the resevoir that had been cut down the day before. After he and petitioner cut the tree branches down on 7/11/17, they stopped because it started raining. They returned on 7/12/17 to pick up the branches and debris so that they could get the mower through. Kawaski testified that while he was dragging tree branches to the trailer on 7/12/17 he heard an explosion. He ran around the other side of the truck and saw petitioner screaming and holding his wrist with blood all over. Kawaski testified that he tried to get petitioner settled down. He then got in the truck and called 9-1-1. As he was calling, Kawaski looked in the rearview mirror and saw the firefighters all over and waved them over. Kawaski testified that petitioner did not tell him what happened to him. He also testified that petitioner did not mention finding, or lighting a firework, before the accident. Kawaski stated that at the time of the blast both he and petitioner were performing their work tasks.

On cross examination Kawaski testified that he was not assigned to pick up objects or garbage on the ground by the respondent or the City of Decatur. Kawaski testified that he saw no fireworks on the ground on 7/11/17 or 7/12/17. He stated that he was not wearing any gloves or safety glasses at the time of the injury. He also stated that on 7/11/17 and 7/12/17 petitioner did not point out any fireworks on the ground. Kawaski did not see petitioner picking up anything other than tree limbs, including fireworks. Kawaski testified that petitioner had a lighter on him on the date of accident, and that the lighter found on the ground after the accident was petitioner's. He stated that before the accident petitioner had the lighter on his pants.

On redirect examination, Kawaski testified that he noticed petitioner would have his lighter clipped on his belt loop or looped on his pants. He did not see petitioner remove the lighter on 7/12/17. He had no idea where the lighter was at the time of the accident.

Kawaski completed a hand written statement on 7/12/17. He wrote that petitioner and him were cleaning limbs on the south side of the fence and there were old fireworks laying all along the fence line. He wrote that he was on the driver's side of the truck when he heard a loud explosion and saw petitioner holding his wrist and screaming. He wrote that he ran around the trailer, saw blood, and then jumped in the truck and radioed that he needed help. As he was going to take petitioner to the emergency room he saw the firemen and started yelling for help.

One of the Decatur Fire Stations was within sound distance of the area where petitioner was injured, and upon hearing the explosion, they exited the firehouse and saw smoke coming from the area south of the reservoir and heard screaming. The EMS report notes that the firefighters headed to the scene of petitioner's injury, and when they arrived observed a city employee holding onto a mangled and deformed right hand, which

was missing many small chunks. Also noted was that petitioner had holes in his shirt, and his right eyebrow was burnt off.

Petitioner was taken by ambulance to Decatur Memorial Hospital trauma bay. Once there, petitioner had x-rays of his right hand that revealed multiple fractures of the right hand that included a fracture with angulation of the proximal first phalanx, a fracture of the base of the distal first phalanx, and, displacement of the proximal phalangeal fracture, a fracture dislocation of the base of the first metacarpal, a displaced fracture fragment measuring 4x11cm, a mildly displaced and mildly angulated proximal 4th phalanx fracture with intra-articular extension, and a fracture of the distal fifth metacarpal that was nondisplaced. Petitioner also had lacerations of the right hand, foreign body presence unspecified, first degree face burns, and 2nd degree burns of the abdomen.

The notes of Nurse Justin Williams noted that "As per triage note. Pt works for city of Decatur and was at 1200 E Main picking up brush and trash when he found unexploded mortar shell. Pts sts wick was intact and when he picked up firework it exploded in hand. Per DPD [Decatur Police Department] who was at bedside a lighter was found near explosion site. Pt denies lighting firework. Pt holding firework in R hand, right hand has laceration that extends from thumb webbing to mid palm. Palm evulsion noted with bone exposed. Pt sts unable to move fingers." He noted that petitioner had 1st and 2nd degree burns anterior to chest, and singed hair on his arms. Abrasions were noted on his left hand, and singed eyebrows. Petitioner was given morphine.

The note of Dr. David Kiel stated "This young man was working this morning picking up brush and left over firework display of the fourth. He picked up a baseball size mortar that was lying in the brush and immediately exploded in his right hand." Dr. Kiel diagnosed superficial hair singing of the scalp, first degree burns to the forehead, injection in the eye globes, 1st and 2nd degree burns of the anterior torso, a severe folate type of laceration to the right hand with lacerations of all the digits and the thenar eminence through and through.

Nurse Amy Jump noted that "Pt arrives DAS/ALS for eval of extensive right hand injury ... DAS sts pt was cleaning up a house and went to pick up what was a dead firework and it exploded in hand...EMS report firework was large type."

Prior to being transferred from Decatur Memorial Hospital, petitioner testified that he was questioned by Officer Claypool with the Decatur Police Department. He testified that he told Officer Claypool that he was on pain medicine and did not want to give a statement at that time. He further testified that Officer Claypool told him that he was guilty if he did not talk.

Petitioner was stabilized at the Decatur Memorial Hospital emergency room and transferred via ambulance to the emergency room at Memorial Health System in Springfield. The mechanism of injury was identified as a fireworks injury. Petitioner stated that he was at work picking up trash when the bag he grabbed exploded. The history of accident was that petitioner was at work and picked up a mortar that exploded in his right hand. Petitioner reported that he was wearing safety glasses at the time of injury. An examination by EENT revealed a 1 mm light brown spot on the inner aspect of the left eye, reddened around, and ringing reported by petitioner to both ears after the blast, with current decreased hearing in both ears. Petitioner's cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, and psychosocial examinations revealed intermittent tachycardia; burns to the abdomen; singed beard, brows and lashes; right hand mutilation; abrasions and bleeding of the first three fingers of the left hand; and, burns to face, neck, chest, shoulders and bilateral hands after mortar firework explosion that morning. Petitioner was agitated, crying and restless. His right hand was noted has being "filleted" open.

Petitioner was an inpatient at Memorial Health System from 7/12/17 through 8/6/17. While admitted petitioner underwent a microvascular arterial anastomosis for right thumb ischemia, revision amputations of the long and ring fingers, nailbed repair of the small finger, open reduction and percutaneous pinning of thumb metacarpal and proximal phalanx fractures along with a DIP joint dislocation; repair of the thumb aductor apponens and flexor pollicis brevis, wound care to abdominal and left hand burns with Xeroform and bacitracin, allograft application to the right thumb wound totaling 2.5 x 4 cm, and 35 cm complex closure of the right hand on 7/12/17 by Dr. Kevin Calder; an irrigation and debridement of right hand wounds up to and including bony tissue, 15 sq cm, with removal of allograft on 7/21/17 by Dr. Robert Russell; a removal of the left embedded subconjunctival foreign body nonperforating in the left medial bulbar conjunctiva, and repair of the conjunctival laceration with rearrangement on 7/21/17 by Dr. Grant Su; a repeat revision amputation of the right long and ring fingers, and debridement of skin, subcutaneous tissue, muscle, and bone of the right hand on 7/26/17 by Dr. Calder; an excisional debridement of the right hand wound, skin, and subcutaneous tissue on 7/28/17 by Dr. Calder; a left free vascularized anterolateral thigh fascia flap for coverage of the right hand wound, and split thickness skin graft 200 sq cm to right hand wound on 7/31/17 by Dr. Kevin Calder.

On 7/14/17 petitioner was seen by Dr. Jeffrey Bennett for his depressed mood, frequent crying spells with flashbacks and nightmares of the recent incident that he experienced. He reported mild insomnia with ideas of helplessness at present. He denied feeling suicidal. Dr. Bennett examined petitioner and assessed an acute stress disorder.

On 7/20/17 Dr. Hunter noted new bilateral conductive hearing loss and tinnitus after blast injury. He had bilateral tympanic membrane perforations, 50% on the right and 20% on the left. No surgical recommendation was made for the acute setting. He was told to follow-up with Dr. Bass in the clinic after discharge to be evaluated for spontaneous resolution versus persistent perforation that would require surgical repair.

On 7/13/19 the notes of Nurse Phyllis Graue included an assessment that had an accident history of "He was picking up trash at work when a firework discharged."

On 7/28/17 the progress note of Robert Twist in Pastoral Care included an Additional Note that stated "he states he was burnt when picking up live fireworks shell with branches that he was unaware it was still live. Shell exploded damaging hands and ears. …. Pt distressed he may not be able to continue to serve in military. Pt also distressed over initial denial of Workman's Comp claim."

Petitioner contracted Clostridium Difficile and was treated with Flagyl. He worked aggressively with occupational and physical therapy regarding his splinting of his right hand and eventually was discharged home with home health once his pain was controlled with oral medications, and he was deemed fit by all providers to be discharged.

The discharge plan instructed petitioner to perform daily dressing changes to the right hand and keep the area clean and dry between dressings. He was restricted from doing any lifting with his right hand, and was instructed to wear his splint and keep it elevated at all times. He was also instructed to not smoke at all. Petitioner was directed to follow-up with SIU psychiatry as needed, and to follow up with SIU ENT. Petitioner was instructed to also follow up with Dr. Calder in the clinic in 7-10 days for evaluation of his wound healing.

On 8/14/17 petitioner presented to Dr. Dennis Heim his PCP. He gave a history of picking up trash at work, and picked up an unexploded firework mortar and it went off. Dr. Heim noted that the left anterior thigh donor site was healing well.

Petitioner followed up as directed with his healthcare providers. On 8/17/17, 8/29/17, 9/5/17, 9/19/17, 10/12/17 and 10/20/17 petitioner followed up with Dr. Calder. He also took part in hand therapy. On 9/20/17 petitioner presented to Dr. Richard Bass for his bilateral tympanic membrane perforations. He reported tinnitus, and improved hearing from his left ear. He also reported persistent anterior inferior left tympanic membrane perforation, but noted that the right tympanic membrane had healed since the injury. He reported his disturbance and ringing at a 4-5/10. An audiogram and tympanogram were performed.

On 10/23/17 petitioner underwent a left lympanoplasty performed by Dr. Richard Bass. Interoperative findings included a 60% tympanic membrane perforation and intact mobile ossicular chain repaired with a

temporal fascia graft. On 11/1/17 Dr. Bass was of the opinion that the fascia graft appeared to be well healing and postauricular incisions showed no signs of infection.

On 11/14/17 petitioner followed up with Dr. Calder because he was contracting his 1st web space and his digits down into a very flexed static position. He continued to have very little range of motion and was quite stiff at multiple joints within the hand including his small finger which was essentially unaffected by the injury. Petitioner had been in a thumb spica splint to help open up the contracture, but had not progressed very far. Petitioner wanted to know what surgical options were available.

On 11/22/17 petitioner underwent a scar contracture release of the right index finger, long finger, 1st web space and palm with FTSG; capsulotomy of right index and long finger PIP; capsulotomy of the right thumb and CMC joint; and percutaneous pinning of the right index finger PIP and right thumb MP joint by Dr. Calder.

On 11/29/17 petitioner returned to Dr. Bass. He denied any ear pain, drainage or hearing difficulties. He had no concerns. Dr. Bass noted that petitioner was healing well without residual perforation or subjective hearing difficulty.

Petitioner continued follow-up visits with Dr. Calder and in hand therapy. Dr. Calder noted that petitioner had a malunion, and that he would benefit from a right ring finger open reduction internal fixation, a malunion release and reduction, followed by PIP joint release on nail remnant ablation.

On 3/1/18 petitioner reported to Dr. Bass that his hearing was not bothersome. He had tinnitus in quiet rooms, that was slightly annoying. He stated that his incision was itchy and irritating. His audiogram showed SRT R NA dB, L15dB, discrimination of R NA%, L 96%, pure tone left only, and very minimal conductive loss with mild high tone frequencies.

On 3/2/18 petitioner underwent a contracture release of the right ring finger proximal interphalangeal joint, open reduction internal fixation of the right ring finger proximal phalanx malunion, removal of foreign body of the right wrist, and nail ablation of the right ring finger. This procedure was performed by Dr. Calder.

On 3/22/18 and 4/17/18 petitioner followed-up with Dr. Calder for his right hand. On 4/17/18 petitioner was unable to fully flex the ring finger due to some tendon adhesions in the proximal phalanx. The middle finger was severely contracted both at the PIP joint as well as over the volar soft tissues. The index finger was contracted at the PIP joint. The 1st web spaces were somewhat contracted. Dr. Calder noted that petitioner was in a position with the flexion of the IP joint where the web space is deepened up in order to grip around a can. Dr. Calder was of the opinion that petitioner was nearing completion of his surgeries and may not regain much more function than he already had.

On 4/24/18 petitioner underwent excision of scar and soft tissue in preparation for skin grafting, 15 sq cm; full-thickness skin graft to the hand, 15 sq cm; adjacent tissue transfer of the 1st webspace, 5 sq cm; percutaneous pinning of the long finger to prevent contracture; removal of nail remnant of the ring finger with primary closure; and removal of the nail plate of the small finger of removal of scar and primary closure of the sterile matrix of the small finger. This surgery was performed by Dr. Calder. His post operative diagnosis was flexion contracture of hand after traumatic hand injury. Petitioner followed-up post-operatively with Dr. Calder and in hand therapy.

On 5/15/18 Dr. Calder noted improved flexion on petitioner's right ring finger and increasing range of motion. They discussed some fat grafting to the right thumb as well as some revision to the split thickness skin graft in the future, if needed. X-rays showed stable fixation to his right ring finger proximal phalanx. Dr. Calder instructed petitioner to continue aggressive scar massage and range of motion exercises. He excused petitioner from work on 5/15/18, and then indicated that he may return to work.

On 5/18/18 petitioner returned to Dr. Calder due to a possible right hand infection. Dr. Calder noted that one pin appeared loose and was concerning for post op pin site infection. Dr. Calder pulled it out.

On 6/19/18 Dr. Calder noted that petitioner reported developing phantom pain over the past month and was taking Norco for it. He noted excellent range of motion in petitioner's fingers. He noted that petitioner was taking Cymbalta, and that petitioner thought he may have PTSD. Dr. Calder referred petitioner to SIU psychiatry. He also noted that petitioner was evaluated in the hospital and it was noted that he could follow up as needed.

On 8/21/18 petitioner returned to Dr. Calder for a final determination in regards to his injury. Petitioner reported that he was coping relatively well, had optimized his hand function, and done well with therapy. Petitioner was able to oppose his thumb to his index finger and to his little finger. His tripod pinch was more difficult. He was unable to touch his ring and little fingers to his palm. His grip was severely compromised and he had limited hand function. Dr. Calder ordered a Functional Capacity Evaluation.

On 9/10/18 petitioner underwent a Functional Capacity Evaluation at Memorial Industrial Rehab performed by Therapist Jennifer Schulz, PT, DPT. The petitioner demonstrated cooperative behavior and was willing to work to maximum abilities in all test items. Movement patterns and psychological responses were consistent with maximal effort. Petitioner gave maximal effort. Petitioner's current functioning level was within the "Light" category (11-20#) for waist to floor lifts and waist to crown lifts, and within the "Medium" DOL category ((21-50#) for front carry. Petitioner demonstrated limitation of right hand grip and pinch strength

below age and gender norms, limited ladder climb abilities, decreased fine motor coordination of the right hand and limited average range of motion of the right hand affecting all digits with partial amputations of select digits. Petitioner demonstrated the ability to perform waist to floor lift with 20#, waist to crown lift with 15# occasionally, and front carry with 25# occasionally. Petitioner was working part time as a unit supply specialist in the United States Army at the time of the FCE and was confident in his abilities associated with that job.

On 8/15/18 petitioner reported to Dr. Heim that the Cymbalta and Seroquel were not helping a lot with his depression management. Petitioner stated that he was in the process of being discharged from the Army and was told by psychiatrist at Fort Knox that he needed some type of brain scan to be ordered. Dr. Heim noted that petitioner had not had any brain MRIs done in regards to his present treatment. On 9/17/18 petitioner presented to Dr. Heim regarding worsening headaches over the last several months. Petitioner had no focal neuro deficits. They discussed possible brain imaging studies to help determined the possibility of traumatic brain injury that occurred during the fireworks explosion and could not be identified by imaging studies.

On 11/7/18 petitioner returned to Dr. Bueno. Dr. Bueno noted significant residual functional limitations on petitioner's right hand following his mutilating blast injury. He was of the opinion that these deficits would be permanent.

On 2/25/19 petitioner underwent a Section 12 examination performed by Dr. James Williams, at the request of the respondent. Petitioner reported that he was currently not working. He gave a history of working for respondent on 7/12/17 to remove yard waste/tree trimming for a city owned lot in Decatur, IL. Petitioner reported that at the time of the injury he had apparently found an undetonated firework among the fallen tree branches. Dr. Williams asked petitioner multiple times if he had ever lit a firework, and he denied that he did. Petitioner stated that the firework was undetonated when he found it. He stated that it exploded after he picked it up with his right hand. He denied ever lighting the firework. Dr. Williams noted that according to the investigation materials, per the Secretary of State Bomb technician, early opinions given to the Decatur Police Department were that it was not the type of firework that would detonate without an ignition source. He also noted that the petitioner's Double Barrel Torch Turbo blue lighter, which he admitted having on his person, was found within 15 feet of the scene of the accident. Petitioner gave a history of his treatment from the date of injury. Dr. Williams reviewed the medical records and had petitioner complete a Medical History Questionnaire. Dr. Williams also performed an examination of petitioner.

Following his examination and record review, Dr. Williams diagnosed status post blast injury of the right hand. He noted that petitioner suffered superficial burns to the left hand. He was of the opinion that petitioner's current condition of ill-being as it relates to his left and right hands is causally related to blast injury on 7/12/17,

and all his treatment has been reasonable and necessary. Dr. Williams was of the opinion that petitioner cannot return to work as a maintenance worker without restrictions. He left all restrictions up to the findings on the FCE, which he agreed with. Dr. Williams believed the petitioner had reached maximum medical improvement with respect to his left and right hands.

Dr. Williams provided an impairment rating pursuant to the most current AMA guidelines. He determined a 72% impairment of the right hand. He was of the opinion that it would actually be 65%, and the whole person would be 39%. He was of the opinion that the only functional thing petitioner has with respect to his right hand was his little finger.

On 3/5/19 petitioner underwent an EEG for problems with headaches and memory loss. The results of the EEG were normal.

On 3/6/19 petitioner followed up with Dr. Rueben Bueno for his right hand blast injury. Petitioner had previously seen Dr. Calder for his right hand injury. Petitioner noted that he was seen by his work comp hand surgeon who suggested a fistula of his 2nd webspace, and wanted it evaluated. He noted tenderness in the snuffbox. Petitioner also mentioned that his right small finger occasionally becomes ingrown, and he had a small nail spike that occurs, and wondered if anything could be done for that. Dr. Bueno was of the opinion that this was likely due to scarring above and below this. He noted there was no communication with deeper structures and no evidence of fistula. For this reason he was of the opinion that no additional treatment was required. Petitioner wanted the small finger addressed instead. Dr. Bueno recommended an ablation of the nail.

On 3/22/19 petitioner underwent a right small finger DIP joint arthrotomy with exploration and debridement of osteophyte, and right small finger excision of nail matrix. This procedure was performed by Dr. Bueno.

On 4/17/19 the evidence deposition of Detective Jeremy Appenzeller, with the Decatur Police Department was taken on behalf of respondent. Detective Appenzeller has been a detective for 6 years. Prior to that he was a patrol officer for 4 ½ years. Prior to working for the Decatur Police Department Detective Appenzeller worked for the National Security Agency in Maryland as a uniformed patrol officer. Detective Appenzeller has a bachelor's degree from Delaware Valley College. He has no specific training in explosive or fireworks. Detective Appenzeller completed his report on 7/12/17, based on his personal knowledge of his investigation of petitioner's injury on 7/12/17. He testified that he was directed to conduct follow-up interviews and an investigation into the origin of where the fireworks could have come from. His job did not include investigating the circumstances of the actual incident. He was never at the actual site of the incident. He testified that he was

to follow up with the neighbors that called about fireworks that were detonated around the 4th of July. So he took the information and went out to those residences, which were in the general vicinity of where the incident happened. He spoke with the people who called to try to gather more information and get some more specific locations about where they saw the fireworks being detonated, and one of these locations was across the street from where the fireworks were lost. That home belonged to Carlos Taylor. Detective Appenzeller testified that the part of the police report regarding his interview with Taylor was redacted. He further testified that he saw evidence of where fireworks were set off in Taylor's yard. He recalled seeing a marking on one of the objects in the bomb technician's hand that was "1.4G". Detective Appenzeller took into evidence that day two wooden sticks, two expended firework rockets and paper debris. He testified that the wooden sticks were commonly known to him as sticks you would put in the ground prior to igniting a firework or small firework so that it would launch into the air. He further testified that paper debris had 1.4G print on them, which would have been an illegal firework. Detective Appenzeller testified that the yard where he found these items was about 40-50 yards from the fence line near where petitioner was injured.

On cross examination Detective Appenzeller testified that he talked with other residents in the area where petitioner was injured. These people included Frank Russel, Herb Porter, Marilyn Hall, and Tina McKnight. He testified that he noticed in one of the photos he took of the debris, cardboard debris with the Consumer Fireworks and 1.4G printed on it. He did not know if that was a company name or brand of firework.

On 4/17/19 the evidence deposition of Detective Jason Kuchelmeister, with the Decatur Police Department, was taken on behalf of the respondent. Prior to becoming a detective, petitioner was a patrol officer. He was a patrol officer for 7 years, and had been a detective for 10 years. Detective Kuchelmeister has a Bachelors Degree in Criminal Justice from the University of Wisconsin, Platteville. He has no training in explosives or fireworks. Prior to the case involving petitioner, he had never investigated any explosive firework incidents. On 7/12/17 Detective Kuchelmeister's assignment was just to make contact or attempt to make contact with the various houses that bordered the location of where the injury occurred. He did not go to the actual scene of the injury. He testified that he talked with Kenny Kuster, Tiffany Lee, Cindy Christerson, and Patrick Porter. He stated that he did not witness the explosion.

On 4/17/19 the evidence deposition of Master Patrol Officer Christopher Eades for the City of Decatur, was taken on behalf of respondent. Officer Eades has been a Master Patrol Officer for three years, and before that was a patrol officer for 20 years. Officer Eades has a Bachelor's Degree from Illinois State University, but has no training in explosives. He testified that he has been on firework related calls, usually nuisance calls, but has not investigated any explosive device or fireworks injuries or incidents. Officer Eades was called as a

backup officer on the call involving petitioner's injury. When Officer Eades arrived at the scene he began walking the fence line on foot and located what he believed to be an unexploded firework mortar along the fence line on the south side of the fence, the side closest to the roadway. He described it as round about the size of a baseball, that had a wick protruding out of it, that did not appear as though it had been burned or exploded. So he assumed it was live. He did not touch it. He reported it to Sergeant Earles, and showed him what he located. In addition to the mortar, he also observed what appeared to be a large spent firework, similar to a bottle rocket, but much larger in size. He believed it was something that would probably propel a mortar, the size of mortar (bottle rocket) he located on the fence line. Officer Eades also conducted a neighborhood canvas and spoke to Allan Musser, Carlos Taylor, and Ronald Pitman, and Paul Earley with the Secretary of State Bomb Squad. After the canvas, Office Eades stood by the unexploded mortar round until the Secretary of State Bomb Squad Technician arrived. He also completed a report regarding his personal knowledge and his investigation that day.

On 4/17/19 the evidence deposition of Sergeant Brian Earles with the Decatur Police Department, was taken on behalf of respondent. Sergeant Earles has been with the Decatur Police Department for 20 years. Prior to becoming a sergeant, he held other police positions in the department. He was on the SWAT team for the last 11 years. He testified that if a firework explodes it is illegal in Illinois. Sergeant Earles has a little knowledge with respect to the names of the different classes of fireworks. Sergeant Earles did not draft any reports with respect to the investigation of petitioner's injury, but reviewed the reports of Officer Claypool, Officer Eades, Officer Clark, Detective Appenzeller, Detective Kaylor, and Detective Kulchelmeister. He testified that he was notified of a sound of an explosion near Firehouse 2 on Williams Street. When he arrived, he noted that petitioner was receiving medical treatment to his right hand, and shortly thereafter was taken away in the ambulance. His role as supervisor was to coordinate the actions of the other officers on the scene, determine how the explosion occurred, and gather as many facts as they could. He went and looked in the area where the explosion occurred and found a charred object on the ground, which was later determined to be a lighter. He testified that it was a Torch lighter and it was blackened like it had been in a fire or explosion. He testified that the lighter was between the truck and the tree line. Sergeant Earles testified that he gave the information to the Bomb Squad mostly because they found other unexploded fireworks on the ground that were in various sizes and shapes. He testified that one of them was a round ball with a wick sticking out of it, and others that were cylinder in shape laying on the grass as well. He testified that one of the items they located was similar in nature to the one petitioner picked up. He testified that the Bomb Squad took possession of these items and none of them exploded or detonated.

On 4/17/19 the evidence deposition of Officer Michael Claypool with the Decatur Police Department was taken on behalf of the respondent. Officer Claypool has worked for the City of Decatur for 20 years. He also was in the Marines from 1992-1996. His highest level of education was an Associate Degree from Illinois Central College. He has no training in explosives, fireworks, or arson. Officer Claypool testified that the only work he had with fireworks or explosive incidents was giving ordinance violations to people with illegal fireworks. Officer Claypool conducted an investigation regarding the incident involving petitioner on 7/12/17 and prepared a report. Officer Claypool personally responded to the call involving petitioner's injury. He testified that he was about the third person at the call. He stated that most of the firefighters were already there because they were nearby. His assignment once he arrived was to just start gathering information. Officer Claypool first spoke with Dustin Kawaski, petitioner's co-worker. He testified that Kawaski told him that he and petitioner had cut down everything the day before at that location, and on 7/12/17 they were there to clean up. Kawaski testified that he was at the front portion of the flatbed loading up branches, and petitioner was at the rear of the trailer, also loading up branches. Officer Claypool testified that Kawaski told him that he looked over and observed petitioner pick up something off the ground, and then looked away. He testified that Kawaski then saw a flash and heard an explosion. He testified that Kawaski told him that he then turned around and petitioner's right hand was in the air and he was screaming. After speaking to Kawaski, Officer Claypool canvassed the injury scene and found the remains of a lighter towards the southwest portion of the trailer. He testified that the lighter was stamped Double Barrel Torch Turbo Blue. He collected it as evidence. Officer Claypool testified that after he found the lighter he asked Kawaski what he saw petitioner pick up, and Kawaski said that he saw petitioner pick up a small brown or black ball. Officer Claypool testified that the lighter was covered in carbon, or grayish-black sticky powder. He testified that it appeared to have been burnt. Officer Claypool took some photographs of the lighter remains, as well as other fireworks secured around the area, some type of bottle rockets, and a ball that was brown in color and wrapped in some type of tinfoil with a short neck, and a fuse protruding.

Officer Claypool testified that he spoke with petitioner in the emergency room at Decatur Memorial Hospital. Officer Claypool testified that petitioner told him he was loading brush onto the flatbed and observed a ball on the ground, and when he went to pick up the ball and throw it away it exploded. Officer Claypool testified that he told petitioner that he had found a lighter on the ground next to where petitioner was standing, and asked him if he lit the firework. He testified that petitioner denied lighting the firework. He also testified that petitioner told him the lighter was on a clip on his right side front pocket and when the firework went off it blew it off of him. Office Claypool testified that he took petitioner's clothing as evidence. He testified that petitioner's jeans smelled of carbon, and he did not see any particular burn marks on the front of his jeans or his

belt, indicating the proximity to the petitioner. He noticed no clip on petitioner's jeans, and testified that there was blood on petitioner's shirt that was cut off in the emergency room. Officer Claypool testified that he is not a fireworks expert.

On 10/3/19 the evidence deposition of Michael Perry was taken on behalf of petitioner. Perry worked at Memorial Medical Center as Manager of Patient Experience and Patient Transport, befriended petitioner when he was a patient there, and discussed the accident with him. Perry testified that he began shooting fireworks in 1993, and became a lead pyrotechnic manager in 1994. He further stated that he quit renewing his license in 2017. He testified that in order to maintain a license after 9/11/01 he had to attend several annual training classes. Perry would assist with the setup of a show, delegate where items were placed for safety reasons, talk with Fire Chief, and secure permits. Perry testified that there was a time in Franklin, IL in 1973 where without any cause or spark a 1.4G two inch shell detonated without any cause or spark. He also reported that there were instances where it was lit and did not go up and then would detonate up to an hour later. Perry testified that weather is a big part in fireworks displays. He stated that he has cancelled shows due to humidity, rain and lightning, because it affects how the firework performs. He opined that a consumer firework that gets damp and then dries can be unstable and spontaneous combustion can occur. Perry testified that the material in the McHenry County case (Franklin) in 1973 that contributed to the spontaneous combustion contained potassium chlorate, which is still available today. Perry opined that the firework in petitioner's hand at the time of the accident either spontaneously combusted or, there were other factors in play, such as him picking it up, dropping it, and picking it up again, which would contribute to its instability. He opined that this occurs in homemade fireworks, so the firework petitioner picked up was more likely than not a homemade firework. Perry opined that the firework that petitioner picked up spontaneously combusted based on several explosions that have happened without any spark or lighting within his 25 years of shooting off fireworks. Perry opined that if petitioner had lit the firework with a lighter and it exploded the lighter would have also exploded and caused more severe burns than he incurred. Perry testified that his opinions were based on his life's experiences, training and 25 years of working with fireworks.

On cross examination, Perry testified that prior to his deposition he met with petitioner's attorney in his office and reviewed the Iowa and Kansas Safe Handling of Fireworks documents. He stated that only these two states, of the state documents he reviewed, included language that says that wet or damp fireworks allowed to dry out can be unstable and spontaneously combust. He stated the other states do not mention spontaneous combustion. He stated that he only relied on those state opinions that supported his opinions. He admitted that the Illinois documents mention that wet or damp fireworks could be unstable, but do not mention spontaneous

combustion. Perry did not know what the basis of the authors opinions in the State report regarding the 1973 incident in McHenry County (Franklin). Perry testified that he told petitioner that he would help out with his case, and petitioner got his attorney in touch with Perry. Perry testified that he worked from 1993 to 2104 for S&N Display Fireworks as the lead pyrotechnician. He would set up and shoot shows. In his shows he dealt with display and consumer fireworks. He testified that his job was a seasonal job. Petitioner had a pyrotechnic operator license until 2017. He testified that the training needed for the license was mostly provided by Natural Resources. He had an 8 hour training course annually. Perry testified that when petitioner told him he picked up a firework in an empty lot and it went off in his hand, he already formulated an opinion before reading any materials, or reviewing any reports or photos. Perry testified that his highest degree of education is an Associate's Degree in Computer Science from San Diego State University. Perry testified that he could not say if the firework in the 1973 incident in Franklin, IL that spontaneously combusted got wet and was allowed to dry out before it spontaneously combusted. Perry stated that it was only his opinion that the firework that exploded in petitioner's hand was a homemade or consumer firework. He has no proof of that. Perry could not say if the conditions in petitioner's case were the same as those in the 1973 firework case in Franklin, IL. He also stated that there is no evidence in the Franklin, IL report that it was a class 1.3G mortar shell that exploded. Perry testified that there is no evidence that potassium chlorate was inside the firework handled by petitioner. Perry testified that he was not aware that petitioner's lighter was found on the ground where the incident occurred. Based on petitioner's burns, Perry was of the opinion that the explosion occurred at petitioner's chest level, and this could have occurred if he was bent over when he grabbed the firework. Perry testified that he has been a lead pyrotechnician at 250 shows with over 5,625 fireworks, and the only instance where he ever heard of spontaneous combustion of a firework was the Franklin, IL case. Perry testified that he is not a certified bomb technician, but he taught explosives in Kandahar when he was in the service.

On 7/26/19 the evidence deposition of Paul Earley, a retired Investigator and Bomb Technician with the Illinois Secretary of State, was taken on behalf of the respondent. Earley was also a SWAT team member. Earley worked as a full time Bomb Technician from 2017-2019. His duties included going to all matters involving explosives and incendiary devices. Earley is currently a Contractor for the US State Department who trains overseas police departments in the field of bomb tech or bomb squads. He has been doing this since he retired in April of 2019. He trains new bomb technicians, and investigates post-blasts. He trains in the classroom and also deals with live explosives in training. Earley's training as a member of a certified tech team included an initial six week training in Huntsville, AL at Redstone Arsenal, an army base, where they did most of their explosive training for the military. Thereafter, he went through the Hazardous Device School, which is run by the FBI. He also underwent ongoing training throughout his time of service. Every three years he would

go back to Redstone Arsenan to be recertified. He finished his first six week training in 2001, and has remained continually certified as a Bomb Technician since then. Earley also has several other certifications in the field of Bomb Technician that include advanced courses provided by the FBI in post-blast investigation. He also has attended courses run by the ATF on homemade explosives, advanced explosive destruction techniques, and numerous ongoing terrorism classes. Earley has also had training with respect to fireworks that was part of the advanced destruction techniques, which was an 80 hour course. Earley testified that he has dealt with a lot of shipments of fireworks that came into the state from Indiana and Missouri that were illegal in Illinois. He collected them all year and they were disposed of twice a year. In addition to his required training, Earley also took a lot of voluntary classes, and was a trainer/teacher at the Illinois State Police Academy for instruction on explosives. He also worked with mobile training units, and other city police/fire departments, and put on safety demonstrations. These activities included fireworks training, how to deal with them, and what to do with them if you find them. Prior to his work for the Illinois Secretary of State, Earley was a police/SWAT officer with the City of Springfield, and on the Drug Task Force out of Decatur. Earley became a police officer in 1988. Earley has an Associates Degree from Illinois Valley Community College, and thousands of hours of ongoing technical training in law enforcement.

Earley responded to the incident involving petitioner on 7/12/17 at the Decatur Public Works. As part of this investigation Earley completed a report. Earley was first contacted regarding the incident by the Illinois Bomb Squad. When he arrived, he was told someone working for the City of Decatur had been injured. He stated that petitioner was already gone, and everything was just waiting for them to search the area for anything else that could be potentially dangerous to anyone in the area. The dogs searched first, and then they walked it again to see if there was anything else they could find. They searched the grass area between the street and the fence, along the entire block area. The search revealed several pieces and parts of burned or partially burned commercial fireworks (low-end fireworks you buy at firework stands in IN and MO, that are not legal in IL). He saw a couple different kinds of fireworks, and the most concerning was the ping-pong/golf ball size ball or shell, that are shot out of a mortar tube (usually a rigid cardboard tube) traditionally, if one functions them as designed, because they are potentially dangerous. Earley testified that some of them had wicks on them. Others had a wick previously, but it had been lit, and for whatever reason, the charge did not go off, which is fairly typical. Earley was of the opinion that most of these fireworks are manufactured in other countries, are usually a class 1.4G, and their standards of quality assurance is pretty low. Earley stated that these type of fireworks are not legal in Illinois. Earley testified that by the time he arrived the thing that had caused the petitioner's injury had been removed by the officers that first responded. The evidence Earley and his team found was placed in a containment vessel for safe transport, and disposal in the fall. Earley testified that they completed repeated

searches of the area. Earley viewed a picture of a class 1.4G mortar shell on the ground in the area they searched, as well as bottle rockets. He did not see a lighter on the ground in the area. Earley and his team cleared the scene and he was comfortable that there was nothing else hazardous or potentially hazardous on the scene.

Following his investigation of the scene of injury, Earley opined that based on the pictures of the injury, the rounds at the scene, the type of rounds that caused the injury, that the type of round they found at the injury location do not, and cannot go off, unless there is an ignition source, and that ignition source has to be some sort of flame or spark. He testified that the reason for this is the makeup of the rounds. He testified that the ball is the shell, and it is filled with black powder, which is the burst charge. After the black powder, the ball is then filled with small stars (a salt compound comprised of metallic and non-metallic compounds that produce the colors). He testified that the black powder disk is the lift charge. It has a wick, that when lit, drops down the tube, and once the lift charges explodes, it pushes the shell up. The amount of black powder in the lift charge determines how high it goes. Earley testified that once the lift charge goes off, it lights the wick inside the shell, and the burst charge disseminates the stars. Earley testified that the black powder, which is the explosive component in the ball, is not shock sensitive. He testified that if black powder was on the table you could hit it with a hammer all day long and it would not ignite. Earley testified that the ignition temperature of black powder is somewhere between 400 and 425 degrees. He stated that you can put it in an oven at 350 degrees and it will not ignite because the heat is not hot enough. Earley testified that heat and spark, or some sort of fire, will ignite black powder. Earley testified that the Material Safety Data Sheets indicates that black powder ignites between 400 and 425 degrees, and has to be contained to explode. He testified that if the internal temperature was 400 to 425 pounds, the exterior of the firework would have most likely have already burned up, because the casing of these type of fireworks are basically heavy paper. Earley testified that his opinions are based upon a reasonable degree of scientific certainty, and based on his training and practical experience.

On cross examination Earley discussed the proper disposal technique for class 1.4G fireworks. He stated that they can be brought down to a state of more or less stability by soaking them in diesel fuel. He stated that they generally soak them for up to a minimum of 12, but they like to do it for 24 hours. He stated that at that time they become burnable. Earley testified that the proper storage for class 1.4G fireworks prior to detonation is being locked in a secure area away from anything that could potentially produce a spark. He testified that class 1.4G fireworks can be allowed to get wet, but it would raise the ignition rate for what it takes to set them off because it's wet. He also testified that once it dries out it is perfectly fine. Earley testified that the damaging part of getting fireworks wet is that they lose their functionality as designed, which means if the paper comes

apart, they could open up, and the black powder would not be contained, which means it would just simply burn, or the fusing system (which is the wick) could be lost.

Earley testified that he did not know when the fireworks he found on the ground were placed there, or if they ended up there after somebody else had fired them and they did not function as designed. He testified that there is the possibility of a slow burn with firework shells that could remain active and pose a potential problem, but only for a very, very short period of time. He noted that the safety standard of a misfire of black powder is 30 minutes, because by that time it will have gone off or the small amount of smoldering would have diminished to the point where it was not going to go off.

Earley opined that it is not possible for class 1.4G fireworks to get wet and dry out, and become unstable. He testified that there is no science behind it. Earley testified that there are thousands of fireworks that fall into the class 1.4G firework. Earley testified that he did not see the physical explosive that went off, and did not see the device shell that caused the injury, other than in a picture. He testified that his opinion that petitioner lit the firework, is not in his report, because he cannot put his opinion in a police report. Earley admitted that in his report he noted that at the scene, there was an attempt to light some of the fireworks that he saw, but they were duds and did not shoot. He testified that some fireworks produced internationally are unreliable and so what happens as a result of this inferior workmanship is that the fuse will be lit, it will burn to where it is supposed to hit, and the lift charge may or may not go off. He stated if it does fire, it may or may not ignite the fuse which goes into the burst charge. So what typically happens is that you have a ball, which is full of live black powder and the salts, the stars, but the fuse is burnt out but did not ignite the rest of the system, and there will be some charred marks on them that show it has been attempted to be lit. Earley testified that he found a firework in the area where the injury occurred that the investigating police officers said looked like the one that exploded. Earley testified that unless the firework went off within a foot or two of the ground, there is not enough charge inside the firework to give any real kind of blast pattern. He stated that all you will see is some debris lying around. Earley opined that the picture he saw of the damage to petitioner's hand was typical of an explosion of the size that the class 1.4G firework would be. He further opined that the burn marks on the opposite hand were consistent with there having been an explosion next to it. Earley opined that the blast area for the firework like the one he believed petitioner was holding would depend mostly on the condition of the firework, or if it was shielded by someone holding it in their hand. He opined that if the person is holding the firework, that would shield the blast, and a lot of the blast rate would be absorbed by into the hand. Earley opined that if a 1.4G aerial shell goes up in the air, does not go off, and hits the ground, they could still go off, while smoldering, for a very short period of time, no longer than 30 minutes, but typically 5 to 10 minutes. Earley testified that "a

1.4G firework can get wet, and then once it's wet, once it's dried, spontaneous combustion can occur", is too general of a statement. Earley was of the opinion that in the right situation, if it's picric acid, because it reacts violently to water, it might happen. But picric acid has not been used in fireworks that have been produced since before the 1940's. Earley testified that none of the fireworks associated with the remnants he found on 7/12/17 would be the type of fireworks that would have picric acid in them. He opined that in all the trainings he has done, the textbooks he's read, or the lectures he's heard, he has never seen anything that shows that if a class 1.4G firework gets wet, it is going to spontaneously combust.

On redirect examination Earley testified that he has never observed or seen an unexploded firework, or a misfire of a firework, smolder for eight days, especially because the science does not support it. Earley opined that after the 30 minute time for a slow burn would expire, the firework would require an ignition source in order to explode. He opined that the properties of black powder do not change unless it is consumed by the flame with an ignition source such as a spark or flame. Earley opined that if a firework was wet, it would require more heat or a higher ignition temperature to explode. Earley opined that the firework that caused the explosion on 7/12/17 had to have been lit or ignited with a spark or flame, because it is not shock sensitive, and is not going to produce enough heat in the blazing sun to explode. He opined that a lighter could be an ignition source or a flame. He further opined that if a lighter was found on the ground within 10 or 15 feet of where the incident occurred, that would confirm his opinion that the lighter would be the ignition source. He testified that if this was the case, the outside of the lighter could have some carbon on it from the explosion, depending on how much of the lighter was held in the hand. Earley testified that all his testimony and opinions are based on his training and experience as a bomb technician, his certification through the ATF and FBI, and his recertification every three years. Earley testified that his opinions would not change regardless of whether or not it was a regulated or unregulated firework.

On 10/3/19 the evidence deposition of Chris Silman, a fire and explosion investigator with SEA Limited, was taken on behalf of respondent. Silman investigates the origin and cause of fires and explosions for residences, heavy equipment, commercial structures, and fireworks instances. Silman does these investigations for insurance companies, manufacturers, and product manufacturers. Silman testified that he has done some fireworks explosions. Silman was in the Army from 1991-2000 and worked as a combat engineer, and demolitions expert that dealt with multiple types of explosives from black powder to C-4. Silman also worked for the Kennett, MO Fire Department for 7-1/2 years. He was a firefighter, and then became the City Fire Marshall doing fire safety inspections and fire investigations. He testified that this work encompassed fireworks. Being in Missouri he had to be able to identify homemade devices. Silman's highest level of

education was some college at Arkansas State University and Mississippi County Community College. Silman is a licensed investigator in Illinois, and a certified fire and explosive explosion investigator through the National Association of Fire Investigators. He is familiar with the different classifications of fireworks. Silman's training also included training with regards to pyrotechnics, with 90% of that training based around mortar type fireworks.

Silman testified that he was paid for his deposition by respondent. Silman reviewed police reports regarding the investigation that occurred on 7/12/17, as well as ambulance and emergency reports regarding petitioner. His understanding from the reports was that petitioner picked up a firework and an explosion occurred from the firework, causing damage to his right hand. He noted that the police reports revealed that there were consumer grade 1.4G mortar round-type fireworks, and a Blue Torch cigarette lighter, found in the area where petitioner was injured. Silman testified that class 1.3G fireworks are not consumer grade, but rather professional grade, and much larger than you would buy at a fireworks stand. Silman opined, based on the information in the police reports regarding the lighter, and the information in the ambulance and emergency room reports regarding the injuries petitioner sustained, that the lighter was likely in petitioner's left hand at the time the explosion occurred. He opined that petitioner had an 80% not-fully-closed fist of the left hand, with the thumb on top of the index finger when the explosion occurred, based on the injury report, as well as the description in the ambulance and emergency reports. Silman opined that the carbon residue on the lighter indicated that the lighter was near where the explosion occurred, and that would also place the lighter at the location with it in the petitioner's hand. He opined that the carbon comes from the black powder inside the firework. Silman also reviewed photographs of the injury scene that confirmed what type of fireworks were at the explosion scene. He also viewed pictures taken at the emergency room which confirmed the location of the injuries to petitioner's hand and torso. Silman did not examine the injury scene, nor did he take any pictures of his own.

Silman also reviewed the weather history of the area from 7/4/17-7/12/17 on Weather Underground Online. Based on this weather information he opined that it was relatively hot during that period and there was some rain on 7/11/17. He was of the opinion that the hot weather was relevant if the firework was around since 7/4/17, because that would allow the fuse to dry out over that timeframe, and if the fuse is dry it is going to burn a lot quicker than it is designed to. He did not think that the fuse on the firework that exploded on petitioner burned the length of time that it was designed to burn because of the hot weather.

Silman was of the opinion the mortar rounds usually have a fairly long fuse about nine inches long, and that gives it time to burn while it reaches the proper altitude before it explodes. He was of the opinion this time

period is usually 6-9 seconds. He opined that fireworks are not designed to ignite without an ignition source, such as a flame or spark. Silman opined that the temperature at which black powder needs to reach before ignition is somewhere between 650 and 675 degrees. He stated that this information is in the Ignition Handbook. He opined that it is impossible for this type of firework to reach that temperature without an ignition source to cause it to explode on an open air day like the date of injury. Silman opined that black powder is not shock sensitive, meaning that it cannot explode based on movement alone. He opined that it will not explode if you drop it or smash it between two rocks. With respect to the petitioner's injury location, Silman opined that petitioner was holding the firework in his right hand and was standing up, holding it about the center of his body with his left hand near it, when it exploded. He opined that this is why petitioner got the severe damage to his right hand, and the burns to his left hand, stomach and chest. Based on the documents he read, Silman saw no evidence of any injuries to petitioner's calves or shins below the knee, or to his legs at all. He opined that if the firework exploded approximately one or even two feet off the ground as petitioner was bent over, he would have expected to see damage and injuries to petitioner's legs at the knee, or potentially below the knee. Silman testified that based on his training and experiences, he has never found any support that a firework that is wet and allowed to dry, would become unstable and spontaneously combust. Silman testified that in addition to petitioner's documents from Iowa and Kansas regarding this issue, he did his own research trying to find something, but could not find anything related to that claim. He also called the analysis lab in Columbus, OH and talked with the lab technician there who has done extensive spontaneous combustion testing, including with black powder, and she had never came up with anything related to black powder or fireworks spontaneous combustion related incidents. He also spoke with other investigators within his company that have conducted fireworks investigations, and none of them were familiar with anything related to spontaneous combustion in fireworks. Silman testified that he found nothing in petitioner's documents that had any scientific basis for that finding. Silman was of the opinion that the Iowa and Kansas documents were just service bulletins by a governmental agency that would be handed out at the fire station or at some type of public service gathering.

Silman opined that black powder, once it dries out, it will go back to its normal state, and it won't explode if it is not confined. He testified that the way black powder is confined in a firework is with paper and when paper gets wet and dries, it tends to unravel. So in this case, if the firework had become wet and then dried out, the paper would have unraveled causing the black powder inside it to no longer be confined. Based on this, Silman was of the opinion that there would probably not have been an explosion. He opined that since there was an explosion with respect to the firework petitioner found, the firework likely had not been wet prior to the incident occurring. Silman opined that the cause of firework explosion involving petitioner on 7/12/17 was that the firework was lit with the lighter that was found. He based this opinion on the information he gathered from

reviewing the reports and petitioner's injuries. He opined that fireworks don't explode by just being handled, and he has never seen any science behind the claim that spontaneous combustion would cause a firework to explode.

On cross-examination Silman testified that he did not know who manufactured the firework that went off in petitioner's hand or when or where it was manufactured. Silman also reviewed Earley's report and deposition. He testified that he saw nothing in his report or the police officers' reports that any of the other fireworks on the ground had exploded while the investigation was taking place. He also testified that there was also no information that there were any homemade fireworks on the ground. Upon review of the police reports and Earley documents, Silman created a map of the area, and from all this information opined that the fireworks were mostly likely launched from a home that was almost directly across the street from the injury location. Silman testified that based on the hospital reports an odor of carbon was found on petitioner's clothes. He further testified that clothes are not an ignition source or a heat source.

On redirect examination, after reviewing pages in the "Fireworks Plant Explosions and Bootleg Traffic in Illinois from 1973" incident report, Silman testified that those portions of the document did not changes his opinions. He testified that those pages referred to an incident where it was found that fireworks had exploded due to spontaneous combustion. He further testified that the report stated that the spontaneous combustion was the result of a chemical called potassium chlorate. He was of opinion that the chemicals used in fireworks today are by far different than the chemicals that were used in fireworks in 1973. He testified that he saw no evidence that the fireworks discussed in the Mc Henry County incident report from 1973 are the same type of fireworks that were involved in petitioner's incident. He testified that the document "Chemistry Behind A Firework Explosion" talks about how they have to be safe in formulating fireworks colors. He stated that the document talks about how years ago blue was made with arsenic, that is now known to be very dangerous. So today they use a different chemical to make the blue color in fireworks. He testified that different chemicals are used in fireworks today than were used in 1973.

On recross examination Silman testified that since the firework in petitioner's hand exploded there is no way to know what chemicals were in that particular firework. He stated that different chemicals are used in fireworks today, but did not claim that potassium chlorate was not available today.

Petitioner offered into evidence certified meteorological records for July 2017. The temperature range on 7/12/17 was a high of 92 degrees and a low of 71. There was no precipitation on 7/12/17. On 7/11/17 there was 1.69 inches of rain, with 1.62 inches during the 9 am hours, and .06 inches, and .01 inches, during the 10 am and 11 am hours, respectively. There was .09 inches of rain reported on 7/10/17.

Petitioner offered into evidence "Fireworks Plan Explosions and Bootleg Traffic in Illinois''. An official report on McHenry County Blast, 6/9/73, by the Illinois Legislative Investigating Commission. The explosion was at Worldwide Fireworks Company. This company specialized in the purchase of Brazilian fireworks containing potassium chlorate, which when damp and exposed to heat are subject to spontaneous combustion. After interviewing many persons, the Commission was satisfied that in all probability some of the Brazilian fireworks, stored in any one of the 12 trailers, exploded from spontaneous combustion, and triggered explosions of all the others, facilitated by their proximity to one another. Two weeks before the explosion, the owner was advised of the highly unsafe storage conditions, that some of the fireworks were unstable, and suggested that to minimize the impact of an inevitable explosion the trailers should be spaced further. An employee at the site heard a sizzling noise as if a firecracker were about to explode and then heard the explosion. Two witnesses hypothesized that the explosion started in the trailer where Worldwide stored rockets. They said the whining noise before the explosion sounded like rockets igniting. The company's explosives storage licenses were revoked because the fireworks were stored illegally. The trailers were completely loaded with fireworks and some of the aisles were cluttered with boxes. After the purchaser selected his fireworks from the trailers, they were left open. The boxes were placed in the purchaser's vehicle, and then they went and got the launching sticks and brought those to the vehicle before going into the office to tabulate the bill. Once in the building for about 10-15 minutes they heard a large hissing sound followed shortly thereafter by the first explosion. The Commission investigators never saw the official report of the incident from the Fire Marshall.

The purchaser, Robert Scaman was unable to offer any explanation for the cause of the explosion, except that the heat possibly caused it, because it was in the 90's that day and much hotter in the trailers. The investigator opined that the explosion was caused by spontaneous combustion, and many of the Brazilian fireworks in the trailers were made with potassium chlorate which, if it becomes damp and the subjected to heat, are very susceptible to spontaneous combustion. The Commission's report stated that Worldwide, on the date of the explosion was working in violation of the State Fire Marshall's codes, and had received an order regarding these violations, following an inspection.

The Fire Chief of McHenry, Peterson, told the investigators that he thought the explosion was caused by spontaneous combustion. He noted that most of the fireworks at Worldwide had been manufactured in Brazil and if they became wet, they became unstable. He stated that even four weeks after the explosion, fireworks that had been scattered all over the surrounding fields would explode at various times of the day spontaneously. He stated that they would especially notice these explosions after a rainfall or heavy dew.

Petitioner testified that the Army Reserves kept him on for about 2-3 months after he was released from care, as a supply sergeant. Thereafter, his group was sent to Afghanistan, and he was told he would be discharged. Petitioner testified that he had severe PTSD, depression, suicidal and loss of purpose in life because he was being pushed out of the military and losing his benefits because he was not hurt on duty. Petitioner earned $2,000/yr in the Army Reserves.

Petitioner was completely off work from 7/13/17 through 11/7/18. He is claiming maintenance benefits from 11/8/18 through 5/19/19, and 8/8/19 through 10/24/19. Petitioner testified that once he was released with permanent restrictions he looked for work and got a job at Caterpillar for a few months. He left his job at Caterpillar after he saw a man fall and die in front of him. After the incident, petitioner had a PTSD incident and had to leave. He testified that the incident at Caterpillar made his PTSD worse. He denied any issues with his PTSD while working for Caterpillar before the man fell and died. Petitioner testified that he looked for work on a regular basis. He claims he applied for work online from 5/201/9 through 8/7/19 at every factory, and only got the job with Caterpillar. He also testified that he applied for 3 retail jobs and got no response. Petitioner testified that he applied for 2-3 jobs a week. Petitioner did no offer into evidence any job search logs.

Petitioner testified that he still suffers hearing loss in his left ear; gets migraines at certain frequencies; has a scar on the inside of his thigh where a skin graft was performed; suffers from PTSD and depression; and difficulty sleeping. Petitioner testified that he is not currently undergoing any psychological treatment. Petitioner denied any diagnosis or treatment of depression or PTSD prior to the accident on 7/12/17.

Petitioner testified that the lighter found on the ground appeared to be his lighter. He testified that he had a Double Barrel Blue Torch lighter clipped to his belt at the time of the explosion.

Petitioner testified that he does not recall if the firework was hot when he picked it up. He stated that it spontaneously combusted. Petitioner had no knowledge of what chemicals were in the firework that exploded. He was not familiar with the type of firework he picked up.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner claims he sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/12/17 when he picked up a round firework (mortar) that spontaneously combusted in his right hand. Respondent claims there was no spontaneous combustion, but rather, petitioner lit the firework wick with his lighter.

Differing histories of how petitioner actually picked up the firework and when it exploded are in evidence. At trial, petitioner testified that the firework he picked up had no wick on it. However, in Nurse Williams report he noted that petitioner told him the wick was intact. At trial, petitioner initially testified that he was bent at the waist when the explosion occurred. Then later in his testimony he stated that he was not sure if he was bent at the knees or the waist. He also initially testified that the explosion occurred a few inches from the ground. Then later in his testimony he stated that he was not sure where the explosion occurred. He also testified that his left hand was 2 feet from his right hand when the explosion occurred, and his right leg was closer to the explosion than his left hand was. Kawaski testified at trial that did not see petitioner get injured, and also did not see petitioner picking anything up because he was on the other side of the truck in the front. However, in Officer Claypool's report it was noted that Kawaski told him that petitioner picked up a small black/brown ball, and as he was throwing it away it exploded. In that same report, Kawaski was noted as saying he looked over and saw petitioner pick something up off the ground and then looked away. Given these varying accident histories, the arbitrator will look at the overall investigation in determining the sequence of events at the time of the injury.

Although the accident histories in the credible evidence vary, the arbitrator finds the specifics of petitioner's injuries consistent throughout the medical records. These records show that petitioner's right hand was mangled and deformed; he had holes in his shirt; his right eyebrow was burnt off; he had 1st and 2nd degree burns to his chest; he had 1st degree burns to his forehead; he had singed hair on his arms; he had burns to his abdomen, face, neck and shoulders; and, he had abrasions and bleeding to the 1st three fingers of his left hand. The burns to petitioner's chest and waist stopped at the top of his jeans, and he had no burns on his legs. Also, there were no burns on his pants.

The arbitrator also finds it unrebutted that the lighter that was found on the ground close to where the injury occurred belonged to petitioner. Petitioner testified that it was his lighter, and Kawaski also testified that it was petitioner's lighter that was found on the ground. Kawaski testified that petitioner always had the lighter on him either clipped to his belt loop, or looped on his pants. Petitioner also testified that the lighter was clipped to his belt at the time of injury. The arbitrator also finds, based on the credible evidence, that the petitioner's lighter, when found on the ground in the vicinity of where the injury occurred, was covered in carbon.

Following the incident, the injury was investigated by members of the Decatur Police Department. Detective Appenzeller saw "Consumer Fireworks 1.4G" markings on cardboard debris in a yard of a home across from the area where petitioner was injured. Officer Eades found an unexploded firework mortar along the outside of the fence line, the size of a baseball, that had a wick protruding. The baseball size mortar

petitioner picked up was on the other side of the fence from where Officer Eades found the similar unexploded firework. Sergeant Earles also found a lighter on the ground near the injury site that was determined to be petitioner's. He noted that this lighter was charred as if it had been in a fire or explosion. Officer Claypool questioned Kawaski. Officer Claypool also interviewed petitioner at the hospital. Petitioner testified that he was on a lot of medication when he was interviewed. Officer Claypool noted that petitioner's jeans smelled of carbon, but there were no burn marks on them. None of these officers have any training in explosives.

Expert testimony regarding fireworks and explosions was given by Perry for the petitioner, and Earley and Silman for the respondent.

Perry was the Manager of Patient Experience and Patient Transport at Memorial Health System, where petitioner was treated. He testified that he befriended petitioner while he was a patient. After petitioner discussed with him what happened he told petitioner that he would testify on his behalf. Perry was a lead pyrotechnic manager from 1994-2017. He also testified that while in the service he taught explosives in Kandahar. From 1994-2017 Perry put on 250 fireworks shows, with 5,625 fireworks, and never had one spontaneously combust. He testified that he took courses after 9/11/01 to maintain his licenses. This consisted of 8 hours of training per year.

Perry testified that he has had to cancel fireworks shows due to humidity, rain and lightening because it affects how the fireworks perform. In support of his opinion that fireworks can spontaneously combust, he relied on both Kansas and Iowa public service documents regarding fireworks, and, the "Fireworks Plant Explosions and Bootleg Traffic in Illinois from 1973" incident report, in which it was determined that an explosion of Brazilian fireworks, many of which were made with potassium chlorate at that time, spontaneously combusted due to dampness and heat. The fireworks that were believed to have exploded in 1973 were in a trailer where there were bottle rockets, not mortars. Additionally, the witnesses to the 1973 incident testified that they heard a sizzling noise before the explosion, and they believed that noise was a rocket exploding. Perry was of the opinion that in the 1973 incident potassium chlorate contributed to the instability of the fireworks. It was his opinion that picking up a firework, dropping it, and then picking it up again can contribute to the instability of a homemade firework. However, in the case at bar, there is no evidence that the mortar petitioner picked up was homemade. Perry also testified that he could not say that what happened in the 1973 case is the same as what happened in petitioner's case, which he believed was that the firework got wet, dried off, and then became unstable, and spontaneously combusted in petitioner's right hand. Perry was of the opinion that if petitioner had lit the firework with his lighter the lighter would have exploded. Perry believed the firework exploded on petitioner at chest level.

Perry testified that he has an Associate's Degree in Computer Science. The only fireworks training he had was an 8 hour course annually to keep his pyrotechnics licenses, but he never mentioned what that training consisted of. The arbitrator finds it significant that Perry is not a certified bomb technician, nor has he has ever investigated a fireworks explosion. The arbitrator also finds it significant that Perry testified that he formulated his opinions on what petitioner told him before reading any materials, or reviewing any reports or photos. The arbitrator finds it significant that Perry did not investigate petitioner's injury, and was never at the site of the injury.

Respondent's first expert testimony was offered by Earley, a retired Investigator and Bomb Technician with the Illinois Secretary of State who investigated post-blast. Earley has been a Certified Bomb Technician since 2001. His certification included 6 weeks of explosive training, followed by Hazardous Device School at the FBI, ATF courses, 80 hours of fireworks training, and other bomb certifications. Since 2001 Earley has also undergone recertification of his explosive training every three years. Earley also does explosive/fireworks training at the Illinois State Police Academy, and deals with illegal fireworks from Indiana and Missouri.

Earley responded to the petitioner's injury on 7/12/17. Earley saw a 1.4G mortar shell in the area where petitioner was injured. He also saw bottle rockets. Based on his investigation of the scene, rounds that were found at the scene, and pictures of petitioner's injury, Earley opined that the type of round that caused petitioner's injury cannot go off without the ignition source of a spark or flame, because of the makeup of the rounds. He opined that the rounds are filled with black powder and are not shock sensitive. He opined, based on the Material Safety Data Sheets, the ignition temperature for black powder is between 400 and 425 degrees, and the black powder must be contained to explode. He testified that if black powder was laying on a table and was lit it would burn, but never explode, because it is not contained. Earley was of the opinion that if a 1.4G firework gets wet that would only increase the ignition rate necessary. He further stated that once it dried it would be fine. Earley opined that if the 1.4G firework is wrapped in paper or cardboard and it gets wet, it will most likely come apart and could open up, thus leaving the black powder no longer contained, and unable to explode. He opined that 1.4G fireworks do not become unstable by getting wet and being allowed to dry. Earley testified that he found a 1.4G firework in the area of the injury, that looked just like the one that petitioner testified had exploded in his hand, based on the remnants on the ground. He also testified that a firework with picric acid could get wet, then dry off and become unstable, but picric acid has not been used in fireworks since the 1940's. Earley opined that the remnants found at the location where petitioner was injured were not consistent with fireworks that would have picric acid in them.

Based on his investigation of the area where the injury occurred, Earley was of the opinion that if the firework had exploded about 1-2 feet off the ground like petitioner claimed, there would have been a blast pattern on the ground, but there was none. Earley opined that the damage to petitioner's right hand was consistent with a 1.4G fireworks explosion, and the damage to his left hand was consistent with an explosion next to it. Earley also opined that there has been nothing in his classes, literature, or lectures to support a finding that a 1.4G firework if wet will spontaneously combust. He opined that a 1.4G firework, similar in description to the one petitioner testified he picked up, can only be lit with a spark or flame because it is not shock sensitive, and the sun does not provide enough heat to constitute a spark or flame. However, he also opined that a lighter can be an ignition source. He opined that the fact that petitioner's lighter was near the location of the injury confirms that the lighter was the ignition source, given that the outside of it had carbon from the explosion on it. Earley testified that his opinions remain unchanged regardless of whether you are talking about a regulated or unregulated firework.

Respondent also provided the testimony of Silman, a Fire and Explosion Investigator with SEA Limited. Silman has investigated some fireworks explosions. While in the army he was a demolitions expert who dealt with explosive from black powder to C-4. He was also a firefighter and City Fire Marshall. Silman is a certified fire and explosive explosion investigator. He is familiar with different classifications of fireworks, and 90% of his pyrotechnic training dealt with mortar type fireworks. Silman did not investigate the accident site. He based his opinions on the police and medical reports he reviewed.

Silman noted that the reports showed there were Consumer Grade 1.4G mortar round type fireworks and a lighter found near the injury. He opined, based on the reports, that petitioner had the lighter in his left hand, and the firework in his right hand, when the explosion occurred. He further opined that the injuries support a finding that petitioner had an 80%-not fully closed fist of the left hand, with his thumb on top of the index finger, when the explosion occurred. He also opined that the carbon residue on the lighter (which comes from the black powder inside of a firework) means that it was near the explosion. He also used the photos of the injury scene to confirm the type of explosion.

Silman was of the opinion that it was relatively hot and there was some rain around the time of the injury. Given these weather condition, a belief that the firework petitioner picked up had been there since 7/4/17, and a belief that the fuse had dried out, Silman was of the opinion that any spark or flame to the fuse would cause the fuse to burn quicker than it was designed to, thus resulting in a quicker explosion. However, he reiterated that there still had to be an ignition source of a flame or spark for this to happen, because the fireworks are not designed to ignite without it. Silman was of the opinion that black powder ignites at 650-675 degrees, and

cannot explode without it. He, like Earley, opined that black powder is not shock sensitive, and cannot explode on movement alone. Silman opined that petitioner was standing and holding the firework in his right hand at the center of his body, with his left hand nearby when it exploded. He testified that this is why he had such severe damage to his right hand, and burns to his left hand, stomach, and chest. The arbitrator finds it significant that Perry also believed that the explosion occurred at petitioner's chest level. Silman was of the opinion that if the firework had exploded 1-2 feet off the ground, and petitioner was bent over, like he claims, he would have had injuries to his legs, which he did not.

Silman opined that nothing in his training and experiences supports a finding that if a firework is wet, and then dries, that it would become unstable and spontaneously combust. Silman also opined that neither the Kansas nor Iowa firework documents relied on by petitioner had any scientific basis for spontaneous combustion. He further noted that these documents were merely service bulletins and not scientific evidence.

Silman, like Earley, opined that once black powder dries after being wet, it goes back to its normal state and will not explode if not confined. Like Earley, Silman was also of the opinion that if the paper on the firework gets wet, dries, and unravels, and the black powder is no longer confined, it will not explode. Silman opined, based on the police and medical reports, that the cause of the explosion was the firework being lit by the lighter that was found on the ground. He opined there is no scientific evidence to support a spontaneous combustion.

Silman noted that there were other fireworks near the injury site that were not exploded and there is no evidence to support a finding that they were homemade explosives. He opined that the chemicals in fireworks today are different than they were in 1973. He was also of the opinion that there is nothing in the report regarding the 1973 firework explosion in McHenry County (Franklin,IL) report to support a finding that the fireworks that were involved in that incident are the same as the one involved in petitioner's injury.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/12/17. The arbitrator bases this finding on the opinions of Earley and Silman, which the arbitrator found were more persuasive than those of Perry, given their extensive training, experiences, and certifications in explosives. The arbitrator also gives the most weight to the opinions of Earley given the fact that he actually investigated the injury site. The arbitrator gives the least amount of weight to Perry's opinions, because he does not have the same amount of training, experiences, and certifications as Earley and Silman when it comes to explosive investigations, and the fact that Perry admitted that he formulated his opinions based on what petitioner said before reading any materials, or reviewing any photos or reports.

The arbitrator also bases this finding on the fact that all experts opined that the explosion occurred at petitioner's chest, and not near the ground given that there was no blast evidence on the ground, and petitioner had no injuries below his waist. The arbitrator also finds it significant that petitioner testified at trial that his lighter was clipped to his belt at the time of the injury, yet his lighter was found covered in carbon on the ground at the site of the injury, despite there being no damage to his belt, his pants or his pant loops, which is where the lighter was supposedly clipped at the time of the injury. The arbitrator finds this significant given that there is no credible evidence to support a finding that the lighter was blown off of petitioner's belt, pants, or pant loop, because there was absolutely no damage or burns to petitioner's pant that would cause the lighter to become unclipped from his pants. The arbitrator also finds the evidence that black powder, which was in mortars like the one petitioner described holding, and found around the area where petitioner was injured, cannot explode without a spark or flame in excess of 400-450 degrees pursuant to the Material Safety Data Sheets, quite persuasive. The arbitrator finds the petitioner's reliance on the "Fireworks Plant Explosions and Bootleg Traffic in Illinois from 1973" report, as its primary evidence in support of its claim that the firework spontaneously exploded in petitioner's hand, less than persuasive, given that the chemicals in the fireworks in 1973 are not necessarily the same as those in fireworks today; that there is no evidence that there was potassium chlorate in the firework that exploded in petitioner's hand; and, that the credible evidence supports a finding that it is more likely than not that the combustible chemical in the mortar petitioner picked up was black powder, based on the description of the firework petitioner provided, and the similar fireworks that were not exploded and found near the injury site.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
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?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner failed to prove by a preponderance of the credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by respondent on 7/12/17, the arbitrator finds these remaining issues moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM TOMERLIN,

Petitioner,

vs. NO: 14 WC 32713

EXTRA HELP,

20IWCC0532

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission views the evidence differently and finds the Arbitrator gave excessive weight to evidence of disability under section 8.1b(b)(v) of the Act- "evidence of disability corroborated by the treating medical records." The Arbitrator noted Petitioner developed bilateral carpal tunnel syndrome accompanied by left Guyon's canal syndrome, which required bilateral carpal tunnel releases and Guyon's canal release but failed to cite to any evidence of disability as corroborated by medical records.

The medical records evidence on December 19, 2014 Dr. Randall Rogalsky discharged Petitioner from care with a release to return to full duty work as of January 5, 2015. Dr. Rogalsky described Petitioner as "fully functional" with an "excellent result." PX5. Petitioner testified he experiences no pain, numbness, or any lingering symptoms associated with his carpal tunnel surgeries. T. 22-23.

The Commission notes that Petitioner is asymptomatic following surgery and finds the

Arbitrator's award excessive considering Petitioner's exceptional outcome. As such, the Commission affords greater weight to this factor in favor of a decreased permanent partial disability.

The Commission vacates the award of 12.5% loss of use of the left hand and 10% of the right hand and instead finds Petitioner sustained an 8% loss of use of the left hand and 7.5% loss of use of the right hand pursuant to Section 8(e)9 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $1,105.60, as set forth in PX8, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $240.00 per week for a period of 29.45 weeks, as provided for in Section 8(e)9 of the Act, for the reason that the injuries sustained caused the 8% loss of use of the left hand and 7.5% loss of use of the right hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 16 2020

LEC/cak

O: 7/21/20

43

D. Douglas McCarthy

Stephen Mathis

DISSENT

A claimant who suffers from a pre-existing condition may recover benefits under the Act where an accident aggravates or accelerates her condition. *International Vermiculite Company v. The Industrial Commission*, 77 Ill. 2d 1 (1979). Further the accident must be a factor which

contributes to the disability. *Caterpillar Tractor Co. v. The Industrial Commission*, 92 Ill. 2d 30 (1982). Mere correlation of symptoms is not enough as causation between the accident and the resulting disability must exist. *Long v. The Industrial Commission*, 76 Ill. 2d 561 (1979). Further, as the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." Petitioner failed to prove his condition is work-related. Therefore, I respectfully dissent.

Petitioner testified he initial worked for Respondent as a forklift operation and then was hired as a machine operator beginning August 24, 2014. T. 11. Petitioner performed the work duties of a machine operator for a total of three weeks, until September 12, 2014. T.12. Petitioner testified he was required to fabricate a flat piece of metal by placing it into a machine that created rivet holes in the metal on both sides creating a pop rivet. T.13. Petitioner created 144 parts per hour. *Id.* Petitioner testified he began experiencing pain in his hands on the first day of his employment specifically while holding the metal in place. T. 17-18; 26.

Both Dr. Rogalsky and Dr. Brown provided opinions as to causation. Dr. Rogalsky testified Petitioner suffered from carpal tunnel syndrome prior to his employment with Respondent and opinioned "by history, that [Petitioner] worked in this physically demanding repetitive gripping, grasping activity, that was the so-called straw, perhaps, that broke the camel's back, and that caused his symptoms to develop, and they were significant." PX6, p. 12-13. Dr. Rogalsky conceded Petitioner was obese and suffered from both hypothyroidism and diabetes all of which are causes for the development of carpal tunnel syndrome. *Id.*, p. 22.

Dr. Brown testified Petitioner suffered from severe chronic carpal tunnel syndrome evidenced by the EMG performed and opined "the extremely short duration of exposure to the work activities, only one day before onset of symptoms and only a total of 16 days total. And I do not believe one day of work would cause any irreversible damage to the carpal tunnel or the ulnar nerve at Guyon's canal, nor do I believe 16 days of work would." RX1, p. 10. Dr. Brown explained Petitioner suffered from numerous non-occupational risk factors such as diabetes, hypothyroidism, and obesity which would be associated with the development of carpal tunnel syndrome. *Id.*, p. 11-12.

As the Court noted in *Sisbro, Inc. v. The Industrial Commission*, 207 Ill. 2d 193, 212-13 (2003):

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to a recovery under the Workmen's Compensation Act. In *Carson-Payson Co. v. Industrial Com. (1930), 340 Ill. 632, 639, 173 N.E. 184*, this court said, quoting from Lord Chancellor Loreburn's opinion in *Hughes v. Clover, Clayton & Co.* (1910), 102 L.T.R. 340, 342, *aff'g* (1909) 2K.B. 798, 101, L.T.R. 475: "In each case the arbitrator ought to consider whether, in substance, as far as he can judge on such a matter, the accident came from the disease alone, so that, whatever the man had been doing, it would probably have come all the same, or whether the employment contributed to it. In other words, did he die from the disease alone, or from the disease and employment taken

together, looking at it broadly. *County of Cook, 68 Ill. 2d at 31-31.*"

Further, as the Court noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." "There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties'").

Petitioner failed to prove a causal relationship between his work duties and his condition of ill-being, carpal tunnel syndrome. Both Dr. Rogalsky and Dr. Brown agree that Petitioner's job duties as a machine operator did not cause his condition. Where they differ is relative to a theory of aggravation. I would afford greater weight to the opinions of Dr. Brown. The fact Petitioner's symptoms manifested while performing his duties as machine operator; on the very first day of his employment, does not equate to an aggravation of the underlying condition. Instead, Petitioner's condition was naturally progressing with certain activities such as grasping causing the symptoms to be more prescient. His job duties were not repetitive and neither caused nor aggravated his condition.

For the above state reasons, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TOMERLIN, WILLIAM
Employee/Petitioner

Case# **14WC032713**

EXTRA HELP
Employer/Respondent

20IWCC0532

On 9/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4463 GALANTI LAW OFFICE
GIAMBATTISTA PATTI
PO BOX 99
E ALTON, IL 62024

1433 McANANY VAN CLEAVE & PHILLIPS
AJ SHEEHAN
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

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

William Tomerlin
Employee/Petitioner
v.
Extra Help
Employer/Respondent

Case # **14** WC **32713**

Consolidated cases: **N/A**

20IWCC0532

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **7/29/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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 **9/12/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**810.00**; the average weekly wage was $**400.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $1,105.60, as set forth in PX 8, as provided in Sections 8(a) and 8.2 of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Respondent shall pay Petitioner permanent partial disability benefits of $240./week for 42.75 weeks, because the injuries sustained caused the 12.5% loss of use of the left hand (23.75 weeks) and 10% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

[signature]

Michael K. Nowak, Arbitrator

8/28/19
Date

ICArbDec p. 2

SEP 6 - 2019

FINDINGS OF FACT

Petitioner, William Tomerlin, was a 56-year-old man who worked for Respondent between August 22, 2014 through September 12, 2014. Petitioner underwent bilateral carpal tunnel releases on November 12, 2014 for the left hand and December 10, 2014 on his right hand. The primary issues are accident and causal connection.

Mr. Tomerlin testified he worked for Extra Help, Inc., a staffing agency, who contracted with Imperial Manufacturing. Mr. Tomerlin began working at Imperial on August 22, 2014. He worked one hour for orientation and began working eight-hour shifts on August 24, 2014. Petitioner testified he worked forty hours per week. Petitioner's testimony was unrebutted.

Petitioner testified he worked in the warehouse at the wrapping machine making metal ducts for duct work. He was required to grab a piece of sheet metal and push the ends together creating a cylinder. Petitioner would then hold the ends together, forming the sheet metal into a cylinder, and place the sheet metal into the union machine to rivet the ends together creating a cylindrical ventilation duct. Petitioner testified these job duties required repetitive gripping, twisting, and grasping. Petitioner testified he was required to complete 144 ducts per hour, 1,008 ducts per shift, or 15,120 ducts during 15 shifts between August 22, 2014 through September 12, 2014.

Petitioner testified he felt symptoms during his first shift and reported same to his supervisor. Petitioner testified that prior to his tenure working for Respondent, he worked as a forklift operator and never had issues with his hands.

Petitioner underwent bilateral carpal tunnel releases on November 12, 2014 and December 14, 2014 respectively. The surgeries were successfully performed by Dr. Rogalsky without complications. Petitioner had a positive outcome with an amelioration of symptoms and improvement in grip strength and dexterity.

Dr. Rogalsky's deposition testimony was offered into evidence as Petitioner's Exhibit 6. Dr. Rogalsky is a board-certified orthopedic surgeon who has performed carpal tunnel releases for 31 years. Dr. Rogalsky first saw Petitioner on September 29, 2014. He performed a physical examination and took a history of accident from Petitioner. Dr. Rogalsky noted Petitioner reported aching with sharp stabbing pain in the wrist that woke him up at night, dropping objects due to weakness and an electrical sense of pins and needles in his thumb, index, and middle fingers. The physical examination revealed positive Tinel signs along with a positive provocative pressure test bilaterally, with a 15% to 20% decrease in strength. Dr. Rogalsky diagnosed Petitioner with bilateral carpal tunnel syndrome. Dr. Rogalsky noted no odd pain behaviors, symptom magnification, nor symptom exaggeration.

Dr. Rogalsky ordered an EMG/Nerve conduction study which he reviewed with Petitioner on October 13, 2014. The EMG revealed bilateral carpal tunnel syndrome and left Guyon canal syndrome. Dr. Rogalsky recommended bilateral carpal tunnel releases and left Guyon canal release.

On November 12, 2014 Dr. Rogalsky performed a left carpal tunnel release and Guyon canal release. Dr. Rogalsky's preoperative diagnosis was confirmed and surgery was successful. Dr. Rogalsky monitored Petitioner's progress post-operatively and proceeded to perform a right carpal tunnel release on December 10,

2014. Dr. Rogalsky's preoperative diagnosis was confirmed and surgery was successful. Petitioner followed up with Dr. Rogalsky on December 19, 2014 and reported he was essentially asymptomatic. The incision site was examined and found to be healing well. Dr. Rogalsky placed Petitioner at Maximum Medical Improvement.

On March 21, 2015, Dr. Rogalsky sent a causation letter opining Petitioner's "activities in the workplace were significant in contributing to the patient's problem". (PX 6 pg. 11) During his deposition testimony, Dr. Rogalsky further explained he reviewed Dr. Brown's IME report and found the work activities listed therein were consistent with his understanding of Petitioner's job duties. Dr. Rogalsky testified Petitioner's job duties involved repetitive gripping, grasping, and twisting of the wrist and hand and those are exactly the type of activities that contribute to the development of carpal tunnel syndrome. Id.

Dr. Rogalsky was asked if Petitioner's tenure was too short to cause or contribute to the development of carpal tunnel syndrome. Dr. Rogalsky explained Petitioner's job duties while working for Respondent for three weeks did not cause carpal tunnel syndrome, it aggravated that carpal tunnel syndrome to the point where it necessitated surgery. (PX 6 pg. 13) Dr. Rogalsky explained Petitioner was likely getting very close to becoming symptomatic prior to working for Respondent and the repetitive gripping, grasping activity was the straw that broke the camel's back. (PX 6 pgs. 12-13) Dr. Rogalsky explained Petitioner was susceptible to the development of carpal tunnel syndrome, and it's possible that he was asymptomatic prior to working for Respondent. (PX 6 pg. 13)

At Respondent's request, Petitioner was sent to Dr. Brown for a Section 12 Exam on December 30, 2014. Dr. Brown testified he asked Petitioner about his job duties and discussed his medical history and medical treatment. At the time of his Section 12 Examination, Petitioner was approximately seven weeks post-op from his left carpal tunnel release and twenty days post-op from his right carpal tunnel release.

Dr. Brown opined Petitioner's severe carpal tunnel release was not related to his work at Respondent due to the short duration of exposure to the work activities. Dr. Brown testified he did not believe that exposure to the job duties after one day, nor a total of sixteen days would not cause irreversible damage to the carpal tunnel, or the ulnar nerve at Guyon's canal. (RX 1 pg. 10)

Dr. Brown felt the electrodiagnostic studies suggested Petitioner had carpal tunnel for several years due to the severity of the latency. (RX 1 pg. 11) Dr. Brown felt Petitioner was at maximum medical improvement on December 30, 2014.

Dr. Brown testified Petitioner had non-occupational risk factors for carpal tunnel. Specifically, Dr. Brown noted Petitioner had diabetes, hypothyroidism, and was obese which are all associated with a higher prevalence of carpal tunnel syndrome. On cross-examination, Dr. Brown admitted Petitioner's job duties could cause subjective complaints of pain, but not irreversible damage to the carpal tunnel. (RX 1 pgs. 16 and 18)

CONCLUSIONS

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

Petitioner provided a consistent history of accident and job duties to both Dr. Rogalsky and Dr. Brown. Petitioner's job duties required repetitive gripping, grasping, and twisting. Petitioner provided unrebutted testimony he was required to complete 1,008 ducts per shift over the course of three weeks. Prior to working for Respondent, Petitioner never had hand pain, numbness, and weakness. Petitioner worked as a forklift driver before working for Respondent forming ducts.

Dr. Rogalsky's causal connection opinion is more persuasive than Dr. Brown's. Dr. Brown only testified as to whether Petitioner's job duties caused carpal tunnel and did not consider address whether Petitioner's job duties may have aggravated Petitioner's carpal tunnel syndrome and Guyon's canal syndrome. In fact, when asked whether Petitioner's job duties may have caused an increase in Petitioner's symptoms, Dr. Brown response was Petitioner did not work for Respondent long enough to cause irreversible change in Petitioner's carpal tunnel. (See RX 1 pg. 18)

Conversely, Dr. Rogalsky's causal opinion recognizes Petitioner's propensity to the development of carpal tunnel while also recognizing Petitioner's job duties aggravated Petitioner's carpal tunnel to the point of necessitating surgery. Dr. Rogalsky acknowledges Petitioner has risk factors associated with carpal tunnel syndrome, but also notes those risk factors represent a correlative, not causative relationship. Dr. Rogalsky's understanding of Petitioner's job duties lead him to conclude the repetitive grasping, gripping, and twisting especially with the frequency which was required of Petitioner is the kind of activities that would aggravate carpal tunnel to the point of requiring treatment.

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

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

Petitioner submitted outstanding medical expenses of $1,105.60. (PX 8) There is no evidence in the record to refute the reasonableness or necessity of the treatment provided to Petitioner. The Arbitrator therefore finds Respondent shall pay $1,105.60 in medical expenses subject to the fee schedule.

Issue (K): What temporary benefits are in dispute?

Petitioner is not owed total disability benefits. At trial, Petitioner testified he was offered light duty work which he declined.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was performing a job assembling duct work which was extremely hand intensive. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of his intensive, repetitive employment, Petitioner developed bilateral carpal tunnel syndrome accompanied left Guyon's canal syndrome, which required bilateral carpal tunnel releases and a Guyon's canal release. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the left hand and 10% of the right hand pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kristin Clarke,

Petitioner,

vs. No. 16 WC 13114

Evanston Skokie School District #65,

20IWCC0533

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, Prospective Medical Care, Temporary Disability and Permanent Disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of Fact:

Petitioner, 31, testified that on April 19, 2016 she was employed by Respondent as a grade school special education teacher. Her duties included working in multiple classrooms with students with disabilities. She worked with 8 classroom teachers in addition to having her own room, and would walk between the classrooms frequently throughout her day. On April 19, 2016, Petitioner was walking down the school hallway to deliver schedules to a teacher in another classroom. As she walked just past two water fountains in the hallway, she slipped, twisted her right leg, and fell onto her right knee dislocating it. Petitioner testified that it felt like she had probably slipped on water. Because of the extreme pain she was in, Petitioner was unable to check to see if her clothes were wet. At the time, Petitioner was wearing flat-soled shoes without a heel, and she had not been in a rush.

The school's occupational therapist and her principal came to assist Petitioner, and she was taken by paramedics to Evanston Hospital. There, she was diagnosed with a dislocated right patella, which was extended and reduced while Petitioner was under conscious sedation. An Ace wrap and immobilizer were applied and Petitioner was discharged with instructions on the use of crutches.

Petitioner's principal, Michelle Cooney, testified at arbitration that she came to the hallway where Petitioner fell, shortly thereafter. She did not observe any water, liquids, debris or foreign objects on the floor. Principal Cooney could not say when the mats under the water fountains, depicted in photographs, were put into place. She admitted she did not touch Petitioner's clothes to check for dampness. She acknowledged that students used the fountains throughout the day to sip water and fill their water bottles.

On April 25, 2016, Petitioner came under the care of Dr. James Bresch. She reported to him that she had slipped and fell, falling onto her right knee. Dr. Bresch took Petitioner off work and prescribed physical therapy, which Petitioner attended for over six months. A right knee MRI taken on May 2, 2016 revealed bone contusions compatible with transient patellar dislocation suggesting a chondral injury at the patellar apex with a small joint body; a possible partial tear of the medial and lateral collateral ligament; mild patellar tendinosis, and small joint effusion.

On April 7, 2017, after conservative care ultimately proved unsuccessful, Dr. Bresch performed a right knee arthroscopy with patellar chondroplasty. He authorized Petitioner completely off work from April 19, 2016 to May 28, 2016, and from April 7, 2017 through April 18, 2017. Dr. Bresch released Petitioner to full duties on May 2, 2017.

While Petitioner was at home, she completed an accident form in which she reported that as she was walking, she felt her left leg slip and her right kneecap move before she fell. Following her surgery, Petitioner was able to return to work at her prior position without restrictions. She testified that most but not all of her medical bills were paid by her husband's group carrier, Blue Cross/Blue Shield.

Petitioner testified that the water fountains were used frequently throughout the day by students to drink and fill their water bottles. There was always water on the floor in the area near the water fountains. At the time of her fall, there were no mats under the fountains; they were placed there at a date after her fall.

Conclusions of Law:

The Arbitrator, in denying that Petitioner sustained an accident which arose out of her employment, found that found that Petitioner's injury did not have its origin in a risk connected with or incidental to the employment so as to create a causal connection between the

employment and the accidental injury. The Arbitrator found Petitioner did not establish there was any foreign substance or liquid on the floor.

The Commission views the evidence differently than the Arbitrator. Although Petitioner did not testify that she saw water on the floor, she did testify that she slipped, and that to her, it felt like she had slipped on water. Petitioner was consistent in reporting that she slipped. The accident form she completed gave that description, and her medical histories reported her mechanism of injury as having slipped. At the time of her fall, Petitioner was not in a hurry, and was wearing flat shoes. There was no evidence presented to suggest Petitioner suffered from any medical condition which might have caused her to fall.

Photographs in evidence show floor mats located underneath the water fountains, but Petitioner testified those were not put in place there until sometime after her fall. Principal Cooney did not dispute that testimony. Petitioner also testified that the water fountains depicted in the photographs, which show a spout designed to fill water bottles in an upright position, had not yet been installed at the time of her fall; they were installed sometime after.

The Commission finds ample evidence that water was frequently found on the floor in the area of the water fountains, as a result of students drinking from them and filling their water bottles throughout the day. Petitioner testified that prior to her accident, there was always water on the floor in the area of the fountains. Principal Cooney acknowledged that the fountains in question were used by students to sip water and fill their water bottles.

The Commission finds it reasonable to conclude that Petitioner slipped and fell as a result of water on the floor near the water fountains – a risk incidental to her employment which created a causal connection between the employment and the accidental injury. Her job required her to frequently walk between eight different classrooms each day, and she was in the process of doing this when she fell. It was reasonable for Petitioner to walk past the water fountains. As such, the Commission finds that Petitioner did prove her accident, in addition to occurring in the course of her employment, also arose out of her employment.

With regard to the issue of causal connection of Petitioner's medical treatment and expenses, the Commission finds Petitioner proved them reasonable, necessary and causally related. She suffered an acute trauma – dislocation of her right kneecap – as a result of her fall, and she required surgery. There is no evidence Petitioner had any preexisting condition of her knee. The Commission finds Petitioner has proved entitlement to Dr. Bresch's bill in the amount of $8,383.07, and NorthShore University Health System's bill in the amount of $4,842.96, pursuant to the fee schedule.

With regard to the issue of temporary total disability, the Commission finds the evidence supports finding that Petitioner is entitled to TTD in the amount of $1,015.04 per week for 8-5/7 weeks, for the periods of April 19, 2016 through May 28, 2016, and April 7, 2017 through April

18, 2017. Petitioner testified that Dr. Bresch authorized her off work during those periods as a result of her work accident.

With regard to the issue of permanent partial disability, the Commission has considered the five factors enumerated in §8.1b(b) of the Act, and assigns the following weights to them:

(i) **Disability impairment rating:** *no weight,* because neither party offered an AMA impairment rating into evidence.

(ii) **Employee's occupation:** *little weight,* because Petitioner returned to her same job as a special education teacher following her accident.

(iii) **Employee's age:** *some weight,* because at age of 31, Petitioner has many decades to live with the disability caused by her accident.

(iv) **Future earning capacity:** *no weight,* because no evidence was presented to show Petitioner had any reduction in her earnings after her return to work.

(v) **Evidence of disability corroborated by the treating records:** *significant weight,* because Petitioner still experiences pain in her knee and is unable to squat or run. Her job requires her to get down on the floor with young students, and she has difficulty getting up from the floor. On occasion, Petitioner has to take over-the-counter pain medications, and use ice on her knee.

Accordingly, the Commission finds Petitioner entitled to 16.125 weeks of PPD at a rate of $755.22, representing the 7.5% loss of right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 2018, is hereby reversed. The Commission finds Petitioner has proved an accident on April 19, 2016 which arose out of and in the course of her employment with Respondent, and finds her right knee condition through May 1, 2017 was causally related to that accident. No prospective medical care is awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner, as temporary total disability, the sum of $1,015.04 per week for 8-5/7 weeks, for the periods of April 19, 2016 through May 28, 2016, and April 7, 2017 through April 18, 2017, as provided by §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the $8,383.07 bill of Dr. Bresch and the $4,842.96 bill of NorthShore University Health System, subject to the fee schedule, as provided in §8(a) and §8.2 of the Act. Respondent shall also hold Petitioner harmless for any causally related bills which have been paid by her husband's group health insurance.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner, for permanent partial disability, the sum of $755.22 per week for 16.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 7.5% loss of use of the right leg.

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

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

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

DATED: SEP 16 2020
o-07/23/2020
MP/mcp
68

Marc Parker

Barbara N. Flores

DISSENT

I respectfully dissent from the Decision of the majority and would have affirmed and adopted the well-reasoned Decision of the Arbitrator in its entirety. To recover under the Illinois Workers' Compensation Act, the claimant bears the burden of proving all elements of her case by a preponderance of the evidence. *Arbuckle v. Industrial Comm'n*, 32 Ill. 2d 581, 585 (1965). Liability cannot rest upon imagination, speculation, or conjecture. *Id.* In the present case, the finding that there was water on the floor that caused Petitioner's fall is pure speculation and contrary to the evidence presented at the arbitration hearing.

It is speculative to assume that there must have been water on the floor simply because Petitioner's fall occurred in a hallway where water fountains were present. This is especially true given that Petitioner's testimony does not indicate that water was on the ground at the time of the accident. Petitioner expressly testified that she did not recall seeing any water or other liquid on the hallway floor. Petitioner further denied seeing any object or defect whatsoever on the floor right before she fell. Petitioner did not notice what had caused her to slip and was unable to check if her clothes were wet following her fall. Moreover, Petitioner testified that she

did not slip in front of the water fountains, instead she had already walked past them at the time of her fall. Petitioner's testimony is consistent with her accident report, which does not indicate that there was any water, defect, or foreign object on the hallway floor.

The testimony of Michelle Cooney, the school principal, also failed to support the assumption that water on the floor had caused Petitioner's accident. Ms. Cooney promptly arrived on the scene of the accident after she heard Petitioner scream. Ms. Cooney testified that when she arrived at the scene and found Petitioner still on the ground, she saw no water, other liquid, debris, or foreign object on the hallway floor. Ms. Cooney testified that when Petitioner was thereafter taken away by emergency responders, she inspected the area of Petitioner's fall and again did not see any water or liquid on the floor.

The testimony of Petitioner and Michelle Cooney, as well as the accident reports, expressly refute the assumption that there was water on the floor that contributed to Petitioner's fall. Regardless of whether Respondent subsequently placed mats under the water fountains or Petitioner had noticed water on the floor on prior occasions, Petitioner still has the burden of proving that the water or defect existed at the actual time of her accident, not at any time before or after her accident. For the reasons above, I would have found that Petitioner failed to meet her burden of proving that there was water on the floor at the time of her accident that caused or contributed to her foot slipping. It should not automatically follow that simply because someone slips on a floor, there must be water on that floor. To find that water caused Petitioner's fall is speculation that is not supported by the evidence presented.

I would have otherwise affirmed and adopted the Arbitrator's thorough risk analysis, as Petitioner has failed to establish that her fall was caused by a compensable risk that arose out of and in the course of her employment. I respectfully dissent from the Decision of the majority accordingly.

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLARKE, KRISTIN Case# **16WC013114**
Employee/Petitioner

EVANSTON SKOKIE SCHOOL DISTRICT #65
Employer/Respondent

20IWCC0533

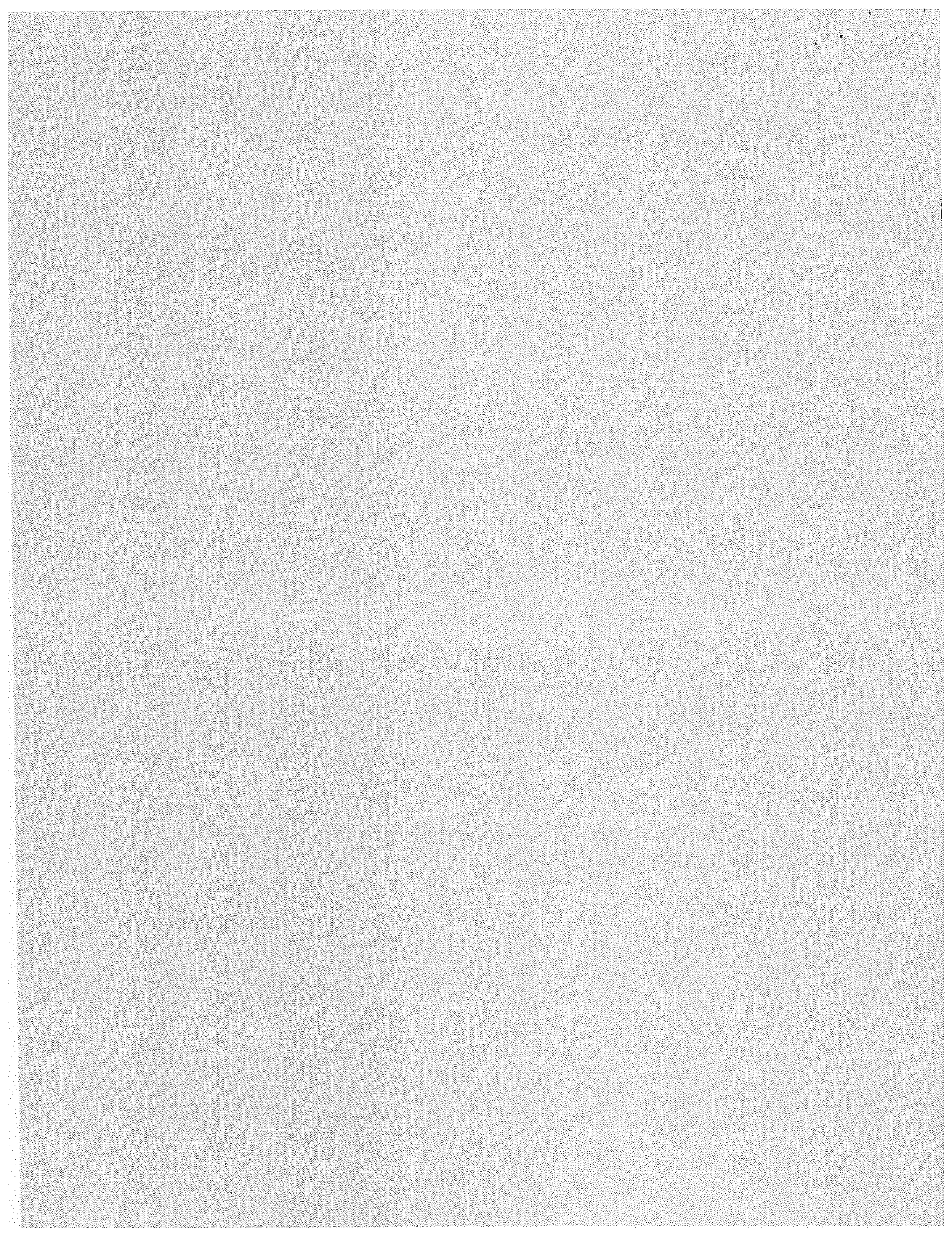
On 11/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2573 MARTAY LAW OFFICES
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
NICHOLAS A RUBINO
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)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kristin Clarke,
Employee/Petitioner

Case # **16** WC **13114**

v.

Consolidated cases: ______

Evanston Skokie School District #65,
Employer/Respondent

20 I W CC0533

An *Application for Adjustment 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 **September 18, 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

20 IWCC0533

FINDINGS:

On **April 19, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

ORDER:

As the Arbitrator finds Petitioner failed to prove she sustain an accident that arose out of and in the course of her employment for Respondent, and failed to prove that her injuries were causally-connected to the alleged accident, all benefits are denied.

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

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

Signature of Arbitrator

11-19-18
Date

NOV 2 9 2018

MEMORANDUM IN SUPPORT OF ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISION

KRISTIN CLARKE,
Employee/Petitioner

v. Case No.: 16 WC 13114

EVANSTON SKOKIE SCHOOL DISTRICT #65,
Employer/Respondent

I. STATEMENT OF FACTS:

Testimony of Petitioner:

Petitioner testified she was employed by Respondent on April 19, 2016 and working as a special education teacher. (T. 7). Petitioner testified on April 19, 2016, she was walking between two fourth grade classrooms to deliver paperwork to fourth grade teachers. (T. 9). Petitioner testified there were a few papers in her hands. (T. 27). Petitioner testified she was not actively using the papers or looking at paperwork as she traversed the subject hallway. (T. 27-28). Petitioner testified she was not rushed while traversing the subject hallway. (T. 27). Petitioner testified she did not recall any defect existing in the subject hallway. (T. 15; T. 35). Petitioner testified she did not observe any foreign object on the subject hallway floor; specifically, she testified she did not "remember seeing anything on the ground." (T. 15; T. 34). Petitioner testified she did not recall seeing any water or other liquid on the subject hallway floor. (T. 15; T. 35). Petitioner's testified she "felt like she probably slipped on some water." (T. 13). However, the Arbitrator does not place weight on the speculation of Petitioner. Petitioner also testified she could not check to see if her clothes were wet. (T. 35).

Petitioner testified water fountains existed in the subject hallway. (T. 11). Petitioner testified students use the water fountain for drinking and filling re-useable water bottles. (T. 11-

12). However, Petitioner testified no students were in the subject hallway at the time of her alleged accident. (T. 29). Likewise, she testified she did not recall seeing any students in the hallway filling any water bottles or taking drinks on or about the time of her accident. (T. 31). Petitioner testified she was not in the hallway prior to that time nor could she say when the last time the subject water fountain was used before her alleged accident. (T. 32). In addition, Petitioner testified no person or event distracted her when she traversed the subject hallway. (T. 29).

Petitioner testified regarding the accident report she completed. (T. 36-38). Petitioner admitted the report indicated her foot slipped out. (T. 37). Petitioner admitted the report did not indicate any foreign object or substance was on the ground. (T. 37).

Regarding the alleged fall itself, Petitioner testified her right leg slipped and her right leg subsequently twisted as she fell. (T. 13). The Arbitrator finds Petitioner's accident report, dated April 19, 2018, claimed her left leg slipped and her right knee landed on the ground. (RX1). The Arbitrator further finds Petitioner's medical records at the emergency room indicated Petitioner's history of accident was a fall on the playground. (PX6). The Arbitrator finds a notable difference in the mechanism of injury alleged at trial and prior to trial.

Testimony of Michelle Cooney:

Michelle Cooney testified she was the principal of the Lincoln School. (T. 49). Ms. Cooney testified as the principal she was in charge of the oversight and supervision of all the faculty, staff, and students. (T. 50). She testified part of her job duties require her to investigate accidents and complete accident reports, which must be submitted to human resources. (T. 50-51).

However, Ms. Cooney testified on April 19, 2016, she was walking up a stairwell, immediately prior to the subject hallway, and heard Petitioner screaming due to her fall. (T. 51). When Ms. Cooney arrived on the scene, she testified she saw Petitioner on the ground just past the water fountains in the subject hallway. (T. 53). Ms. Cooney testified there was no debris or foreign object in the subject hallway, there was no water on the floor, and there was no other liquid on the floor of the subject hallway. (T. 55 - 56). Ms. Cooney also testified there had been no safety complaints concerning the subject hallway within the few days prior to or on the date of alleged accident. (T. 56-57).

Additionally, Ms. Cooney testified regarding three accident reports she played a role in completing immediately after the alleged accident. (T. 57). Ms. Cooney testified she completed an accident report, which was unsigned, immediately after the alleged accident. (T. 59). Ms. Cooney testified she then signed off on the formal accident report completed by Petitioner. (T. 59). Finally, Ms. Cooney completed the supervisor's accident report, which was part of the submission package of documents for the human resources department for Respondent. (T. 59). The accident reports confirm her testimony that there were no defects in the subject hallway; there was no debris or foreign object in the subject hallway, and there was no water or other liquid on the floor of the subject hallway. (T. 62). Petitioner's own report did not make any allegation of defect, debris, or liquid on the floor. (RX1).

Ms. Cooney testified she completed the supervisor's report after performing an inspection of the subject hallway. (T. 69-71). Ms. Cooney testified and the subsequent report reinforces that after the inspection, she did not see any liquid in the area where Petitioner had fallen in the subject hallway. (T. 71). Ms. Cooney also testified it was not raining on the date of the alleged accident. (T. 71).

Exhibits Admitted at Trial:

The Arbitrator finds the following exhibits to be pertinent to the decision rendered.

Respondent's Exhibit #1:

Respondent's Exhibit 1, includes sub-exhibits A through C, which purport to be accident reports prepared by Petitioner and Michelle Cooney, the principal at the subject school. Exhibit 1A is the accident report completed by Michelle Cooney on the date of the alleged accident as Petitioner was unavailable and in the hospital. Exhibit 1B is the accident report completed by Petitioner and signed by both Petitioner and Respondent representative, Michelle Cooney. Exhibit 1C is the supervisor's report of accident completed by Michelle Cooney.

The Arbitrator finds these three reports consistently report the mechanism of Petitioner's alleged accident from April 19, 2016. Specifically, the reports all indicate Petitioner slipped and fell. However, and most notably, the Arbitrator finds the reports confirm no defect existed in the subject hallway, no foreign object caused or contributed to Petitioner's fall, and no water or other liquid existed on the subject hallway floor. Exhibit 1C confirms Michelle Cooney performed an inspection of the subject floor immediately after the alleged accident on April 19, 2018 and no defect, foreign object, or water/other liquid was present in the area of Petitioner's fall.

Respondent's Exhibit #2:

Respondent's Exhibit 2, includes sub-exhibits A through D, and purport to be photographs of the subject hallway. The Arbitrator finds these photographs instructive as to his understanding of the subject hallway.

The Arbitrator finds the photographs confirm where Petitioner alleged her accident occurred. Specifically, by agreement between Petitioner and Ms. Cooney during their respective

testimonies, Petitioner fell in an area past the drinking fountain and bathrooms in the subject hallway.

CONCLUSIONS OF LAW

C. Whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent?

Applicable Law and Precedent:

It is well established that the petitioner bears the burden of proof that an incident arose out of and in the course of a risk connected to her employment. *Union Stark v. Industrial Commission*, 56 Ill.2d 272, 277, 307 N.E.2d 119 (1974); *Dodson v. Industrial Commission*, 308 Ill.App.3d 572, 720 N.E.2d 275 (1999).

Illinois Courts have consistently rejected positional risk as a theory of compensability under the Illinois Workers' Compensation Act. *Brady vs. Louis Ruffolo & Sons Construction Company,* 143 Ill.2d 542, 578 N.E.2d 921 (1991). The mere presence of a claimant on his employer's property is insufficient to create liability under the Act. *Id.*

An injury arises out of one's employment when the injury has its origin in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Sisbro, supra* 207 Ill.2d at 203, 797 N.E.2d at 672. A risk is "incidental" to the employment where it belongs to or is connected with what an Employee must do in fulfilling his employment duties. *Sisbro, supra,* 207 Ill.2d 204, 797 N.E.2d 672. In assessing the relationship between the risk and the employment, the Courts of Illinois have identified three categories of risk to which an Employee may be exposed: (1) risk distinctly associated with her employment; (2) personal risks; and (3) neutral risks which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Commission,* 2013 Ill.App.(4th) 1202 19WC27, 990 N.E.284.

Risks distinctly associated with the employment are generally compensable as they are inherently connected to an incidental to the employment. By contrast, personal risks are generally not compensable as they are associated with the individual or personal characteristics of the Employee. Neutral risks are those which have no specific relationship to either the employment or the claimant. Neutral risks are compensable only where the employee is exposed to that risk to a greater degree than the general public because of the demands and terms of his employment. *Don Young v. Illinois Workers' Compensation Commission,* 2013 Ill.App.(4th) 130392WC, 13 N.E.3d 1252.

Illinois Courts have held that a claim is compensable under the Act when the injury results from a risk "appreciably and substantially beyond the ordinary risk so that there is extra danger to which employees in ordinary occupations or places of employment are not subject…the burden of proof is on the applicant to show that the position of the injured person was more hazardous than that of others in the same community or that by reason of the employment the risk was greater." *Alzina Construction Co. v. Industrial Com.*, 309 Ill. 395, 398, 141 N.E.2d 191 (1923). A claimant must show the "by reason of his employment, [he] is exposed to a risk greater than the risk to which the public in the vicinity is subjected, or if his employment…" *American Freight Forwarding Corp. v. Industrial Com.*, 31 Ill.2d 293, 294, 201 N.E.2d 399 (1964) (emphasis added).

In the current case, in evaluating whether Petitioner was exposed to a risk greater than that of the general public, the Arbitrator finds Petitioner's alleged accident was not a personal risk, as Petitioner was technically at her place of employment for Respondent. However, the Arbitrator further finds Petitioner's alleged accident also was not an employment risk, as Petitioner was not performing a task specific to her employment by walking down a hallway.

The Arbitrator holds that Petitioner's alleged accident was a neutral risk under the Act. *Metropolitan Water Reclamation District v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010 (2011).

In a neutral risk setting, the Petitioner must establish that a "quantitative" or "qualitative" increase in risk occurred in order for a claim to be compensable. A "quantitative" risk assessment addresses whether a petitioner engages in an activity so frequently as to increase the level of risk associated with a normally neutral task. The Arbitrator finds Petitioner did not testify to any "frequent" use of the subject hallway, and therefore, Petitioner did not establish a quantitative increased risk under the neutral risk assessment.

A "qualitative" risk assessment addresses whether an activity specific to the employment increased a normally neutral task. *Noonan v. Ill. Workers' Compensation Comm'n*, 2016 IL App (1st) 152300WC. Based on Petitioner's testimony, the Arbitrator finds Petitioner did not establish a qualitative risk increase. In support of the holding, the Arbitrator looked directly towards Petitioner's testimony, which was that no defect existed in the subject hallway. Moreover, all Petitioner could testify to when asked regarding any debris, water, or liquid in the subject hallway was that she did not recall any debris, water, or liquid on the floor of the subject hallway. Petitioner essentially is asking the court to "assume" water or another foreign object was present on the subject floor solely due to the nature of water fountains being present in the area of the alleged fall. The Arbitrator holds the facts do not support such an assumption.

In reviewing Respondent's group exhibit number 2, and the testimony of Petitioner and Principal Cooney, the alleged fall occurred after Petitioner had passed by the water fountain area. In addition, the Arbitrator finds the testimony of Principal Cooney persuasive, as she was on scene immediately after the accident, assisted Petitioner, and performed an inspection of the area

immediately after the paramedics removed Petitioner from the scene. Ms. Cooney testified after the alleged accident she found no debris, water, or liquid on the scene of the alleged accident. Finally, this was substantiated by Petitioner's own reporting of the accident subsequent to the alleged occurrence. In her accident reporting to Respondent and throughout the course of her medical treatment, Petitioner never alleged debris, water, liquid, or any foreign substances caused or contributed to her alleged slip and fall.

The Arbitrator also notes two frequent "fact patterns" where a neutral risk is increased to an employment risk from a qualitative assessment. These are where an employee carries objects directly contributing to the increased risk, or where an employee is forced to rush through an otherwise neural task. *See Nabisco Brands, Inc. v. Indus. Comm'n,* 266 Ill. App. 3d 1103 (1994) and *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000). The Arbitrator finds these cases distinguishable from the claims of Petitioner. Petitioner testified she only had a few pieces of paper in her hand, was not looking at the paperwork, and the paperwork did not directly cause or contribute to the alleged accident. Moreover, Petitioner specifically testified she was not rushing in any manner. A few sheets of paper does not equate to an increased risk of injury.

In sum, The Arbitrator finds the facts of this case distinguishable with the notable case law on "qualitative" risk claims:

- The Arbitrator finds Petitioner was not forced to rush, which could have created an increased risk. *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000); *O'Fallon School District No. 90 v. Indus. Comm'n*, 313 Ill. App. 3d 413 (2000);
- The Arbitrator finds Petitioner was not alleging a defect in the subject hallway, no debris in the subject hallway, and could not testify with any certainty that water or liquid was present in the subject hallway, which could have created an increased risk.

First Cash Financial Services v. Indus. Comm'n, 367 Ill. App. 3d 102, 106 (2006); and,

- The Arbitrator finds any paperwork in Petitioner's hand did not cause or contribute to his alleged fall or cause a dangerous situation while traversing stairs. *Knox County YMCA v. Indus. Comm'n,* 311 Ill. App. 3d 880 (2000); *Nabisco Brands, Inc. v. Indus. Comm'n,* 266 Ill. App. 3d 1103 (1994).

Finally, the Arbitrator finds Petitioner was essentially asking for a positional risk finding of compensability, or a finding which stated water must have existed on the floor solely based on circumstantial evidence, i.e. proximity to a water fountain. The Arbitrator finds no such evidence exists and no conclusion can be drawn from the record. As such, the Arbitrator holds Petitioner did not sustain an accident that arose out of her employment for Respondent.

F. Whether Petitioner's condition of ill-being was causally connected to her injury.

As the Arbitrator finds that Petitioner did not sustain an accidental injury that arose out of his employment for Respondent, the issue of "causation" is not applicable, and benefits are denied to Petitioner.

J. Whether Petitioner's medical services were reasonable and necessary?

As the Arbitrator finds Petitioner did not sustain an accident under the Illinois Workers' Compensation Act, and further, that Petitioner's alleged conditions of ill-being were not causally connected to his employment for Respondent, the Arbitrator finds Petitioner is not due any medical benefits. As such, Respondent is not required to pay any medical benefits to Petitioner.

K. Whether Petitioner is due temporary total disability benefits?

As the Arbitrator finds Petitioner did not sustain an accident under the Illinois Workers' Compensation Act, and further, that Petitioner's alleged conditions of ill-being were not causally

connected to his employment for Respondent, the Arbitrator finds Petitioner is not due any temporary total disability benefits.

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

As the Arbitrator finds Petitioner did not sustain an accident under the Illinois Workers' Compensation Act, and further, that Petitioner's alleged conditions of ill-being were not causally connected to his employment for Respondent, the Arbitrator finds Petitioner is not due any permanent partial disability benefits.

O. Other: Application of Subsequent Remedial Measure.

The Arbitrator holds any testimony as to subsequent remedial measures made by Respondent to the subject hallway is inadmissible testimony and not weighed as evidence in coming to the decision in this matter.

The Rules Governing Practice Before the Illinois Workers' Compensation Commission have specifically adopted the Illinois Rules of Evidence, Section 7030.70(a). The Illinois Rules of Evidence in Illinois have "reserved" ruling on whether Rule 407 (Subsequent Remedial Measures) will be codified by the State from the Federal Rules of Evidence.

The rule was reserved due to a circuit split with Illinois Appellate Court decision on the limited issues of application relative to timing of the subsequent remedial measure **in products liability claims.** *Jablonski v. Ford Motor Co.*, 398 Ill. App. 3d 222 (2010). However, that conflict under the law has since been overturned by *Jablonski v. Ford Motor Co, 2011 IL 110096*. As such, there is currently no bar to the Application of the reserved Rule 407 in Illinois concerning a subsequent remedial measure even though it has not been codified to date.

Moreover, under common law Illinois has barred the use of subsequent remedial measures to show negligence. *Solis v. BASF Corp.*, 2012 Ill. App. (1st) 110875. The Arbitrator

acknowledges negligence is not an element or aspect of Illinois Workers' Compensation. However, the Arbitrator finds no rule before the Illinois Workers' Compensation bars the application of generally held rule across Illinois against the use subsequent remedial measures. Moreover, the Petitioner is essentially using the evidence of a subsequent remedial measure, which in this case is the placement of mats below the subject hallway water fountains, as a means to show negligence or admission of guilt by Respondent by alleging it supports an acknowledgement of a risk with the water fountains in the school. Such a use would frustrate the purpose of the Act and the Illinois rules and precedent cited above.

II. CONCLUSION

WHEREFORE, the Arbitrator finds Petitioner did not sustain an accident that arose out of Petitioner's employment with Respondent. Petitioner's slip and fall was the result of a neutral risk, which was not qualitatively or quantitatively greater than the general public, and as a result, is not compensable under the Illinois Workers' Compensation Act.

Dated: November 29, 2018

Honorable Kurt Carlson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE MEJIA,

Petitioner,

vs. NO: 17WC 33518

ADVANCED DISPOSAL,

Respondent.

20IWCC0534

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2019, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 6 2020
O082020
MP/jrc
068

Marc Parker

Barbara N. Flores

Deborah L. Simpson

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

MEJIA, JOSE
Employee/Petitioner

Case# **17WC033518**
17WC033517

ADVANCED DISPOSAL
Employer/Respondent

20IWCC0534

On 3/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
NICHOLAS A VENTOLA
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSE MEJIA
Employee/Petitioner
v.
ADVANCED DISPOSAL
Employer/Respondent

Case # **17 WC 33518**

Consolidated cases: **17 WC 33517**

20IWCC0534

An *Application for Adjustment 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 **OCTOBER 12, 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 **August 14, 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 as it relates to the ***right knee is*** causally related to the accident. By oral stipulation, the parties reserve the right shoulder for a subsequent hearing as necessary.

In the year preceding the injury, Petitioner earned **$80,184.00**; the average weekly wage was **$1,542.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$85,686.98** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$85,686.98**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Petitioner's current condition of ill-being as it relates to the ***right knee is*** causally related to the accident. By oral stipulation, the parties reserve the right shoulder for a subsequent hearing as necessary.

Respondent shall pay reasonable and necessary medical service from IBJI of **$4,818.00** subject Sections 8(a) and 8.2 of the Act. The parties have represented to the Commission that the Illinois Medical Fee Schedule reduces the medical bills to $4,256.96.

Respondent shall pay for and authorize the recommended right knee surgery and treatment per Dr. Chams, including any and all incidental care thereto.

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

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

Signature of Arbitrator

3-22-2019
Date

MAR 2 2 2019

FINDINGS OF FACT

Background

Jose Mejia ("Petitioner") alleged injuries to his right knee and right shoulder arising out of and in the course of his employment with Advanced Disposal ("Respondent") occurring on August 14, 2017. Ax1. By oral stipulation, the parties indicated that as to case number 17 WC 33518, only the right knee issues would be arbitrated, reserving any potential disputes with respect to the right shoulder for a later hearing as necessary. The parties proceeded to arbitration on February 13, 2019 for case 17 WC 33518 as to the right knee only. Ax1. The following is a recitation of the facts adduced at trial as it pertains to the right knee. Nothing in this decision should be construed as findings or conclusions of law for any other body part.

Testimonial and Other Evidence

On August 14, 2017, Petitioner was a 41-year-old Front Load Truck Driver for the Respondent with no prior history of right knee injuries.

On that date, Petitioner was putting a compacter in the back of a 6-wheeler truck when the compactor started to roll off. The Petitioner attempted to hold on and was pulled from the back of the truck approximately 4-5 feet off the ground, twisting his right shoulder, and fell to the ground onto his right knee. He injured his right knee and complained of right shoulder and neck pain as well.

He immediately reported the injury to the Operations Manager and was directed to Physicians Immediate Care, where he was diagnosed with "sprain of right knee, strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm, strain of muscle, fascia and tendon at neck level." Px1. An MRI of the right knee taken on August 18, 2017 demonstrated Patellar erosion from severe chondromalacia and anatomic anomaly discoid lateral meniscus. Px1. Petitioner was scheduled for follow up. PIC diagnosed Petitioner with chondromalacia of the right knee.

On September 5, 2017, Petitioner went to Illinois Bone and Joint for his follow up with Dr. Roger Chams who reviewed his MRI and diagnosed Petitioner with patellofemoral arthritic changes in the lateral meniscus and discoid with a tear. Px2. On that date, Dr. Chams requested a right knee arthroscopy for Petitioner. Px2. Petitioner testified he received a cortisone injection to the knee and that he wishes to undergo the recommended surgery. Petitioner testified he has a lot of pain, cannot walk straight and has been compensating with the left doing all the work. Petitioner testified that now his left is bothering him. On questioning by the Arbitrator, Petitioner testified that at the time of the accident, he landed on both legs but most of his weight was on his right knee and that he actually hit his right knee on the curb.

On January 29, 2018, Petitioner was examined by Dr. Verma pursuant to Respondent's request under Section 12 of the Act. Dr. Verma disagreed with Petitioner's treating physician that Petitioner's current right knee condition was related to the work-related accident. Dr. Verma did, however, agree that further treatment of the right knee was necessary. Dr. Verma testified consistent with his examination.

CONCLUSIONS OF LAW

ISSUE (F) Whether Petitioner's current condition of ill-being as it relates to the right knee is causally related to the work injury of August 14, 2017, the Arbitrator finds the following:

Petitioner credibly testified that he never treated for any medical condition referable to his right knee prior to the accident. He testified that at the time of his accident, he landed on both legs, most of his weight was on the right knee and that his right knee hit the curb. Petitioner timely reported and sought treatment. Timely medical records note and immediate onset of right knee symptoms. Petitioner's testimony was credible and otherwise unrebutted in this regard.

The Arbitrator adopts the medical conclusions of Dr. Chams, which credibly demonstrate that Petitioner's right knee conditions were caused and/or aggravated by Petitioner's work accident. The Arbitrator notes Dr. Verma's opinion and testimony in this case but finds that the doctor failed to consider and address whether Petitioner's pre-existing condition, even if not acute, was aggravated by the work accident.

ISSUE (J) Whether the medical services that were provided to Petitioner were reasonable and necessary as to the right knee, the Arbitrator finds the following:

Having found in favor of Petitioner on the foregoing issues, the Arbitrator finds Petitioner's right knee treatment has been reasonable and necessary. Respondent disputes liability only and the Arbitrator notes that Dr. Verma agreed Petitioner's treatment as to the right knee had been reasonable and necessary.

Petitioner testified that the outstanding medical bills from Illinois Bone and Joint Institute for the dates of 9/5/2017-11/29/2018, for both the right knee and right shoulder, are in-fact the medical bills that are owed for his initial treatment for his work-related injury the day after the accident (Px 4). Moreover, a review of the treating records (Px 2) establishes the visit to Illinois Bone and Joint Institute on the date of 9/5/2017-11/29/2018 as reasonable and necessary. Therefore, Respondent shall pay reasonable and necessary medical service from IBJI of **$4,818.00** subject Sections 8(a) and 8.2 of the Act. The parties have represented to the Commission that the Illinois Medical Fee Schedule reduces the medical bills to $4,256.96.

ISSUE (K) Is Petitioner entitled to any prospective medical care?

Having found in favor of Petitioner on the foregoing issues, the Arbitrator awards the requested prospective right knee surgery as recommended by Dr. Chams. Respondent shall pay for and authorize the recommended right knee surgery and treatment per Dr. Chams, including any and all incidental care thereto.

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division, SEP -9 2020	)	20WC021221
Petitioner,	)	No. 14 INC 342
v.	)	
Ted Kolovos, individually and as President of Maple Restaurant, Inc.	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents, as this matter has settled.

D. Douglas McCarthy

Commissioner Douglas McCarthy

Dated: 9/9/2020

SEP 1 6 2020

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DERRICK GLUCK,

Petitioner,

vs. NO: 19 WC 18097

SOI/MURRAY DEVELOPMENTAL CENTER,

Respondent.

20 I W C C 0 5 3 5

DECISION AND OPINION ON REVIEW

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

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A.O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator considered the five factors under Section 8.1b of the Act, assigned weight to each factor, and awarded 15% loss of use of the right thumb for Petitioner's post-traumatic stenosing tenosynovitis and partial grade I collateral ligament tear.

The Commission modifies the weight afforded to the second factor under Section 8.1b of the Act – the occupation of the injured employee. The Arbitrator gave weight to the second factor noting Petitioner's returning symptoms and stating that Petitioner would likely need future treatment which could preclude Petitioner from performing his job duties. The Commission finds

that the evidence does not support the Arbitrator's findings. Petitioner had testified that he was not presently under any treatment, he was not wearing a brace, he was not taking any medication for his right thumb, and he was able to perform his regular job duties without restriction. The Commission therefore modifies the Arbitrator's Decision and assigns no weight to this factor under Section 8.1b of the Act.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission further modifies and reduces the Arbitrator's award to ten-percent (10%) loss of use of the right thumb pursuant to Section 8(e) of the Act. The Commission finds that this award corresponds with the evidence in the record and the injuries sustained by Petitioner as a result of the May 2, 2019 work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 7, 2020, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $369.97 per week for 7.6 weeks, because the injuries sustained caused the ten-percent (10%) loss of use of the right thumb, as provided in Section 8(e) of the Act.

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

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

DATED: SEP 17 2020

DDM/pm
D: 9/15/2020
052

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GLUCK, DERRICK
Employee/Petitioner

Case# **19WC018097**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

20IWCC0535

On 1/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1,52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
NATALIE N SHASTEEN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN - 7 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Derrick Gluck
Employee/Petitioner

v.

SOI/Murray Development Center
Employer/Respondent

Case # **19** WC **18097**

Consolidated cases: **N/A**

20IWCC0535

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **11/7/19**. By stipulation, the parties agree:

On the date of accident, **5/2/19**, 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 $**32,064.39**, and the average weekly wage was $**616.62**.

At the time of injury, Petitioner was **31** years of age, ***single*** with **no** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**369.97**/week for a further period of **11.4** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **15% loss of use of the right thumb**.

Respondent shall pay Petitioner compensation that has accrued from **6/20/19** through **11/7/19**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Michael K. Nowak, Arbitrator

1/6/20
Date

ICArbDecN&E p.2

JAN 7 - 2020

20IWCC0535

FINDINGS OF FACT

On date of the accident, Petitioner was a 31-year-old Mental Health Technician at Respondent's Murray Center. (AX1; T. 8)

The parties stipulated that on the date of the accident, May 2, 2019, Petitioner was putting an individual to bed when the individual became unsteady and grabbed Petitioner's right thumb and twisted it. (T. 9) Petitioner felt and pop and immediate pain. *Id.*

Prior to the date of the injury, Petitioner had no prior injuries, workers' compensation claims or treatment to his right thumb. *Id.*

Immediately following the injury, Petitioner was seen in the emergency department at SSM Health St. Mary's Centralia Hospital where the history of the injury was taken, and x-rays were performed. (PX3) The x-rays showed soft tissue swelling in the thumb, but no fracture or dislocation. *Id.* Petitioner was given an injection, Ace wrap and a splint and was instructed to follow up with an orthopedic doctor if pain worsened or did not improve. *Id.*

On May 6, 2019, Petitioner saw Dr. Aziz Rahman, his primary care physician. (PX4, 5/6/19) Dr. Rahman took the history of the injury, noted pain in the thumb and made a referral to a hand specialist. *Id.*

On June 10, 2019, Petitioner was seen by Dr. Patrick Stewart, a hand specialist, who also took the history of the injury. (PX5, 6/10/19) Petitioner had complaints of a pop, catch and click with range of motion on the IP joint of his thumb. *Id.* On physical examination, tenderness over the A1 pulley of the thumb was documented. *Id.* Dr. Stewart also noted that Petitioner was unable to bring his right thumb to the degree of hyperextension that he could on the contralateral side without considerable force, and that when he did, there was a click. *Id.* The click was also demonstrated with passive range of motion by bringing the IP joint into full extension. *Id.* Dr. Stewart's assessment was post traumatic stenosing tenosynovitis of the right thumb and a partial grade I collateral ligament tear verses sprain MP joint of the right thumb. *Id.* An injection was performed and Petitioner was given a spica splint. *Id.*

Petitioner returned to Dr. Stewart on June 20, 2019. (PX5, 6/20/19) Dr. Stewart noted that Petitioner had responded favorably to the injection and that his catch, click and pain had resolved. *Id.* He returned Petitioner to work full duty with instructions to follow up in 3 to 4 weeks. *Id.*

At Arbitration, Petitioner testified that he did not return to Dr. Stewart after June 20, 2019 because his symptoms had subsided, and he felt better. (T. 10, 11) However, since returning to his job, he has noticed some of his symptoms have returned. (T. 11) He testified that he again has a popping in his knuckle, which was a symptom he had prior to his injection. *Id.* The pain has also returned, along with decreased strength when he needs to grab or pick something up. *Id.* He has had no intervening accidents. (T. 14) He is trying his best to tolerate his symptoms for now but feels that he will probably need to go back to the doctor. (T. 11, 12) He has also noticed that his thumbs look differently and that he cannot extend his injured thumb as far, and same was demonstrated for the Court. (T. 15, 16) He also notices tightness in the morning, for which he must do about 10 minutes of slow stretching. (T. 16)

CONCLUSIONS

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner continues to serve as a Mental Health Technician for Respondent, but his returning symptoms and likely need for future treatment may preclude him from performing his job duties in the near future. (T. 8, 11, 12) The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 31 years of age at the time of his injury. (AX1) He is a younger individual and must live and work with his disability for an extended period of time. *See Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time). The Arbitrator 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 direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of his accident, Petitioner sustained a post traumatic stenosing tenosynovitis of the right thumb and a partial grade I collateral ligament tear of the right thumb. (PX5, 6/10/19) Petitioner managed his condition conservatively with an injection and splint. *Id.* Although his symptoms initially resolved after conservative treatment, they have since begun to return. (T. 11) Petitioner again experiences popping, pain, decreased strength when he grasps or picks things up, loss of range of motion and tightness in his thumb. (T. 11, 15, 16) The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right thumb pursuant to §8(e) of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MANUEL QUIZHPI,

Petitioner,

20IWCC0536

vs.

NO: 12 WC 30906

CHIPOTLE MEXICAN GRILL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical treatment and temporary total disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission strikes the following sentences from paragraph one on page five of the Arbitrator's decision: "In addition, Dr. Motella testified a degenerative condition does not become symptomatic without a trauma. Thus, considering the testimony of Dr. Montella, and the lack of shoulder complaints for six months, a separate, unrelated trauma must have occurred, causing an asymptomatic condition to become symptomatic, and requiring medical treatment." Additionally, the Arbitrator's decision contains a scrivener's error on page five in the first sentence of paragraph one. It states, "[t]he Arbitrator notes when the Petitioner presented to H & M Medical, he complained of right shoulder pain while lifting weights, and back pain from a ball onto his back." The Commission hereby changes the word "ball" to the word "fall" in that sentence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 12, 2018, is hereby affirmed and adopted with the correction noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

20 I W C C 0 5 3 6

interest under §19(n) of the Act, if any.

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

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

DATED: SEP 1 7 2020

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

MEP/dmm
O: 081820
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUIZHPI, MANUEL
Employee/Petitioner

Case# **12WC030906**

20IWCC0536

CHIPOTLE MEXICAN GRILL
Employer/Respondent

On 3/12/2018, 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 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:

1471 MARL L KARNO & ASSOCIATES
33 N LASALLE ST
SUITE 3500
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JILL M KASTNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)

)SS **20IWCC0536**

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

MANUEL QUIZHPI
Employee/Petitioner

v.

CHIPOTLE MEXICAN GRILL
Employer/Respondent

Case # **12** WC **30906**

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 **JANUARY 31, 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: **PROSPECTIVE MEDICAL CARE**

FINDINGS

On **SEPTEMBER 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**65,887.64**; the average weekly wage was $**1,267.07**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **4** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**14,174.50** for other benefits, for a total credit of $**14,174.50**.

Respondent is entitled to a credit **"for all bills paid"** under Section 8(j) of the Act. (*Arbitrator's Exhibit* 1).

ORDER

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

1) The Respondent shall pay the Petitioner the sum of **$695.78 per week** for a further period of **17.50 weeks**, as provided in **Section 8(d)2** and **Section 8.1b** of the Act, because the injury caused a **3.5% loss of use of the person-as-a-whole**;

2) The Petitioner's claim for TTD benefits **is denied**;

3) The Petitioner's claim for medical bills after November 7, 2011, **is denied**; and

4) The Petitioner's claim for prospective medical care **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

MARCH 12, 2018
Date

MAR 12 2018

MANUEL QUIZHPI v. CHIPOTLE MEXICAN GRILL

12 WC 30906

20IWCC0536

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on January 31, 2017. The issues in dispute were causal connection, medical bills, TTD, prospective medical care, and the nature and extent of the injury.[1] (*Arbitrator's Exhibit* 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act and agreed to receipt of this Arbitration Decision via e-mail. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

The Petitioner testified he was working as an IT consultant for the Respondent on September 29, 2011. On that date, while performing his job duties, he was carrying a bag of cables and a computer while wearing a backpack on his back. After completing the job, he walked into the lobby of the Respondent's restaurant and slipped onto a wet floor. He fell onto his back and arched his back, landing on his backpack. He reported the incident the following day to his supervisor. The Petitioner testified he was working a food festival that weekend and, therefore, was busy over the weekend and did not seek immediate medical treatment.

The Petitioner initially presented to H&M Medical on October 7, 2011, and advised his chiropractor that he fell onto his back and had back pain. He sought treatment with H & M Medical as it is in his neighborhood. Petitioner completed a "Request for Treatment" form in his own handwriting, giving a history of a fall "on my back". (*Petitioner's Exhibit* 1). During the initial evaluation, he also complained of right shoulder pain while lifting weights. However, during cross examination, the Petitioner denied giving this history concerning his right shoulder. (*Petitioner's Exhibit* (hereinafter, *PX*) 1). He underwent physical therapy with his chiropractor from October 7, 2011 through July of 2012. The Petitioner testified the chiropractic therapy did not provide him with relief.

---

[1] The parties agreed nature and extent would be at issue if prospective medical care was denied. (*Transcript* at 5-7).

The Petitioner was referred to Dr. Diesfeld, who performed injection therapy. On December 21, 2011, the Petitioner underwent an MRI of the lumbar spine that revealed L4-5 mild loss of normal hydration, representing early disc desiccation changes, minor 2 – 3 mm bulge. (*PX* 1). Dr. Hasaam of H&M Medical ultimately referred the Petitioner to Dr. Montella.

The Petitioner presented to Dr. Montella on February 22, 2012, complaining of low back pain. (*PX* 2). On that date, the Petitioner complained of low back pain. He underwent a physical exam for his low back. However, there is no documentation of complaints or physical exam to Petitioner's right shoulder, and his cervical exam was normal. Dr. Montella recommended continued chiropractic treatment. The Petitioner continued to follow up with Dr. Montella for lumbar spine complaints and, subsequently, lumbar spine surgery was recommended. On August 29, 2012, the Petitioner complained of right shoulder pain. (*PX* 2).

The Petitioner underwent surgery with Dr. Montella on July 16, 2013 for his right shoulder in the form of an arthroscopy. (*PX* 2). The post-operative diagnosis was right shoulder impingement, degenerated biceps anchor, global grade 2 chondromalacia and osteophytosis of the AC joint. (*PX* 2). The Petitioner testified he underwent shoulder surgery first, despite an ongoing recommendation for lumbar surgery, as he believed we would have better movement if he underwent the lumbar spine surgery. He continued to treat with Dr. Montella and continued to undergo physical therapy for his right shoulder. He underwent an epidural injection into his neck but did not undergo a cervical MRI.

The Petitioner underwent a second course of physical therapy for his right shoulder and lumbar spine at La Clinica at the recommendation of Dr. Montella. He presented on October 23, 2015, and continued with therapy through November 11, 2015. While attending La Clinica, he gave a history of lifting a computer monitor and it got stuck, he fell to the floor, and had a fracture of the right shoulder. (*PX* 6). The Petitioner then underwent a second surgery with Dr. Montella on December 22, 2015. (*PX* 2). He participated in physical therapy following the second surgery at Centers for Physical Therapy from January 5, 2016 through April 1, 2016. (*PX* 5). He then was released from physical therapy and testified his shoulder was feeling better. The Petitioner also stated he has a current order for a lumbar disc decompression and wishes to proceed with the surgery. He also is continuing to work in a full duty capacity for the Respondent.

Pursuant to the Respondent's Section 12 request, the Petitioner met with Dr. Michael Kornblatt on August 20, 2012. (*Respondent's Exhibit* 3). He understood the examination was a part of his workers' compensation claim. The Petitioner admitted he was not examined by Dr. Kornblatt because, during the history portion of Dr. Kornblatt's exam, he did not like the way the exam was proceeding and left the doctor's office. He agreed he never returned to Dr. Kornblatt to complete the examination. However, Dr. Kornblatt issued a report based upon his review of

the Petitioner's medical records. (*Respondent's Exhibit (*hereinafter, *RX)* 3). Dr. Kornblatt opined the Petitioner should have reached maximum medical improvement (MMI) regarding the lumbosacral strain and contusion, and right shoulder strain and contusion, within six to eight weeks post-injury. Dr. Kornblatt did not believe the Petitioner was a surgical candidate for his right shoulder or lumbar spine. Furthermore, he opined the MRI findings involving the lumbar spine were consistent with mild pre-existing degenerative disc disease at L4-5 consistent with Petitioner's age and stature, and were not caused, aggravated or accelerated by the work-related fall. (*RX* 3). Additionally, he stated the MRI findings of the right shoulder were consistent with a mild inflammatory fluid around the distal portion of the rotator cuff tendon. (*RX* 3).

Pursuant to another Section 12 request by the Respondent, the Petitioner also met with Dr. Steven Mather on June 29, 2015. (*RX* 1). Dr. Mather reviewed the MRI film from December of 2011 and found very mild disc desiccation at L4-5, but no herniation or nerve root compression. He opined the MRI was normal. On physical exam, Dr. Mather noted several positive Waddell findings, and agreed with Dr. Kornblatt that any strain would have resolved within six to eight weeks. (*RX* 1). Dr. Mather noted large scratches on the right lower extremity and a large bruise on the left thigh that the Petitioner admitted to him were from playing soccer. Dr. Mather also reported the cervical epidural steroid injection performed by Dr. Montella would fall below the standard of care as it was done without an MRI or CT scan. Dr. Mather did not believe the Petitioner's cervical spine complaints were related to his fall. Dr. Mather also opined only up to ten visits of chiropractic treatment would be indicated for the lumbar strain. He further agreed the Petitioner could continue working in a full duty capacity. (*RX* 1).

During his evidence deposition on March 9, 2016, Dr. Montella agreed that there were no documented complaints referable to the Petitioner's right shoulder until August 29, 2012. (*PX* 3). Dr. Montella did not believe a degenerative condition could become symptomatic without a trauma, and believed the trauma which caused the Petitioner's complaints and need for surgery was his September 29, 2011, fall. (*PX* 3). He also stated the Petitioner may require lumbar surgery, but it would depend on how the Petitioner felt and whether he could live with the pain. (*PX* 3).

Dr. Michael Bryan Neal performed a medical records review at the Respondent's request on May 11, 2016. (*RX* 2). Dr. Neal opined that at most Petitioner had a soft tissue condition which was resolved and asymptomatic as of November of 2011. Dr. Neal also reported the impingement syndrome which resulted in the surgery was not related to the fall and, likely, was a preexisting condition. (*RX* 2). The Respondent also requested a utilization review study of the Petitioner's medical care. The February 12, 2016, utilization review (UR) report non-certified 197 of the Petitioners' chiropractic sessions. (*RX* 4).

20IWCC0536

The Petitioner acknowledged he had group medical coverage through his employment with the Respondent and that medical bills had been submitted and paid by that group carrier. He also agreed he had received short-term disability benefits totaling $14,174.50 for those periods when he underwent his shoulder surgeries. He admitted the Respondent pays a portion of the premiums for the group medical policy, as well as the short-term disability policy.

The Petitioner further admitted being an active soccer player, and that he continues to play soccer on a weekly basis, multiple times per week. He plays all year round and has done so his entire life. He also acknowledged he participated weight lifting prior to the accident date, but disputed that the medical records would indicate complaints of right shoulder pain after lifting weights. The Petitioner testified he continues to work as an IT consultant for the Respondent, and is making the same or a higher hourly pay rate as he was prior to the accident.

CONCLUSIONS OF LAW

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

Issue F: *Causal connection*

A petitioner bears the burden of proving every aspect of his or her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill.App.3d 706 (1992). "Liability under the Workman's Compensation Act may not be based on imagination, speculation or conjecture, but must have a foundation of facts established by a preponderance of the evidence." *Shell Petroleum Corp. v. Industrial Commission*, 10 N.E. 2d 352 (1937). The burden of proof is on a claimant to establish the elements of his or her right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment there is no right to recover. *Revere Paint and Varnish Corp. v. Industrial Commission*, 41 Ill.2d 59. Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. *Spankroy v. Aleksy*, 45 Ill.App.3d 432 (1st Dist. 1977).

The Petitioner sustained an injury to his lower back when he slipped and fell while entering the lobby of the Respondent's restaurant. The Petitioner did not seek medical treatment for eight (8) days, despite having group coverage through the Respondent. He initially presented to a chiropractor and agreed he continued to be physically active while receiving treatment. The Arbitrator finds it disconcerting that the Petitioner walked out of a Section 12 evaluation in 2012 with Dr. Kornblatt when he specifically knew that appointment was being used to investigate his workers' compensation claim.

The Arbitrator notes when the Petitioner presented to H & M Medical, he complained of right shoulder pain while lifting weights, and back pain from a ball onto his back. (*PX* 1). He also admitted on cross examination that, prior to his injury, he would lift weights. The Arbitrator also considers the testimony of Dr. Montella relevant as Dr. Montella agreed the first documented shoulder complaint during the Petitioner's medical treatment was on August 29, 2012, six (6) months following his initial visit. In addition, Dr. Motella testified a degenerative condition does not become symptomatic without a trauma. Thus, considering the testimony of Dr. Montella, and the lack of shoulder complaints for six months, a separate, unrelated trauma must have occurred, causing an asymptomatic condition to become symptomatic, and requiring medical treatment. Furthermore, the Arbitrator considers the opinion of Dr. Neal stating the Petitioner's shoulder situation was a degenerative condition. Therefore, the Arbitrator finds the Petitioner's condition of ill-being concerning his right shoulder is not related to his September 29, 2011, fall onto his back.

The Arbitrator also relies on the credible opinions both of Dr. Kornblatt and Dr. Mather in finding the Petitioner sustained a lumbar contusion/strain, necessitating a brief course of chiropractic treatment, with up to ten (10) sessions being reasonable. Therefore, the Arbitrator finds the Petitioner's ***current*** condition of ill-being regarding his lumbar spine, if any, to be unrelated to his fall of September 29, 2011. In addition, the Arbitrator relies on the UR report non-certifying the Petitioner's ongoing chiropractic treatment, and the Petitioner's testimony that the chiropractic treatment did not improve his symptoms. Lastly, the Arbitrator, relying on the credible opinions of Dr. Mather, finds the Petitioner's cervical spinal condition to be unrelated to his fall of September 29, 2011.

<u>Issue J</u>: *Medical bills*

Based upon the findings regarding **Issue F** above, the Arbitrator, finds the Petitioner underwent chiropractic therapy and continued to work in a full duty capacity. He also testified the chiropractic treatment did not help his symptoms and, therefore, the Arbitrator finds the chiropractic treatment excessive and unnecessary. Concerning the Petitioner's lumbar contusion/strain, the Arbitrator finds ten (10) visits of chiropractic treatment was reasonable and related and awards the bills for appointments from October 7, 2011 through November 7, 2011 with H & M Medical. Pursuant to the stipulation of the parties, the Respondent shall receive credit for payment of said bills under Section 8(j). The Arbitrator finds that any medical treatment after November 7, 2011 was not necessary or related to the injury of September 29, 2011.

Concerning the right shoulder component of the Petitioner's claim, the Arbitrator above found the Petitioner's right shoulder condition was not causally related and, therefore, his claim for medical benefits concerning his right shoulder is denied.

Concerning the Petitioner's cervical spine, the Arbitrator above found the Petitioner's cervical spine condition was not causally related and, therefore, his claim for medical benefits concerning his cervical spine is denied.

Issue K: *TTD*

The Petitioner testified that prior to his shoulder surgery, he did not lose any time from work. The only time the Petitioner was unable to work was during and shortly after each of the two surgeries performed to his right shoulder. Based upon the findings regarding **Issue F** above, the Petitioner's claim for TTD benefits is denied.

Issue L: *Nature and extent of injury*[2]

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

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

[2] The Petitioner's accident date (9/29/2011) falls after the June 28, 2011 effective date of 820 ILCS 305/8.1b. Accordingly, this Arbitration Decision ***will*** utilize the factors set forth in Section 8.1b in determining the nature and extent of the Petitioner's injury.

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

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

(See 820 ILCS 305/8.1b)

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

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

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

ii. The Arbitrator finds the Petitioner worked for the Respondent as a full-time IT consultant for the Respondent. As such, the Arbitrator therefore gives ***some weight*** to this factor.

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

iii. The Arbitrator notes that the Petitioner was 37-years-old at the time of the accident (*AX* 1), but no specific credible evidence as to how the Petitioner's age might affect his disability was offered by either party. As such, the Arbitrator therefore gives ***no weight*** to this factor.

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

iv. The Arbitrator notes the record is devoid of credible evidence as to the Petitioner's future earnings capacity as required by this section. Furthermore, the Petitioner did testify he continues to work as an IT consultant for the Respondent and is making the same or a higher pay rate as he was at the time of his accident. As such, the Arbitrator therefore gives ***some weight*** to this factor.

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

v. The Petitioner's treating medical records show he suffered a lumbar strain because of a work accident on September 29, 2011. He received conservative

medical care for his lumbar spine and Dr. Kornblatt and Dr. Mather credibly opined he should have reached MMI within six to eight weeks after his accident. Although the Petitioner continues to complain of lumbar spine pain symptoms, those symptoms are not causally related to his work accident. As such, the Arbitrator therefore gives ***moderate weight*** to this factor.

Based on the above factors, and the entire record, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of a **3.5%** loss of use of the **person-as-a-whole** pursuant to Section 8(d)2 and Section 8.1b of the Act.

Issue O: *Prospective medical care*

The Petitioner failed to prove his current condition of ill-being is causally related to his injury. The Arbitrator relies on the credible MRI interpretations of Dr. Mather and Dr. Kornblatt, both who noted the Petitioner had a normal, age appropriate MRI of his lumbar spine. In addition, the Arbitrator notes the Petitioner's testimony that he has returned to all pre-injury activities, including physical exercise and participation in his local soccer games. The Arbitrator, having reviewed the evidence deposition of Dr. Montella, who states the goal of any lumbar surgery is not to eradicate the problem, but to get the patient to "live well with it." (*PX* 3). Incorporating the Petitioner's testimony, it is evident to the Arbitrator the Petitioner is living quite well without the need for lumbar surgery and, therefore, the same is not necessary to cure or relieve the effects of the fall on September 29, 2011, and is hereby denied.

____
Signature of Arbitrator

MARCH 12, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIM BEAN,

Petitioner,

20IWCC0537

vs.

NO: 17 WC 27094

STATE OF ILLINOIS – ILLINOIS STATE UNIVERSITY

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 ("in the course of" and "arising out of" employment) and notice 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.

Petitioner worked part time for Respondent as an usher. On April 8, 2017 she was working as an usher at the University's arena. She testified that she was walking down the ramp and she did not know exactly what happened but she woke up with "blood gushing from her head." Petitioner testified that her supervisor, Ms. Spellmeyer, was summoned and came to the site of the accident. Ms. Spellmeyer executed an incident report in which she wrote that she observed a cut on Petitioner's face. Petitioner filled out her official accident report on July 5, 2017. Immediately after the accident, Petitioner went to OSF Prompt Care and reported the fall but also reported she really did not know how she fell. The day was sunny, the ramp was dry, and there was no evidence whatsoever that the ramp was in any way defective or hazardous.

The Arbitrator denied compensation. He found that "Petitioner has neither proved that her accident occurred in the course of her employment with Respondent nor that it arose out of her employment with the same." In addition, the Arbitrator also found that Petitioner had not provided timely notice in the Findings section but did not explain the basis for that finding in the body of the decision.

The Commission agrees with the Arbitrator that Petitioner did not sustain her burden of proving that her accident arose out of her employment. The ramp on which Petitioner fell was open to the public, it was not in a hazardous condition, and Petitioner consistently testified/reported that she did not know how she fell. Therefore the Commission finds that the risk to Petitioner was neutral in that she was exposed to the same risk as a member of the general public and her testimony establishes that her fall was idiopathic in nature. Therefore the Commission agrees that the accident is not compensable under the Act.

However, in the interests of clarity, the Commission notes that it disagrees with the conclusions of the Arbitrator that the accident did not occur in the course of her employment or that Petitioner did not provide timely notice. On the issue of whether the accident occurred in the course of Petitioner's employment, the Arbitrator noted that generally an accident on the employer's premises when the claimant was on the way to work was compensable. However, he found that the accident did not occur in the course of Petitioner's employment citing the fact that the ramp was used by the public. In our opinion that factor is relevant to the issue of whether an accident "arose out of," rather than whether it occurred "in the course of" employment. Therefore, while the Commission agrees with the finding of the Arbitrator that the accident did not arise out of Petitioner's employment, we disagree with the finding of the Arbitrator that the accident did not occur in the course of her employment.

On the issue of notice, as noted above, the Arbitrator found that Petitioner did not provide timely notice of the accident in the Findings section of the decision, he did not explain the basis of that finding in the body of his decision. Apparently, the Arbitrator relied on the date Petitioner filed her accident report on July 5, 2017, three months after the accident. However, Petitioner testified that her supervisor was summoned to the site of the accident and her testimony was not rebutted. In addition, in her report, Ms. Spellmeyer noted that she observed a cut on Petitioner's face, verifying that she was aware of the accident immediately after it occurred. Therefore, the Commission finds that Petitioner did provide adequate notice of the accident.

Finally, even though the Arbitrator denied compensation, he included language indicating that the award was not a bar to additional subsequent TTD or PPD benefits. While this proceeded pursuant to §19(b), that language would only apply if an accident is found compensable and the matter would be remanded for consideration of any possible additional benefits. Here, the Commission affirms the Decision of the Arbitrator that Petitioner's accident was non compensable and the matter will not be remanded for determination of benefits. Therefore, this matter is not remanded and the language sited above is not applicable.

Accordingly, the Commission deletes the second paragraph in the Order section of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated December 6, 2019 is hereby affirmed with the changes noted above, and compensation is denied.

DATED: SEP 1 8 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-8/6/20
46

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

20IWCC0537

BEAN, KIM
Employee/Petitioner

Case# **17WC027094**

ILLINOIS STATE UNIVERSITY
Employer/Respondent

On 12/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
WILLIAM TRIMBLE
2001 FOX CREEK RD
BLOOMINGTON, IL 61701

0000 ASSISTANT ATTORNEY GENERAL
L LAUGGES
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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST, 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC -6 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0537

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)

Kim Bean
Employee/Petitioner

Case # **17** WC **027094**

v.

Consolidated cases: **---**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Bloomington**, on **September 25, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [ ] 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. [ ] 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 **April 8, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner, working part time, earned $**1,725.10**; therefore, the average weekly wage, being lower than the minimum, shall be $**330.00**.

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

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

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

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

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

ORDER

Petitioner has failed to prove by a preponderance or greater weight of the evidence that she suffered any accident arising out of or in the course of her employment with Respondent. Petitioner's claim for compensation is denied.

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

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

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

Signature of Arbitrator

December 5, 2019
Date

DEC 6 - 2019

Finding of Facts

On September 15, 2017, Petitioner Kim Bean filed an Application for Adjustment of Claim alleging she injured her head, arms, and other parts of her body in a fall on April 7, 2017, while working for Respondent, Illinois State University ("ISU"). The date of injury was amended to be April 8, 2017 during the 19(b) hearing. (transcript of hearing (TX) p. 9).

On April 8, 2017, Petitioner was a 54-year old part-time ticket taker and usher for ISU events. (Arbitrator Exhibit (AX) 1, TX pp. 5, 9, 20). At that time, Petitioner also worked a full-time job at mechanical devices, but is unsure what her wages were at the time of the accident. (TX pp. 20-21, 39). On April 8, 2017, Petitioner was scheduled to work an event for the Gamma Phi Circus. (TX p. 22). Petitioner testified that while walking in to work, she was walking down a ramp toward the Redbird Arena back entrance and she fell to the ground, which caused a cut to form on her head which began to bleed. (TX pp. 22-23). Petitioner could not say why she tripped. (Id). Petitioner testified that it was a sunny, clear day, with no rain, no wetness on the ground, and testified that there was no debris where she tripped. (TX pp. 42-43). Petitioner also completed an Employee's Notice of Injury Form detailing the injury. (RX 1) On that form, completed on July 5, Petitioner described the mechanism of the injury as:

> [she] was walking down ramp to clock in, outside not sure how tripped on concrete, fell, put my arm out tried to break my fall cut by eye was caused by my glasses. (Id)

Petitioner testified that this incident occurred on the back ramp leading from the parking lot where she parks for work into Redbird Arena. (TX pp. 24). Petitioner testified that this is the only entrance that she can use because all of the other doors are locked for this event. (Id). This entrance is near where Petitioner clocks in for work at the beginning of her shifts. (TX p. 26). Petitioner testified that on the date of the accident she was supposed to be working during a Gamma Phi Circus event, which is a circus event put on by a student organization. (TX p. 23).

Petitioner testified that after her fall, she was initially evaluated by EMTs who were present at Redbird Arena for the Gamma Phi Circus event. (TX pp. 28-29). Petitioner, during the fall, had broken her glasses, had a cut on her head, had a sore arm, skinned elbow, skinned knee, and was just generally in pain. (TX p. 30). Petitioner then, at the advice of the EMTs, called her fiancee, who came to Redbird Arena and drove her to seek medical care. (TX p. 29). Because of insurance concerns, she did not go to the emergency room, and instead went to her walk in clinic. (Id). At the clinic, they treated cut above her eye and generally evaluated her. (TX p. 31). Although she missed her first event shift that day due to the fall, after she was treated at the clinic, she was able to return to campus and work the second Gamma Phi Circus event shift. (TX p. 46). Other than that initial shift that day, her injury and arm pain did not cause her to miss another work shift. (TX p. 47). Also, though, Petitioner noticed that the pain in her right arm did not go away as time went on, and in fact only got worse. (TX pp. 31-32).

Medical Treatment for right arm

Petitioner first sought medical treatment on April 8, 2017, the day of the accident, with OSF Prompt Care. (TX p. 31). On the day of the accident, the medical professionals were more concerned about the cut around her eye and her eyesight than her arm, but they did examine her arm despite not treating it that day. (Id). When Petitioner noticed that her right arm pain did not go away, she contacted Illinois State University regarding her arm pain due to the fall and was sent to Occupational Health. (TX p. 32). An X-Ray of her arm was performed. (Id). Through the X-Ray, it was found that Petitioner's arm had been broken but was already beginning to heal. (TX p. 34). It was recommended that Petitioner see an orthopedic surgeon, and she went to Dr. Kolb. (Id). As Petitioner did not want surgery, Dr. Kolb recommended physical therapy, and Petitioner went to 20 sessions of physical therapy. (TX p. 35-36). Petitioner was

also given a brace which she wore at night to keep her arm straight. (TX p. 36). With the physical therapy and the brace, her arm began to feel better. (Id). Although her arm did feel better while she was doing physical therapy, on the day of the trial, Petitioner testified that she has some pain and numbness and that she has now decided that she wants to move forward with surgery. (TX p. 38). Despite her more current pain and numbness, she has not sought medical intervention for her pain and numbness. (TX p. 48). Petitioner stopped doing the stretches and exercises which she had done with her physical therapist when the physical therapy sessions ended. (TX p. 48). The Petitioner does not currently have any restrictions due to her arm. (TX p. 47).

Petitioner's related medical bills are contained in Petitioner's exhibit 7. (TX p. 15).

Conclusions of Law

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

In regard to disputed issue (C), the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner's injuries were caused by the fall, however, the fall and injuries did not arise out of and in the course of employment with Respondent. In support of this conclusion, the Arbitrator notes the following:

Proving an accident occurred in the course and arose out of employment is a Petitioner's burden of proof and is necessary for finding an accident compensable. *Baggett v. Industrial Comm'n, 201 Ill.2d 187, 266 Ill.Dec. 836, 755 N.E.2d 908 (2002).* "The phrase 'in the course of' refers to the time, place, and circumstances under which the accident occurred." *Orsini v. Industrial Comm'n, 117 Ill.2d.38, 44, 109 Ill.Dec 166, 509 N.E.2d 1005, 1008 (1987).* On the other hand, to arise out of one's employment, an injury "must (1) have an origin in some risk connected with or incidental to the employment; or (2) be caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment." *Wal-Mart Stores, Inc. v. Industrial Comm'n, 206 Ill.Dec. 585, 590, 326 Ill.App.3d 438, 434-44 (2001), citing Dodson v. Industrial Comm'n, 308 Ill.App.3d 572, 575-76, 241 Ill.Dec. 850, 720 N.E.2d 275, 278 (1999).* Here, Petitioner has neither proved that her accident occurred in the course of her employment with Respondent, nor that it arose out of her employment with the same. The following analysis will first address the in the course of requirement followed by the arising out of requirement.

Generally speaking, when an employee is going to or from work on the employer's premises, an injury is compensable. *Williams v. Country Mut. Ins. Co., 28 Ill.App.3d 274, 277, 328 N.E.2d 117, 120 (1975). Williams* quotes *M&M Parking Co. v. Industrial Comm'n*, in providing a succinct statement of this ruling principle:

> It is well settled that an injury accidently received by and employee on the premises of his employer while going to or from his place of employment by a customary or permitted route, within a reasonable time before or after work, is received in the course of an arises out of his employment.

55 Ill.2d 252, 257, 302 N.E.2d 265, 268. Yet, *Williams* distinguishes itself from this statement by recognizing there are certain facts which indicate that some injuries on an employer's premises are not compensable. Relevant here is that the location of the injury is not used by members of the public at large, and instead is used primarily facilitate employee traffic movement inside the large areas of the hospital "complex" belonging to the employer. *Williams, 28 Ill.App.3d 274, 278, 328 N.E.2d 117, 121.* Here, Petitioner's injury did occur on the employer's premises, being on a walkway leading to an entrance to the building, but it occurred in an area that is used by members of the public, which

distinguishes this case from the *Williams* case. (TX p. 58). The witness for the state testified that the ramp on which Ms. Bean fell was open to the public and is used by the public. (Id). As such, the facts of this case are not similar to *Williams* or *M&M Parking Co.* and Petitioner's fall did not occur in the course of her employment.

Even if the facts were similar to *Williams*, and Petitioner's fall occurred in the course of her employment, Petitioner must also establish that her accident arose out of her employment with Respondent. An injury "arises out of" employment only when there is some risk connected with, or incidental to, Petitioner's employment so as to create a causal connection between the employment and the accidental injury. *Jewel Cos. V. Industrial Comm'n, 57 Ill.2d 38, 40, 310 N.E.2d 12; Chmelik v. Vana (1964), 31 Ill.2d 272, 277, 201 N.E.2d 434 (1974).* Often, such a nexus exists when an employee performs acts as instructed by the employer, when the employee had a common law or statutory duty to perform an act, or when the employee might reasonably be expected to perform an act within the scope of her duties. *Howell Tractor & Equipment Co. v. Industrial Comm'n, 78 Ill.2d 567, 573, 38 Ill.Dec. 127, 403, N.E.2d 215 (1980),* A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties. *Fisher Body Division, General Motors Corp. v. Industrial Comm'n, 40 Ill.2d 514, 516, 240, N.E.2d 694 (1968).* "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." *Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d. 52, 58, 541N.E.2d 665, 667 (1989).*

The Commission's decision in *O'Hara v. State of Illinois, Vienna Correctional Center* is also instructive. *13 I.L.W.C. 13451 (Ill.Indus.Com'n), 17 I.W.C.C. 0093, 2017 IL 946817* In *O'Hara*, the Petitioner was injured as a result of not watching where he was walking. *Id at ¶ 1.* The Commission found the injury compensable as arising out of the course of his employment because Petitioner was a prison guard, the injury occurred at the prison, and the nature of his work required that Petitioner be on the lookout for prisoners moving around him. *Id at ¶ 7.* This risk arose out of Petitioner's work because of the "high-security environment constituted an increased qualitative risk which increased the likelihood of Petitioner's injury." *Id.*

Unlike in *O'Hara*, the Petitioner was not yet working during her fall, and had no reason to have her concentration elsewhere while she walked.

In a recent appellate case, *Dukich v. Illinois Workers' Compensation Comm'n*, 2017 IL App (2d) 160351WC, the Court found that, despite the petitioner's testimony that she fell due to wetness on the handicapped ramp on the route from her parking spot into her place of employment, her injury was not compensable. The Court found that the dangers created by the rainfall were no different for her than the dangers presented to the general public, a neutral risk, and found that the wet pavement was in no way a hazardous condition creating any employment associated risk. *Dukich*, 2017 IL App (2d) 160351WC.

Here, like in *Dukich*, the Petitioner was injured when she was walking down a ramp from the parking lot into her place of employment. (TX pp. 22-23). Unlike in *Dukich*, the Petitioner cannot describe what caused her fall. (TX pp. 22-23). According to a recent case decided by the Commission, *Hawkins v. Georgetown-Ridge Farms #4*, 27 ILWCLB 111 (Ill. W.C. Comm. 2018), the failure of a petitioner to present any evidence establishing the cause of their fall is a failure to prove that their injury arose out of their employment. Here, the Petitioner failed to prove the cause of her fall, and in fact had no clue as to what could have caused her fall at all. (TX pp. 22-23). Petitioner testified that it was a sunny, clear day, with no rain, no wetness on the ground, and testified that there was no debris where she tripped. (TX pp. 42-43). Petitioner told medical staff, the same day as the fall, that her shoe simply stopped, and she fell forward. (Respondent's Exhibit 5, TX pp. 43-44). The petitioner did not prove that she was at any greater risk to any greater degree than the general public. She testified, and the entirety of the record shows, that she simply fell. Because the

Petitioner failed to establish any work-related cause for her fall through her testimony at trial, she failed to prove that her injury arose out of her employment, and her claim cannot be compensable.

All other issues are moot. Compensation is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DWIGHT L. JOHNS,

Petitioner,

20 IWCC0538

vs.

NO: 17 WC 21116
17 WC 21117

KOCH FOODS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering all issues, and being advised of the facts and law, modifies the Decisions of the Arbitrator as stated below and otherwise affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part thereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

While otherwise affirming and adopting the Decision of the Arbitrator, the Commission modifies the Decision with respect to the issues of dependency and temporary total disability benefits as stated below.

The Arbitrator awarded temporary total disability (TTD) from June 7, 2017 to June 12, 2017. The Commission finds this award to be supported by the treatment records from Physicians Immediate Care, which show that Petitioner remained on work restrictions before being released to full duty on June 12, 2017. The Commission further finds that Petitioner has established his entitlement to additional TTD benefits claimed from June 15, 2017 through April 25, 2019, the hearing date.

In addition to the lack of pre-accident symptoms in the low back, the record also reflects objective diagnostic and clinical evidence of an injury. Petitioner's MRI shows an annular bulge and herniation. Petitioner's treating physician, Dr. Salehi, also testified that Petitioner's limited range of motion was also an objective finding that supported his opinions that Petitioner suffered

from low back issues that were causally connected to the accidents at work.

Both Dr. Salehi and Dr. Kornblatt, Respondent's Section 12 examiner, agree that Petitioner had suffered a work-related injury on both accident dates; however, the doctors disagree as to whether or not it was a temporary aggravation that had since resolved. Dr. Kornblatt's opinion that Petitioner sustained only a temporary aggravation is in contravention of the medical evidence contained in the treatment records as a whole. Petitioner continued to consistently complain of ongoing lumbar symptoms both before and after his second examination by Dr. Kornblatt. There were no gaps or significant changes in Petitioner's complaints, symptoms, or treatment that suggest any aggravation had resolved. Prior to the work accidents, Petitioner had no back issues and he was able to work full duty. After each of his accidents, Petitioner remained symptomatic requiring ongoing work restrictions imposed by his treating physicians, with one exception, up to the date of the arbitration hearing. As such, the Commission finds Dr. Salehi's opinions to be more persuasive than those of Dr. Kornblatt in this case.

There is additional consideration to be given to the results of Petitioner's functional capacity evaluation (FCE), which placed him at the heavy physical demand level, and whether those results represent a valid determination of his capabilities. At the March 26, 2018 FCE, the evaluator indicated that Petitioner's behavioral factors had affected his evaluation to such an extent that she could not identify Petitioner's true impairment. It is notable that the physicians did not find the FCE results to prevent their assessment of Petitioner's condition. Dr. Salehi considered the FCE findings, but nonetheless continued to impose restrictions of desk work only on Petitioner. Respondent's Section 12 examiner, Dr. Kornblatt believed that Petitioner's FCE effort was sufficient despite ultimately opining that Petitioner's restrictions fell at the medium demand level at the time of his Section 12 examination. Moreover, Dr. Kornblatt, testified that he found Petitioner's complaints to be credible and saw no malingering behavior. The Commission is hard-pressed to ignore the foregoing and interpret the FCE evaluator's expressed difficulty as the sole measure of whether Petitioner should be deemed credible with regard to his physical capabilities.

As such, the Commission finds objective evidence of Petitioner's disability evident in his treatment records, and that the restrictions imposed by his physician were made in consideration of the FCE results. For these reasons, the Commission finds that Petitioner was appropriately kept off work or on light duty work restrictions that Respondent could not accommodate during the claimed TTD periods. Thus, the Commission awards additional TTD benefits after the second accident beginning on June 15, 2017 through April 25, 2019.

With respect to Petitioner's claim of dependency, the Commission finds that Petitioner has established by a preponderance of credible evidence that he had three dependents on the accident dates. Respondent argues that Petitioner only had one dependent on the accident dates, his one biological child. Petitioner argues that his two stepchildren were also dependent upon him, and therefore, he had three dependents on the accident dates.

Section 8(b)2 of the Act addresses permanent partial disability rates. 820 ILCS 305/8(b)2 (West 2016). Moreover, "[a]s used in this Section the term 'child' means a child of

the employee including any child legally adopted before the accident or whom at the time of the accident the employee was under legal obligation to support or to whom the employee stood in loco parentis, and who at the time of the accident was under 18 years of age and not emancipated. The term 'children' means the plural of 'child'." 820 ILCS 305/8(b)3 (West 2016).

The questions of dependency, and the extent thereof, are questions of fact for the Commission and such determinations will not be disturbed unless they are against the manifest weight of the evidence. *Chicago, Wilmington & Franklin Coal Co. v. Industrial Comm'n*, 345 Ill. 78, 80-81 (1931). "The test to be applied in determining the existence of dependency is whether the contributions of the deceased were relied upon by his dependents for their means of living as determined by their station in life, or whether the dependents were to a substantial degree supported by the employee at the time of the latter's death." *Id.* at 81.

Petitioner testified that he had three children under 18 years old, including one biological child and two stepchildren. Although two of the children were his through marriage, Petitioner established that his stepchildren were dependent upon him. The record establishes that the biological fathers of the stepchildren were not dually responsible for their support, as one had passed away and the other was incarcerated. Petitioner gave uncontroverted testimony that he was the full-time father of his stepchildren and that they lived with him except for a period after his family's eviction. Even when the family briefly split up due to the eviction, all three children remained together with his wife. Petitioner also claimed all three children on his taxes, further establishing that his stepchildren were financially dependent upon him.

In consideration of these facts, the Commission modifies the Decisions of the Arbitrator to find that Petitioner had three dependent children on the accident dates.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator dated August 29, 2019 are modified as stated herein. The Commission otherwise affirms and adopts the Decisions of the Arbitrator.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of $319.00 per week from June 7, 2017 through June 12, 2017 and June 15, 2017 through April 25, 2019, which represents a period of 98 weeks, in accordance with §8(b) of the Act.

IT IS FURTHER FOUND that Petitioner had three dependents on his accident dates of June 1, 2017 and June 14, 2017.

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

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

IT IS FURTHER ORDERED 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 $35,000.00. 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: SEP 1 8 2020

Barbara N. Flores

DLS
O- 7/23/20
46

Marc Parker

DISSENTING IN PART, CONCURRING IN PART

I concur with the Decision of the majority on all issues except for the duration of temporary total disability benefits and the number of Petitioner's dependents. I would have instead found that Petitioner failed to prove his ongoing entitlement to temporary total disability benefits after the date of his functional capacity evaluation on March 26, 2018. The functional capacity evaluation placed both Petitioner's capabilities and his job for Respondent at the heavy physical demand level. The evaluator further indicated that Petitioner gave an inconsistent performance and could have performed at higher levels than he was willing to during the testing. The record establishes that this functional capacity evaluation represents a valid determination of Petitioner's capabilities, as even Dr. Kornblatt, the Section 12 examiner, opined that Petitioner's consistency of effort at the testing was high and acceptable. Because the functional capacity evaluation established that Petitioner met the same heavy physical demand level of his job, his temporary total disability benefits should be terminated as of March 26, 2018.

As to the issue of dependents, I would have affirmed the Arbitrator's finding that Petitioner had one dependent at the time of his work accidents, as Petitioner failed to prove by a preponderance of the evidence that his two stepchildren were also his dependents. Although Petitioner lived with his wife's two children and claimed them on his taxes, there was no evidence in the record as to who specifically paid for the stepchildren's expenses, whether Petitioner filed his tax returns jointly with his wife, or whether the stepchildren were financially dependent upon Petitioner for their daily needs. As Petitioner never formally adopted his stepchildren, such evidence would be critical in determining whether his stepchildren were truly dependent upon him. Due to the lack of corroborating evidence establishing the stepchildren's financial dependence on Petitioner, I would have found that Petitioner only proved that he had one dependent, his biological child, on the accident dates.

In all other respects apart from those herein stated, I concur with the Decision of the majority.

DLS/met
46

Deborah L. Simpson

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

20 IWCC0538

JOHNS, DWIGHT L
Employee/Petitioner

Case# **17WC021116**

17WC021117

KOCH FOODS INC
Employer/Respondent

On 8/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JOEL METAJ
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

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

20IWCC0538

20 IWCC0538

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

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

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

DWIGHT L. JOHNS
Employee/Petitioner

Case # **17** WC **21116**

v.

Consolidated cases: **17 WC 21 117**

KOCH FOODS, 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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **April 25, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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: **Number of dependent children**

FINDINGS

On the date of accident, **June 1, 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 $**Unknown**; the average weekly wage was $**455.39**.

On the date of accident, Petitioner was **40** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of $**17,774.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**17,774.16**.

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 6/1/17. The Arbitrator further finds that the Petitioner's lumbar spine condition of ill-being was causally related to the 6/1/17 accident, but currently is due to the 6/14/17 accident which is the subject of companion case 17 WC 21117. The Arbitrator further finds that while a cervical strain was also causally related to the 6/1/17 accident, the causal relationship of this condition ended prior to the hearing date because the condition resolved to the point of maximum medical improvement prior to the hearing date.

The Arbitrator finds that the Petitioner had one dependent under the age of 18 at the time of the 6/14/17 accident.

Respondent shall pay Petitioner temporary total disability benefits of $303.59 per week for 6/7 weeks, commencing June 7, 2017 through June 12, 2017, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for any portion of the $17,774.16 credit for temporary total disability benefits that have been paid which are applicable to this period versus what is applicable to the post-June 14, 2017 period which is the subject of case 17 WC 21117.

Respondent shall pay reasonable and necessary medical services of Physicians Immediate Care, as provided in Sections 8(a) and 8.2 of the Act.

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

The Petitioner has failed to prove entitlement to penalties and attorney fees pursuant to Sections 16, 19(k) or 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

August 21, 2019
Date

AUG 29 2019

STATEMENT OF FACTS

Petitioner testified he had initially worked for Respondent from June through October 2016 before returning to school for his associates degree, before returning to work for Respondent in May 2017 as a machine operator. In that position he testified he ran two constantly running conveyor machines that sealed chicken products in plastic. He was hired to work 48 hours per week over 6 days and sometimes worked a mandatory 7th day as well. Overtime was mandatory when a production job was running and had to be completed before he could leave.

Petitioner testified he was married with three children under age 18 at the time of accident: Leah Johns (d/o/b - 12/1/00), Kavont Smith (12/10/00) and Shatrice McNeal (10/8/06). Leah is his biological child while the other two are his wife's children. Petitioner testified he claims all three as dependents on his taxes. He did not graduate high school but has his GED. He is a certified production technician with certifications in safety, quality control, maintenance, manufacturing and precision measurement.

On 6/1/17, Petitioner testified he was lifting totes containing chicken product and hurt his back. He reported it to his boss and was sent by Respondent to Physician's Immediate Care (PIC). He testified the totes contained 70 or more pounds of chicken, which he had to physically bend to pick up and lift them onto his shoulder, cross over a conveyor belt and take them upstairs. That day, he indicated the machine wasn't working properly so he had to move about 8 totes. He testified he also hurt his upper back in this incident, but the low back was worse.

The initial 6/1/17 report from PIC notes complaints of back pain when he was "lifting 70-pound bag of chicken and throwing back over shoulder." A separate portion of the note indicates he was repeatedly lifting approximate 70-pound bags of chicken that day and hurt his right upper/lower back. Petitioner denied any prior low back injuries and denied any current leg symptoms. Cervical x-ray was normal with possible muscle spasm

while lumbar x-ray reflected a loss of disc space height at L4/5 with spondylolisthesis. The diagnosis was cervical and lumbar sprains and pain medication was prescribed along with light duty restrictions (20 pounds with no prolonged bending or twisting). Petitioner testified the Respondent was able to accommodate his work restrictions and he was able to perform the assigned work. He returned the next day, reporting he felt worse, and was prescribed prednisone, Robaxin and more significant work restrictions. On 6/7/17, Petitioner reported he felt better after the weekend off work but when he had to stand for 8 hours when he returned and got worse. He continued to deny radicular symptoms and he was restricted to seated duty. On 6/12/17, the PIC report indicates Petitioner improved and had no pain. It was determined he had reached maximum medical improvement (MMI) and he was released to return to full duty work. (Px2).

On 6/14/17, Petitioner testified: "I messed myself up pretty bad" when he was again lifting totes. On about the fifth one, he indicated he had it on his shoulder, went to cross over the conveyor belt and "my back just went totally messed up." He testified when he crossed his right leg over, his left leg got lacerated badly from the metal, he fell forward and smacked his hands on the ground. His right ankle/foot swelled and he couldn't walk on it. Petitioner's counsel asked: "Would you say that the pain in the lower back is what caused you to fall over?" Petitioner responded: "Yeah, that's what happened. When I had it, my back just went like - - I couldn't even control it. My weight was like I couldn't stop it." Petitioner reported the incident to supervisor Gabriel, whom he said tried to get him to stay at work to keep the machines running. He testified that the left leg laceration wound opened up the next day and he was again sent to PIC.

The 6/15/17 report from PIC notes Petitioner returned to full duty on Monday and on Tuesday was lifting chicken and felt pain in his low back. A separate statement in the note indicates he was lifting a 70-pound crate on Tuesday and developed recurrent back pain that night. He denied any leg symptoms. He was provided with a back brace, prescribed Flexeril and Provil and was again given light duty restrictions. A lumbar MRI was also ordered. (Px2).

On 6/21/17, the PIC report states that Petitioner was carrying chicken on 6/14/17, walked over a conveyor, twisted his right foot and lacerated his left shin. He complained of left leg and right ankle swelling. The report references the laceration as superficial in depth and approximately 5 cm length. Right ankle x-ray was normal except for an old medial malleolus avulsion fracture and left shin x-rays were normal. Petitioner was advised to return to work the next day, but then on 6/22/17 was restricted to seated duty only. (Px2).

The 6/22/17 lumbar MRI report indicated the following findings: 1) multilevel spondylosis of facet arthrosis and ligamentum flavum hypertrophy, 2) an L4/5 annular bulge with superimposed central disc herniation causing moderate foraminal and central canal stenosis, and 3) annular bulges at L3/4 and L5/S1. (Px2; Px11). On 6/27/17, Petitioner reported persistent back pain, improvement in the left shin and weakness in the right ankle. Physical therapy was prescribed for the back and he was again limited to seated duty. (Px2). Petitioner testified that Respondent could not accommodate the restriction and he was advised to follow up with them after each medical appointment.

On 7/11/17, Petitioner reported that therapy was helping and his right ankle swelling and pain were improved. He was advised to continue therapy and the same work restrictions. While this was Petitioner's last examination at PIC, therapy continued through 7/14/17. At that time, Petitioner reported significant ongoing low back pain and concern about increased right ankle pain with prolonged walking. (Px2).

Petitioner sought a second opinion with pain management physician, Dr. Glaser, on 7/14/17. Dr. Glaser's report states Petitioner reported upper back and right shoulder pain as well as bilateral low back pain into the buttocks and leg. He reported that he initially had lifted a tote on 6/1/17 then lifted a 75-pound tote after being released

back to work and his back pain was so severe his right leg collapsed. With regard to his low back pain, the report indicates the precipitating event was a motor vehicle accident. Petitioner reported his pain as 10 out of 10 (10/10) and also reported having 5 children. Dr. Glaser prescribed bilateral facet joint injections at L4/5 and L5/S1 as well as Tramadol and 6 weeks of therapy. Petitioner was continued on regular duty. (Px3). The initial 7/21/17 report from Athletico PT notes diagnoses of acute midline low back pain without sciatica, lateral right ankle pain/sprain. Petitioner reported instability and numbness in the right ankle. He denied radicular symptoms but noted an intermittent burning sensation near his tailbone with lifting his legs while lying down or prolonged standing and sitting. (Px3; Px5).

On 8/1/17, Dr. Glaser performed the prescribed facet injections and also prescribed a GameReady cold/compression therapy device. Billing for this device appears to be $6,825.00. On 8/17/17, Petitioner reported his bilateral buttock and leg pain had increased since the injections, but also that he'd had 80% improvement for a week. He reported his upper back and right shoulder pain had increased as well. The pain was noted to be 10/10. Medial nerve branch block injections were prescribed from L3 to L5. Regular duty was continued. (Px3; Px5).

On 8/31/17, Petitioner reported the same ongoing symptoms and that his pain would go from 5/10 to 10/10 depending on activities. Dr. Glaser diagnosed lumbar facet syndrome without myelopathy as well as cervical radiculopathy and facet syndrome without myelopathy, and ankle pain. It appears that in addition to bilateral L3 to L5 medial branch blocks, Dr. Glaser prescribed Tramadol, Mobic, Cyclobenzaprine and a "drug preparation kit", i.e. MetroTopicals A2. The Arbitrator notes the doctor's office charged $2,846.88 for this latter topical alone. Petitioner was advised to return to seated work only on 9/1/17. (Px3; Px5; Px10).

Petitioner was evaluated at the request of the Respondent on 9/11/17 by orthopedic surgeon Dr. Kornblatt. Petitioner testified he was in the office with the doctor for only about two minutes and: "He just did some of this and this and kicked me out of the room." The doctor's report indicates Petitioner reported that on 6/1/17 he "noted increasing low back pain while performing his duties including filling 75-pound totes with chicken" but continued to work, then on 6/15/17 noted increasing low back pain while lifting at work and that he had not worked since that time. The leg laceration was also noted. Petitioner reported symptoms including constant low back pain radiating up his back into the bilateral buttocks and right ankle/foot pain with numbness and tingling. His symptoms would increase in both locations with standing and walking. Dr. Kornblatt indicated the MRI showed L4/5 disc desiccation with slight disk space narrowing and a moderate central right greater than left disc herniation with slight extrusion behind the superior body of L5 and no significant facet arthropathy. Following examination, Dr. Kornblatt diagnosed a central right L4/5 disc herniation with right lumbar radiculopathy and a healing left leg laceration. He opined Petitioner's prognosis was excellent as there was no clinical presentation which would indicate a need for surgery. He opined that Petitioner's lumbar complaints were related to his 7/15/17 work duties and that his treatment to date had been reasonable other than the facet injections "as the patient has never warranted a facet injection as he does not present with facet abnormalities or facet-mediated pain." He further opined that while Petitioner had reached MMI as to the left leg laceration, he had not yet reached MMI as to the low back. He indicated that following a recommended epidural injection and 2 to 3 weeks of work conditioning, Petitioner should undergo a functional capacity evaluation (FCE) and return to work. (Rx1).

There is an undated note in the records of Dr. Glaser where he responds to the report of Dr. Kornblatt. First, he indicated Dr. Kornblatt is an orthopedic surgeon that does not specialize in interventional pain management, and so his opinions need to be "evaluated in this light and compared to treatment recommendations of a board-certified Interventional Pain Management specialist." He disagreed that Petitioner's prognosis was excellent, indicating "Not needing surgery does not equal a good prognosis." He did agree that epidurals were appropriate,

but not that Petitioner would be at MMI following them. He opined Petitioner's ability to go to work conditioning would depend on his response to the injections. (Px3).

On 9/28/17, Dr. Glaser again noted no change in Petitioner's condition, again charged $2,846.88 for MetroTopicals A2, and again prescribed medial branch blocks. Sedentary duty was continued. (Px5; Px10).

On 10/11/17, Athletico issued a discharge report after 16 visits, noting Petitioner remained "in progress" with his long-term goals. It appears that the last actual therapy session took place on 8/29/17, as that was visit 16. Petitioner reported most of his symptoms were in the morning and that his low back eventually loosens up after moving around. On 8/22/17, Petitioner noted a spike in pain and his ability to move the prior Sunday after spending Saturday at the Air & Water Show and a friend's barbecue. (Px9).

On 10/26/17, Dr. Glaser's report states Petitioner's pain had increased (10/10) since 9/28/17 and that medial branch blocks still had not been approved. Again, Dr. Glaser prescribed MetroTopicals A2 ($2,846.88). (Px10). A virtually identical report was issued by nurse practitioner Cheryl Bruno. Then, there are notes from either the same date, 10/26/17, or 11/2/17 which appear to change the recommendation to L4/5 and L5/S1 epidurals. A separate note from 10/23/17 also prescribes the epidurals. A note holds Petitioner to sedentary duty. (Px3; Px5).

Dr. Glaser performed L4/5 and L5/S1 epidurals on 11/21/17. (Px3). On that same date, Petitioner signed a leasing agreement for a GameReady cold compression therapy device for two weeks. The Arbitrator did not note a prescription for this device in the 10/26/17 note of Dr. Glaser or NP Bruno, but there is a 11/21/17 note with an Instant Care Equipment Leasing that was signed by Dr. Glaser. (Px3).

Petitioner testified the epidural injections provided only temporary relief for two to three weeks. At this point, he testified he had pain in his low back and upper buttocks and into his legs. He said that physical therapy was helping.

On 12/28/17, Dr. Glaser's report indicates both that Petitioner reported his pain stayed the same following 11/21/17 lumbar epidural injections, and in the same paragraph states he had 40% relief and was pleased. Tramadol, Mobic and Cyclobenzaprine were again prescribed, along with MetroTopicals A2 ($2,846.88), as well as additional epidural. Sedentary duty was continued, and Petitioner was referred to a neurosurgeon. (Px3; Px5; Px10). Dr. Glaser's records also contain a 1/29/18 note referring Petitioner to a neurosurgeon. (Px5).

Petitioner initially saw surgeon Dr. Salehi on 3/1/18, reporting a 6/1/17 initial injury when he felt low back pain lifting a heavy tote but was told to continue working. He reported a 6/14/17 incident where he was carrying a tote on his shoulder and stepping over a conveyor when he got a sharp pain that caused him to fall over, rolling his right ankle and cutting his left leg. He complained of tolerable low back pain at rest that was severe with activity. He denied any radiating pain or numbness. Neither therapy nor injections provided lasting relief. He denied any prior back pain. He noted mild ankle pain at times. There was no indication of abnormal findings on physical or neurologic examination. Dr. Salehi's review of the lumbar MRI films reflected single level degenerative disc disease at L4/5 without any loss of disc height, mild bilateral facet arthropathy and a disc herniation causing moderate bilateral recess stenosis. Dr. Salehi opined Petitioner had low back pain related to the work accident secondary to aggravation of disc disease/annular tear at L4/5. He opined Petitioner was a single level lumbar fusion candidate if his symptoms were intolerable but that he indicated his symptoms were manageable at that point. To prevent further aggravation Dr. Salehi recommended a functional capacity evaluation (FCE) after which permanent restrictions would be determined. In the meantime, he was held off work. (Px7).

Petitioner testified he was initially afraid to have surgery and wanted to continue conservative treatment, so he underwent the FCE. The 3/26/18 FCE noted an 86% consistency of effort and an 88% quality of effort but a 46% reliability of pain. The report then notes an inconsistent performance/unacceptable effort, and that the Petitioner's perceived limitations were markedly affecting symptom expression, consistency of effort, reliability of pain and quality of effort. It was determined that Petitioner demonstrated the ability to perform at the heavy physical demand level and could have performed "at markedly higher levels than willing during musculoskeletal and functional testing." While he gave good effort, his self-reported pain levels were not consistent with his pain behaviors and movement patterns observed during testing. This was based in part on higher pain ratings than would be expected given his heart rate and functional movement patterns. His pain was often self-rated at 10/10. It was noted Petitioner's main complaint was in his central lower back, and that his ankle was fine, and his neck was "just a little stressed." Waddell testing was negative. (Px9). He testified he was "pushed to the limit" during testing and had to go to the Roseland Community Hospital ER afterwards with severe pain.

On 4/5/18, Petitioner returned to Dr. Glaser. He reported his pain had increased since the December visit, that he had been to the ER twice since then and that he had decided to proceed with surgery. He also reported his pain was severely exacerbated by the FCE and he received Valium at the ER afterwards. Epidurals were still noted to be prescribed at L4/5 and L5/S1, and Mobic, Cyclobenzaprine and Norco were prescribed along with, again, MetroTopical A2 ($2,846). Dr. Glaser indicated Petitioner was to be on sedentary duty but also that he should be off work and could return to sedentary duty on 9/29/17. (Px3; Px5; Px10).

Epidurals were performed on 4/17/18 at L4/5 and L5/S1. (Px3; Px5). On 5/15/18, Petitioner reported his back pain remained the same but was less frequent. The report stated Petitioner had 90% relief of his radicular pain. Dr. Glaser then prescribed bilateral facet joint injections as well as refilled prescriptions, including, once again, MetroTopical A2. (Px10).

Following repeat L4/5 and L5/S1 epidural injections on 4/17/18, Dr. Glaser again ordered a GameReady device for two weeks. On 5/15/18, Glaser indicated Petitioner reported no change in his back pain following epidurals but 90% improvement in radicular pain. Bilateral facet injections were prescribed. He was held to sedentary duty. (Px3; Px5).

Petitioner returned to Dr. Salehi on 5/24/18 reporting typical back pain at a 5 out of 10 (5/10) level that would go up to 9/10, noting a recent visit to the ER due to pain. He had the FCE and indicated he now had intolerable pain and wanted to undergo surgery. He had no radicular symptoms. Dr. Salehi continued to recommend surgery, provided Petitioner quit smoking due to the risk of pseudarthrosis. Dr. Salehi indicated that approximately 7 to 9 weeks post-surgery Petitioner would be able to return to sedentary/light duty, and approximately 7 months post-surgery would be able to return to work per a valid FCE. In the meantime, he continued sedentary restrictions. (Px3; Px7).

Petitioner acknowledged at hearing that he remains a smoker but testified he has cut back on it in preparation for the surgery. Petitioner testified he had continued to receive benefits and TTD until approximately 5/9/18, and he hasn't received anything since.

On 6/11/18, Respondent obtained a utilization review (UR) with regard to the medical necessity of the surgery recommended by Dr. Salehi. Neurosurgeon Dr. Richardson certified the procedure as medically necessary and appropriate based on ODG guidelines, noting Petitioner had an extruded L4 disc and progressive pain despite conservative measures with minimal reduction of symptoms, and an indication in Salehi's 5/24/18 report that Petitioner's pain was intolerable. The Arbitrator notes the report was actually also signed off on by orthopedic surgeon Dr. Milos. (Px8).

On 7/11/18, Dr. Glaser's report indicates Petitioner's back pain had increased. It was noted the Petitioner had been in jail: "He has exacerbated his lower back pain. He also injured his right toe jumping off of a bed." His upper back pain had also increased. Dr. Glaser prescribed physical therapy and MetroTopicals N3 ($2,958.52). On 8/2/18, Petitioner again reported increased pain since 7/11/18. He also reported an increase in right foot pain. Bilateral facet injections, Mobic, Cyclobenzaprine and MetroTopicals N3 ($2,958.52) were prescribed. It appears a back brace was also ordered, and physical therapy prescribed. Sedentary duty was continued. (Px3; Px5; Px10).

Petitioner was again evaluated by Dr. Kornblatt on 8/6/18. He noted Petitioner's updated treatment history and current complaints that included constant central low back pain and chronic right foot ache but with no radiating leg pain or numbness. Petitioner denied a neck injury but has noted upper back pain between the shoulder blades that had recently improved. Examination reflected less pain behavior findings and Dr. Kornblatt diagnosed lumbar degenerative disc disease, mechanical axial low back pain and cervicothoracic myofascial pain. He opined that "subjective complaints are supported by a lack of abnormal objective findings on physical examination as well as known L4/5 degenerative disc disease." He further opined that Petitioner's work injuries resulted in a central L4/5 disc herniation with radiculitis/radiculopathy, that the radicular symptoms had resolved and that the current lumbar and cervical conditions were unrelated to the work accident but rather to preexisting L4/5 degenerative disc disease as well as longevity of inactivity, deconditioned state and chronic pain dysfunction. He believed the accident caused a temporary aggravation of the preexisting condition at L4/5, and that it did not result in any cervical or thoracic injury. He opined that any treatment after the FCE would not be related to the work accident. The only treatment recommended for the low back was to be aerobically active and fit with a home exercise program and discontinuation of narcotic medication. He advised that Petitioner be restricted to medium physical demand level, stating "These restrictions are causally related to the work accident." As he believed Petitioner had reached MMI as to anything related to the accident, Dr. Kornblatt determined Petitioner had sustained a 6% whole person impairment pursuant to AMA guidelines. (Rx1).

Following this report of Kornblatt, Dr. Glaser again issued a response narrative which again is undated. He questions Dr. Kornblatt's diagnosis of lumbar degenerative disc disease as "not an adequate diagnosis." He also disputed the diagnosis of myofascial pain as something that by definition resolves with time, and that if symptoms do not so resolve "either a joint or a nerve is involved as injuries to those structures are the most common causes of chronic pain", and that Petitioner is suffering from pain from injured intervertebral joints. Given Petitioner was asymptomatic before the accidents, he opines that Petitioner's condition would not be related to preexisting degenerative disc disease. He goes on to state that there is no literature to support that a lack of objective findings on exam does not justify subjective complaints. He goes on to, twice, indicate that Dr. Kornblatt "should be ashamed."

Facet injections were performed on 8/21/18. (Px3; Px5). On 9/6/18, Dr. Glaser noted Petitioner's pain had decreased with injections 80% for about a week before the pain gradually returned. Mobic, Cyclobenzaprine and MetroTopicals N3 ($2,958.52) were prescribed along with repeat medial nerve branch blocks. Petitioner apparently also indicated 40% relief in his right foot. The work status note states: "Patient Not Working" with no indication of what his recommended work status was. (Px3; Px5; Px10).

Petitioner last saw Dr. Salehi on 9/18/18, testifying he still wanted to undergo surgery but was advised he couldn't return at that point because insurance wasn't authorizing the treatment. The doctor's report notes he stated he continued to have constant low back pain into the buttocks. He wasn't working and had been let go from his job. Dr. Salehi indicated he had mechanical back pain that was rendered permanently symptomatic by the accident and he continued to recommend surgery. He reviewed the report of Dr. Kornblatt and indicated

disagreement that the aggravation of Petitioner's condition was temporary since he had no prior symptoms and has had no resolution of symptoms, noting surgery had been previously approved and "it appears arbitrary" that it was now being denied. (Px7). Dr. Salehi issued a work note on 10/3/18 continuing Petitioner's restrictions on desk duty, noting he'd be re-evaluated on 11/7/18. (Px7). The Arbitrator notes there is a copy of this note in Px3 which has the date crossed out and has written in: "9/18/18 Corrected K.O." (Px3).

Medial branch blocks were performed on 10/2/18 at L2 to L5. (Px3; Px5). On 10/10/18, Dr. Glaser states Petitioner's low back pain decreased with the injections 45% while his upper back pain remained the same. Radiofrequency ablation from L2 to L5 was discussed. Petitioner reported pain relief by using ice. He was reporting 4/10 to 8/10 pain. Norco, Cyclobenzaprine and Mobic were refilled along with MetroTopicals N3 ($2,958.52). (Px10). Petitioner then saw Sharon Koys on 10/10/18, and she reported essentially the same information as Dr. Glaser had with a virtually identical report. (Px3; Px5).

At the last noted visit with Dr. Glaser on 11/13/18, Petitioner again reported increase back pain back up to 10/10 at its worst. MetroTopicals A2 was prescribed (2,846.88) this time. A note states "Patient is currently not working." (Px3; Px5; Px10).

Petitioner testified he has seen Dr. Glaser since that time but has not undergone any further injections since October 2018. He has prescribed a radiofrequency ablation (RFA) procedure, however Petitioner indicates he does not want further invasive treatments other than surgery so he can get back to work. Petitioner testified he is on public aid and cannot afford to return for treatment or to obtain medications, though he recently received a medical card and planned to obtain prescriptions through that.

Neurosurgeon Dr. Salehi testified via deposition on 11/13/18. He testified that Petitioner's neurologic exam was normal but there was mild loss of range of motion on physical exam. Given the lack of improvement with conservative treatment, Dr. Salehi's prognosis was likely ongoing back pain and he believed Petitioner had undergone adequate conservative treatment by the 3/1/18 visit. He advised him he was a one level fusion surgery candidate if his symptoms were bad enough, but at that time Petitioner opted for the FCE. Dr. Salehi believed Petitioner's mechanical back pain was due to an annular tear at L4/5. He noted at this visit Petitioner's "main" complaint was not his lower extremities. He testified that the fusion recommendation is dependent on Petitioner's pain level. He opined that while Petitioner may have had preexisting degenerative disc disease, he felt the accident aggravated the condition, noting the majority of the time this condition is asymptomatic. He testified the Petitioner's mechanism of injury supported causation, as he did not have prior symptoms and the symptoms correlated with the MRI findings. Petitioner indicated he had been let go from work at that time, but Dr. Salehi indicated he would have been at least capable of sedentary duty at that point. (Px6).

Dr. Salehi testified that when he saw Petitioner again on 5/24/18 it appeared he wanted to proceed with surgery. He had essentially the same complaints and Dr. Salehi advised he would need to take urine tests to show he quit smoking before he could undergo fusion given the risk of pseudarthrosis, advising that he could perform sedentary duty in the meantime and should undergo an FCE. Dr. Salehi reviewed Petitioner's FCE report and agreed the testing indicated he could do much more than sedentary duty, but he testified that the Petitioner nevertheless remained a surgical candidate, noting that heavier activities would be more likely to aggravate his symptoms. Dr. Salehi noted no other objective findings outside of the L4/5 annular tear to explain Petitioner's symptoms. At Petitioner's 9/18/18 visit, Dr. Salehi reviewed the report of Dr. Kornblatt. He noted Kornblatt agreed Petitioner had an injury and had a herniated L4/5 disc, and believed Dr. Kornblatt's determination that the aggravation was temporary didn't make sense without any factual basis, given Petitioner's complaints remained ongoing. He opined that if a patient's symptoms last beyond three months, an aggravation would no longer be considered temporary. Dr. Salehi further testified that 80 to 90 percent of patients with a herniated

disc respond to conservative care, consisting of time, therapy, injections and medication. If six months pass without improvement, surgery becomes an option. Dr. Salehi could not say why he issued the 10/3/18 note continuing Petitioner's restrictions without a visit. He continues to believe Petitioner should be limited to sedentary duty to avoid risk of reaggravation. (Px6).

Cross-examined, Dr. Salehi agreed he was not aware of Petitioner's lifting requirements at work. He also agreed that the surgical choice is based on the Petitioner's determination of whether his subjective symptoms are tolerable, and that on 3/1/18 he indicated his symptoms were tolerable. Asked about the FCE findings indicating behavioral factors, Dr. Salehi testified that Petitioner's complaints were consistent from visit to visit and the degree of pain, but acknowledged the complaints were subjective and Petitioner could exaggerate them. He found loss of range of motion on exam but acknowledged this also involved a subjective component. At the initial visit, the Petitioner hadn't complained of pain with lumbar palpation. He agreed with Dr. Kornblatt that Petitioner's neurologic exam was normal regarding radiculopathy, but he disagreed with Kornblatt's chronic pain dysfunction diagnosis, and indicated if his opinion was based on pre-accident records which reflected symptoms, Dr. Salehi would like to review them. Dr. Salehi testified that if the symptoms are mild, you don't want to offer surgery, but that a patient becomes a surgical candidate when they reach the point they cannot deal with it. On redirect exam, he testified that the Petitioner was capable of lifting something 70 or even 100 pounds, but that this could aggravate his condition and increase his pain. He testified that both he and Dr. Kornblatt agree that Petitioner's accident caused the L4/5 disc herniation. Dr. Salehi opined that the herniation came from the annular tear, and that its the annular tear that was aggravated by the accident and is what's driving Petitioner's pain. (Px6).

UR neurosurgeon Dr. Richardson was deposed on 4/5/19. He reiterated the opinion contained in his report. He noted Petitioner had an obvious damaged disc per MRI with partial obstruction of his central canal and was on the way to having significant spinal stenosis as well as bilateral nerve root canal stenosis, "so there wasn't much question. The poor man needed something done." He noted he reviewed only the MRI report, not the films. He testified Petitioner's symptoms are consistent with the MRI and physical exam findings. He'd had symptoms for a year or so without lasting improvement from multiple forms of conservative treatment. He testified that he practices in Louisiana and uses their workers' compensation guidelines, and he appeared unfamiliar with ODG guidelines on both direct and cross exam. He testified he has performed the recommended procedure himself. He testified the surgery recommended by Dr. Salehi is not an emergency, but that older literature indicates that if a nerve is compressed for over a year you could end up with permanent nerve damage. He was not certain why Dr. Milos also signed off on his report, or if Illinois required an Illinois doctor to sign off on a UR. (Px8).

On cross-examination by Respondent's counsel, Dr. Richardson testified he was not aware that the ODG guidelines referenced in his report indicate fusion surgery is not recommended for degenerative disc disease and disk herniation, noting if that is what the guidelines actually indicate: "That's absurd that ruptured discs don't require surgery." He testified that most people with chronic pain tend to overestimate their pain. Dr. Richardson testified that he reviewed the FCE and the post-FCE report of Dr. Kornblatt, acknowledging the FCE indicated Petitioner complained of significantly higher pain levels than would be expected, but testified: "I don't know who can tell you what to expect with pain." People with similar conditions can have varying levels of pain. While Dr. Kornblatt did note no radiculopathy or abnormal objective findings, he did note a loss of lumbar lordosis which is seen in people with organic back pain and is something that can't be faked. Dr. Richardson agreed there were no findings of radiculopathy with Petitioner but testified that someone with spinal stenosis due to disc rupture may not have a positive straight leg raise test. Neither the FCE nor Dr. Kornblatt's opinions changed the fact that the MRI films were abnormal. While he didn't review the MRI films, Dr. Richardson testified he did see a very small thumbnail copy of film and evidence of significant disc and/or bone can be seen in the spinal canal. While he agreed that a person who aggravates a spine condition, returns to an asymptomatic

baseline and then has an altercation can re-aggravate the condition, Dr. Richardson testified that the Petitioner has not been asymptomatic since the work accident in this case. Dr. Richardson questioned Respondent's counsel's interpretation of "necessary" surgery, in that he agreed the Petitioner's life does not depend on the surgery, but that it would be necessary to be comfortable and to function and get back to work on a pain-free basis. (Px8).

On redirect, Dr. Richardson testified that if the Petitioner wants to be pain free and to return to work, he should have the surgery, which was recommended for back pain, not radiculopathy. He noted there are patients like Petitioner where the MRI shows a damaged disc but who have severe pain without a disc rupture and the pain is relieved by fusion or removal of the disc. People have various pain levels, and Dr. Richardson testified there are multiple reasons for complaining that may not be specific to back pain, such as using pain to manipulate their families, to gain sympathy, etc., and they may complain of 10 out of 10 pain which means they should be on a gurney to the hospital. He testified that after he answered the questions asked of him on the UR, the company that hired him added in other information and made the final edits. He testified he did not sign off on the report itself, but signed off on a questionnaire he completed. (Px8).

Orthopedic surgeon Dr. Kornblatt testified on 10/22/18. Regarding his 9/11/17 exam of Petitioner, he stated that he found Petitioner's complaints credible despite a normal physical exam. He reviewed both the lumbar MRI report and films. His diagnoses of central/right L4/5 disc herniation with right lumbar radiculopathy and the healing left leg laceration were causally related to the 6/1/17 and 6/15/17 work accidents. With regard to his 8/6/18 exam, Dr. Kornblatt testified he again found Petitioner's ongoing symptomatic complaints to be credible. He testified that he indicated that Petitioner was functioning at the medium physical demand level at that time and acknowledged the FCE evaluator indicated inconsistencies regarding the viability of Petitioner's pain and could function at the heavy demand level pursuant to the FCE. Dr. Kornblatt further testified that when he saw the Petitioner in August 2018, he believed the work aggravation of lumbar degenerative disc disease had resolved and the ongoing degenerative condition was not related to the accident. He noted treatment after the FCE would not be causally related to a work accident, and that the pre-FCE facet injections were not warranted. (Rx1).

Dr. Kornblatt opined that Petitioner was not a surgical candidate as he didn't present with neurologic complaints, his examination was objectively normal and he had one known level of degenerative disc disease "which in my opinion, is not an indication for any type of surgery." He agreed that such disease could be exacerbated by a physical altercation, noting it could also be exacerbated with no activity whatsoever. He believed Petitioner could have returned to work when he initially saw him, testifying: "I noted medium level type activity initially, but what I stated here certainly was not permanent." He believed he could lift 50-pound occasionally and 25 pounds frequently. In reviewing Petitioner's written job description, he noted the job duties fit within the restrictions he outlined. He opined Petitioner had reached MMI. Asked if this would still apply after he saw the Petitioner, the doctor testified that "it would be determined upon how he's doing." (Rx1).

On cross-examination, Dr. Kornblatt was asked what he would do, given his initial diagnosis, if Petitioner failed to subsequently respond to the therapy and epidurals he recommended, and he testified it would depend on the examination and MRI findings. Based on the MRI, "it would be highly unusual for him not to respond to conservative management" given the normal clinical exam, and "I think it's very hard to state that you're going to be aggressive with a patient whose exam is normal whether they have complaints or not." Whether the Petitioner's disc herniation had resorbed/resolved by the time of the 8/6/18 exam did not matter, what matters are the subjective complaints and exam findings. Had Petitioner presented with ongoing radicular complaints and findings he would have wanted to see an updated MRI. He testified that Petitioner had no such complaints or findings, and so repeat MRI was not needed because an ongoing presence of the disc would not warrant

surgery ("nobody in their right mind would do anything about it"). He did not believe Petitioner needed further treatment at that time, he would only have initially instituted restrictions due to Petitioner's deconditioning over time, but that these would be reduced within 6 to 8 weeks and eventually he most likely should be able to return to full activities. Dr. Kornblatt appeared to acknowledge he has performed fusion surgeries for patients with only a degenerative disc condition, but then indicated this was in cases of spinal fractures or instability. He would consider surgery for patients with radiculopathy to remove pressure from a nerve root. He didn't comment on whether he found pain behaviors as he had not been asked to do so, but indicated he saw no evidence of malingering with Petitioner. His opinion that Petitioner's preexisting condition was aggravated by the accident was based on the herniation and radiculopathy, but given the radiculopathy had dissipated, the temporary aggravation had resolved. He testified that other medical records indicating Petitioner continued to complain of radicular pain would probably not change his opinion. He could not comment on any current need for work restrictions since he hasn't seen Petitioner again. He testified that if Dr. Salehi thinks the Petitioner needs surgery he is wrong. He noted the FCE indicated Petitioner's consistency at 81%, and "that's pretty good", while noting that a lack of effort is a different story. (Rx1).

The Respondent obtained two URs in this case with Dr. Grattan. He testified that in coming to his conclusions, he used the Official Disability Guidelines (ODG). Dr. Grattan testified that he non-certified the initial cervical and lumbar (6/1/17 and 6/15/17) x-rays, the lumbar brace, the lumbar MRI, prescriptions for Robaxin, Prednisone, Flexeril and Provol, the bilateral facet injections, the sixteen session of therapy attended between 7/12/17 and 8/29/17, the Game Ready unit and the bilateral medial branch blocks. He also non-certified the Metrotopical A2 cream. He did certify per ODG six sessions of physical therapy, Naproxen, Keflex, Tramadol, Meloxicam, and the neurosurgical referral given on 9/12/17. He made his determinations based on the diagnosis he was provided with, back strain/ankle. The x-rays were non-certified based on there being no red flags or mechanism of injury that would be likely to cause a fracture, and there had been no conservative care performed at that point. Back braces are not used as first line treatment unless there is evidence of instability or spondylolisthesis. Lumbar MRI was also obtained prior to any conservative treatment and there were no neurologic symptoms. Robaxin, a muscle relaxer, was not certified because there was no documentation of muscle spasm on exam and Petitioner had not failed anti-inflammatory treatment. Prednisone is typically used for significant inflammatory conditions and Petitioner had no radicular symptoms. Provol is an herbal supplement that isn't in ODG and is not frequently used in common medical practice, so Dr. Grattan noted no explanation from the treater as to why this unusual supplement would be appropriate. On 8/1/17 there was no diagnosis or documentation of facet mediated pain to justify facet blocks, plus the current recommendation for such pain would be medial branch blocks. However, Dr. Grattan's testimony that medial branch blocks (9/28/17 and 10/26/17) were noncertified was difficult for the Arbitrator to understand other than Petitioner had undergone nonspecific prior injections that hadn't helped. The same reasoning applied to the 5/15/18 injections. While ODG does not address the GameReady unit, but Grattan testified that while advanced cold compression therapies do provide relief, they have never been shown to be more effective than a basic ice bag. As to Flexeril, he testified that the literature is sparse that muscle relaxants are helpful for chronic/subacute back pain and generally isn't used for longer than two weeks. The Metrotopical cream is not recommended for certification, as very few topicals have supporting studies, and where there are such studies it is typically for neuropathic pain. (Rx4).

On cross, Dr. Grattan testified that an Illinois physician signs off on his report, which is prepared based on his answers to questions. He was not asked to comment on the FCE or the neurosurgical referral. He agreed that x-ray are commonly performed at initial ER-type visits, and medications are often prescribed. A back brace can be beneficial, but in most studies isn't shown to work any better than a placebo. Whether a treatment can potentially be "beneficial" to a patient is not the same thing as determining if it meets the appropriate standard of care. He testified the MRI was not appropriate at the time it was prescribed, though it may have been later on.

Facet pain is determined by seeing if there is pain with facet loading, imaging showing facet arthritis or edema in the facet joints with an acute injury and lack of other potential sources of back pain, such as discogenic or radicular. Again, for this purpose, medial branch blocks would be the appropriate injections. If those work, the next step would be radiofrequency ablation (RFA). Facet joint injections are less accurate, as they have a greater volume of numbing medication and can impact other structures, so you can then overestimate facet involvement in the patient's pain. With topicals, again, in general studies show mild benefit at best versus placebo, and there are no randomized studies for the specific one used in this case. Dr. Gratton certified physical therapy from 7/3/17 to 7/16/17 but noncertified the therapy thereafter because the first 6 sessions provided no benefit and Petitioner was reporting 10/10 pain. He should have had some benefit in those first 6 sessions if it was going to provide relief. He also certified Naproxen, Keflex, Tramadol, Meloxicam and Norco. The neurosurgical referral was appropriate as Petitioner had already undergone conservative care without improvement. (Rx4).

Respondent also obtained a UR from pain management physician/anesthesiologist Dr. Hagle with regard to the reasonableness and necessity of the 4/17/18 injections, and he opined that they were not medically necessary per ODG, as they are appropriate for radiculopathy, not for stenosis or nonspecific low back pain, and he saw no documentation of radicular pain in the medical records consistent with nerve root compression as of the time the injection was prescribed on 4/5/18. MRI showed only mild foraminal narrowing. On cross, he agreed that an epidural can be both therapeutic and diagnostic, and if an injection is performed and provides significant symptomatic relief it is fair to say a pain generator has been identified. He agreed stenosis and/or a herniated disc can potentially cause nerve root impingement. He agreed that Dr. Glaser's 5/15/18 report stated that Petitioner had 90% relief of his radicular pain with the injection but no relief of axial back pain. He also agreed if prior medical records noted radicular complaints and signs of nerve compression on exam, a lumbar epidural would be a reasonable treatment. He agreed that he was not asked to provide a diagnosis in this case, or to make a determination of the reasonableness of the treatment based on the response to it. Dr. Hagle testified that pain from a facet joint would manifest primarily as axial low back pain, which could radiate to the buttocks and thigh, but should not go below the knee. (Rx6).

Petitioner testified he is not currently working but has contacted Respondent multiple times seeking to return and was turned down. He testified his previous TTD checks were often delayed, sometimes months at a time, and this put him behind on his bills and got him evicted from his residence. He moved in with his mother and sleeps on the couch, while his wife went to live with her mother. To his knowledge, he still has outstanding medical expenses. He testified he had no prior back, left leg or right foot injuries and was under no active treatment for his back prior to the accident date.

The written job description (Rx1) indicates a machine operator for Respondent must be able to physically stand for most of the working hours, must be exposed to cold temperatures, must operate a battery-operated pallet jack and must be able to physically lift 50 to 70 pounds.

On cross-examination, Petitioner agreed the original Applications for Adjustment of Claim he signed indicated he had only one dependent (Rx9). On redirect, he indicated he thought the question referred only to his biological child. He testified that after his benefits ended in May 2018 he ended up being evicted from his home in October 2015 and his wife and the kids then left the home and he went to go live with his mother. Petitioner testified that, of his stepchildren, one of the biological fathers died and the other has been in jail since the child was a one year old. He agreed he has not formally adopted the children but that they are a family – "I am married to their mother. That's our family."

As to the written job description for machine operator (Rx2), Petitioner disputed the document's statement that he had to lift up to 50 pounds, indicating it was not accurate and that the totes weighed 70 pounds. He testified

that his job orientation handbook from Respondent indicates that full gray totes should never weigh over 70 pounds, not 50 pounds. He initially could not recall if he told either Dr. Glaser or Dr. Salehi the weight of the totes he lifted at work, but then testified he said 70 pounds and did describe to them how he was injured at work. He did not provide them with a written job description.

On further cross-examination, Petitioner agreed he was aware his FCE indicated he could at least perform at the heavy work demand level and that it stated he provided inconsistent performance and unacceptable effort. He testified he did reapply for work with Respondent after the FCE, indicating he had reapplied twice in the six months prior to the hearing but he couldn't provide the exact dates he did so. He testified he has looked for work, "tried to find two, three", but no one would hire him due to his restrictions. He testified was ultimately terminated by Respondent, indicating he was supposed to come back to work but hadn't been cleared by his doctor to do as he remained restricted to seated duty. He denied being a union member, as he hadn't yet signed his papers to join after he returned to Respondent's employ after he had gone to school

As to Dr. Glaser's 7/11/18 report indicating he exacerbated his low back pain while in jail, Petitioner testified he told Glaser his back was hurting from sleeping on a hard bed with a thin mattress and he needed more medication. He agreed he told the doctor he hurt his right toe jumping off a bed. As to Dr. Kornblatt's second report indicating he was defending his wife when she was attacked, Petitioner denied being involved in an altercation in the January 2018 incident. Petitioner's testimony regarding this incident was not easy for the Arbitrator to understand, but he essentially indicated his wife was attacked and robbed, but that he was not involved. As to why he then told Kornblatt that he was defending his wife if he wasn't involved, Petitioner testified three women were jumping on his wife, two ran and a family member got the last one and his wife apart, and the three females lied and made a false police report to use the system against Petitioner as a weapon. He denied having any physical involvement in the incident.

Regarding the 11/13/18 report of Dr. Glaser indicating he had increased his activity, he testified that his treatment was no longer being authorized and he meant he was trying to perform the exercises he'd learned in physical therapy.

In the January 2018 altercation involving his wife, Petitioner reiterated that he was not physically involved. He testified that his wife didn't know the people who robbed her and after months passed, in May 2018, the police came to his house and arrested him, and his wife based on a false report of one of the female attackers. He agreed fusion surgery had been prescribed for him prior to January 2018. He indicated he was advised by his doctors to perform a home exercise program given formal therapy had been denied. He testified that Dr. Salehi advised him not to lift anything over 40 pounds. He agrees he is capable of working in some capacity, but Respondent hasn't taken him back despite him reapplying three times, and that he hadn't received a TTD check in about a year.

After reviewing the records of Dr. Salehi, it was agreed that the first time he recommended surgery was in March 2018, which was two months after the alleged January 2018 altercation, not before.

CONCLUSIONS OF LAW

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

Petitioner testified he was lifting totes containing chicken product and hurt his back. He reported it to his boss and was sent by Respondent to Physician's Immediate Care (PIC). He testified the totes contained 70 or more pounds of chicken, which he had to physically bend to pick up and lift them onto his shoulder. The initial 6/1/17 report from PIC notes complaints of back pain when he was "lifting 70-pound bag of chicken and throwing back over shoulder." A separate portion of the note indicates he was repeatedly lifting approximate 70-pound bags of chicken that day and hurt his right upper/lower back.

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 6/1/17. The Petitioner testified that on that date he lifted multiple large totes full of chicken product onto his shoulder, which he estimated weighed approximately 70 pounds each, when he developed low back and upper back/right shoulder pain. He testified that he reported this to his supervisor, and Respondent presented no evidence to rebut this. The contemporaneous medical records from PIC were consistent. While the initial report on 6/15/17 indicated he hurt his back lifting the chicken, a more detailed history was noted on 6/21/17. The Arbitrator also notes with interest that the Petitioner had just returned back to work following a 6/1/17 accident which involved his low back.

As the Petitioner testified the incident occurred while he was working at a time he was scheduled to work, the injury occurred in the course of his employment. As to the "arising out of" element, the question is whether the Petitioner's risk of injury was increased due to his job duties. The Petitioner testified that his job as a machine operator is to monitor the sealing machines and if they are not working properly, to collect the chicken into large totes, to lift them up and onto his shoulder and to then bring them upstairs in order to run them through the machines again. He testified that these totes weighed approximately 70 pounds when filled. While the Respondent's written job description indicated the totes would weigh up to 50 pounds, the Arbitrator finds that whether the totes weighed 50 or 70 pounds is not relevant to this issue, as in either case the lifting and carrying of these totes would constitute an increased risk of injury within the meaning of the Illinois Workers' Compensation Act. Because lifting the heavy totes was a risk incidental to his work for the Respondent, it arose out of his employment with Respondent.

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 work accidents of 6/1/17 and 6/14/17 were competent causes of the Petitioner's lumbar condition of ill-being, as it involved the lifting of heavy totes of chicken product onto his shoulder and walking with them over a conveyor belt and up a stairway. However, because the Petitioner had improved significantly and had been released to full work duties prior to the 6/14/17 accident, the Arbitrator finds that the causal relationship of the lumbar condition to the 6/1/17 work accident ended. The Arbitrator finds that the Petitioner's condition after 6/14/17 was causally related to the 6/14/17 accident that is the subject of consolidated case number 17 WC 21117.

With regard to the Petitioner's claimed cervical strain condition, the Arbitrator finds that this condition was initially causally related to the 6/1/17 work accident, but that the condition has since resolved and reached maximum medical improvement well prior to the 4/25/19 hearing date, and therefore is no longer causally related to the 6/1/17 accident.

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

The Arbitrator finds that the treatment rendered to Petitioner at PIC between 6/1/17 and 6/13/17 was reasonable and necessary, and Respondent is liable for same pursuant to Sections 8(a) and 8.2 of the Act. Respondent is entitled to credit for all payments made towards there awarded expenses prior to the hearing date and shall hold the Petitioner harmless with regard to same.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

All awards made with regard to this issue have been made in the companion case, 17 WC 21117.

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

The parties have essentially stipulated that the Petitioner is entitled to TTD benefits, assuming that the Petitioner has proven accident and causal connection, from 6/7/19 through 6/12/17.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

All awards made with regard to this issue have been made in the companion case, 17 WC 21117.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

It is unclear how much of the agreed credit of $17,774.16 for TTD previously paid by Respondent is applicable to the case at bar versus the companion case, 17 WC 21117, but the Respondent is entitled to credit towards the awarded TTD period for any portion of this total credit which is applicable to 6/7/17 through 6/12/17.

WITH RESPECT TO ISSUE (O), THE NUMBER OF DEPENDENT CHILDREN, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that he has more than one dependent under the age of 18. The only evidence of dependence that was provided by Petitioner is that he lives with his wife's two children, that their biological fathers were either deceased or incarcerated, and that he claims the children on his tax returns as dependents. This is simply not enough, in the Arbitrator's view, to find that the children are Petitioner's dependents under the Act.

No information was elicited as to who pays the expenses of the children. No information was elicited as to whether the tax returns are filed jointly with his wife or solely on behalf of Petitioner himself. No information was elicited on whether his wife works or whether it is solely her earnings that pay for the expenses of her children. The Petitioner has acknowledged that he has not adopted the children. While he provided an explanation after the fact, the Petitioner did not claim more than one dependent on his initially filed Applications for Adjustment. In order to claim these children as his dependents, the Petitioner needed to provide significantly more detailed information with regard to whether these children were financially dependent upon him, and he has failed to do so by the preponderance of the evidence. The Arbitrator finds that the Petitioner had one dependent under the age of 18 at the time of the 6/1/17 accident.

20IWCC0538

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

20IWCC0538

JOHNS, DWIGHT L
Employee/Petitioner

Case# **17WC021117**

17WC021116

KOCH FOODS INC
Employer/Respondent

On 8/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JONEL METAJ
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
BRIAN ROSENBLATT
200 N LASALLE ST SUITE 2700
CHIICAGO, IL 60601

20IWCC0538

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)/8(a)

DWIGHT L. JOHNS
Employee/Petitioner

Case # **17** WC **21117**

v.

Consolidated cases: **17 WC 21116**

KOCH FOODS, 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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **April 25, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] 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. [x] Other: **Number of dependent children**

FINDINGS

On the date of accident, **June 14, 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***, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $**Unknown**; the average weekly wage was $**442.08**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**17,774.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**17,774.16**.

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

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 6/14/17. The Arbitrator further finds that the Petitioner's lumbar spine condition of ill-being is causally related to the 6/14/17 accident. The Arbitrator further finds that while a right ankle injury and left leg laceration were also causally related to the 6/14/17 accident, the causal relationship of these conditions ended prior to the hearing date because both conditions resolved to the point of maximum medical improvement prior to the hearing date.

The Arbitrator finds that the Petitioner had one dependent under the age of 18 at the time of the 6/14/17 accident.

Respondent shall pay Petitioner temporary total disability benefits of $294.72 per week for 47 weeks, commencing June 15, 2017 through May 9, 2018, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $17,774.16 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services as indicated below in Issue J of Conclusions of Law, as provided in Sections 8(a) and 8.2 of the Act.

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

The Respondent shall authorize the L4/5 fusion surgery recommended by Dr. Salehi.

The Petitioner has failed to prove that he is entitled to penalties and attorney fees pursuant to Sections 16, 19(k) or 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

August 21, 2019
Date

AUG 29 2019

STATEMENT OF FACTS

Petitioner testified he had initially worked for Respondent from June through October 2016 before returning to school for his associates degree, before returning to work for Respondent in May 2017 as a machine operator. In that position he testified he ran two constantly running conveyor machines that sealed chicken products in plastic. He was hired to work 48 hours per week over 6 days and sometimes worked a mandatory 7th day as well. Overtime was mandatory when a production job was running and had to be completed before he could leave.

Petitioner testified he was married with three children under age 18 at the time of accident: Leah Johns (d/o/b - 12/1/00), Kavont Smith (12/10/00) and Shatrice McNeal (10/8/06). Leah is his biological child while the other two are his wife's children. Petitioner testified he claims all three as dependents on his taxes. He did not graduate high school but has his GED. He is a certified production technician with certifications in safety, quality control, maintenance, manufacturing and precision measurement.

On 6/1/17, Petitioner testified he was lifting totes containing chicken product and hurt his back. He reported it to his boss and was sent by Respondent to Physician's Immediate Care (PIC). He testified the totes contained 70 or more pounds of chicken, which he had to physically bend to pick up and lift them onto his shoulder, cross over a conveyor belt and take them upstairs. That day, he indicated the machine wasn't working properly so he had to move about 8 totes. He testified he also hurt his upper back in this incident, but the low back was worse.

The initial 6/1/17 report from PIC notes complaints of back pain when he was "lifting 70-pound bag of chicken and throwing back over shoulder." A separate portion of the note indicates he was repeatedly lifting approximate 70-pound bags of chicken that day and hurt his right upper/lower back. Petitioner denied any prior low back injuries and denied any current leg symptoms. Cervical x-ray was normal with possible muscle spasm

while lumbar x-ray reflected a loss of disc space height at L4/5 with spondylolisthesis. The diagnosis was cervical and lumbar sprains and pain medication was prescribed along with light duty restrictions (20 pounds with no prolonged bending or twisting). Petitioner testified the Respondent was able to accommodate his work restrictions and he was able to perform the assigned work. He returned the next day, reporting he felt worse, and was prescribed prednisone, Robaxin and more significant work restrictions. On 6/7/17, Petitioner reported he felt better after the weekend off work but when he had to stand for 8 hours when he returned and got worse. He continued to deny radicular symptoms and he was restricted to seated duty. On 6/12/17, the PIC report indicates Petitioner improved and had no pain. It was determined he had reached maximum medical improvement (MMI) and he was released to return to full duty work. (Px2).

On 6/14/17, Petitioner testified: "I messed myself up pretty bad" when he was again lifting totes. On about the fifth one, he indicated he had it on his shoulder, went to cross over the conveyor belt and "my back just went totally messed up." He testified when he crossed his right leg over, his left leg got lacerated badly from the metal, he fell forward and smacked his hands on the ground. His right ankle/foot swelled and he couldn't walk on it. Petitioner's counsel asked: "Would you say that the pain in the lower back is what caused you to fall over?" Petitioner responded: "Yeah, that's what happened. When I had it, my back just went like - - I couldn't even control it. My weight was like I couldn't stop it." Petitioner reported the incident to supervisor Gabriel, whom he said tried to get him to stay at work to keep the machines running. He testified that the left leg laceration wound opened up the next day and he was again sent to PIC.

The 6/15/17 report from PIC notes Petitioner returned to full duty on Monday and on Tuesday was lifting chicken and felt pain in his low back. A separate statement in the note indicates he was lifting a 70-pound crate on Tuesday and developed recurrent back pain that night. He denied any leg symptoms. He was provided with a back brace, prescribed Flexeril and Provil and was again given light duty restrictions. A lumbar MRI was also ordered. (Px2).

On 6/21/17, the PIC report states that Petitioner was carrying chicken on 6/14/17, walked over a conveyor, twisted his right foot and lacerated his left shin. He complained of left leg and right ankle swelling. The report references the laceration as superficial in depth and approximately 5 cm length. Right ankle x-ray was normal except for an old medial malleolus avulsion fracture and left shin x-rays were normal. Petitioner was advised to return to work the next day, but then on 6/22/17 was restricted to seated duty only. (Px2).

The 6/22/17 lumbar MRI report indicated the following findings: 1) multilevel spondylosis of facet arthrosis and ligamentum flavum hypertrophy, 2) an L4/5 annular bulge with superimposed central disc herniation causing moderate foraminal and central canal stenosis, and 3) annular bulges at L3/4 and L5/S1. (Px2; Px11). On 6/27/17, Petitioner reported persistent back pain, improvement in the left shin and weakness in the right ankle. Physical therapy was prescribed for the back and he was again limited to seated duty. (Px2). Petitioner testified that Respondent could not accommodate the restriction and he was advised to follow up with them after each medical appointment.

On 7/11/17, Petitioner reported that therapy was helping and his right ankle swelling and pain were improved. He was advised to continue therapy and the same work restrictions. While this was Petitioner's last examination at PIC, therapy continued through 7/14/17. At that time, Petitioner reported significant ongoing low back pain and concern about increased right ankle pain with prolonged walking. (Px2).

Petitioner sought a second opinion with pain management physician, Dr. Glaser, on 7/14/17. Dr. Glaser's report states Petitioner reported upper back and right shoulder pain as well as bilateral low back pain into the buttocks and leg. He reported that he initially had lifted a tote on 6/1/17 then lifted a 75-pound tote after being released

back to work and his back pain was so severe his right leg collapsed. With regard to his low back pain, the report indicates the precipitating event was a motor vehicle accident. Petitioner reported his pain as 10 out of 10 (10/10) and also reported having 5 children. Dr. Glaser prescribed bilateral facet joint injections at L4/5 and L5/S1 as well as Tramadol and 6 weeks of therapy. Petitioner was continued on regular duty. (Px3). The initial 7/21/17 report from Athletico PT notes diagnoses of acute midline low back pain without sciatica, lateral right ankle pain/sprain. Petitioner reported instability and numbness in the right ankle. He denied radicular symptoms but noted an intermittent burning sensation near his tailbone with lifting his legs while lying down or prolonged standing and sitting. (Px3; Px5).

On 8/1/17, Dr. Glaser performed the prescribed facet injections and also prescribed a GameReady cold/compression therapy device. Billing for this device appears to be $6,825.00. On 8/17/17, Petitioner reported his bilateral buttock and leg pain had increased since the injections, but also that he'd had 80% improvement for a week. He reported his upper back and right shoulder pain had increased as well. The pain was noted to be 10/10. Medial nerve branch block injections were prescribed from L3 to L5. Regular duty was continued. (Px3; Px5).

On 8/31/17, Petitioner reported the same ongoing symptoms and that his pain would go from 5/10 to 10/10 depending on activities. Dr. Glaser diagnosed lumbar facet syndrome without myelopathy as well as cervical radiculopathy and facet syndrome without myelopathy, and ankle pain. It appears that in addition to bilateral L3 to L5 medial branch blocks, Dr. Glaser prescribed Tramadol, Mobic, Cyclobenzaprine and a "drug preparation kit", i.e. MetroTopicals A2. The Arbitrator notes the doctor's office charged $2,846.88 for this latter topical alone. Petitioner was advised to return to seated work only on 9/1/17. (Px3; Px5; Px10).

Petitioner was evaluated at the request of the Respondent on 9/11/17 by orthopedic surgeon Dr. Kornblatt. Petitioner testified he was in the office with the doctor for only about two minutes and: "He just did some of this and this and kicked me out of the room." The doctor's report indicates Petitioner reported that on 6/1/17 he "noted increasing low back pain while performing his duties including filling 75-pound totes with chicken" but continued to work, then on 6/15/17 noted increasing low back pain while lifting at work and that he had not worked since that time. The leg laceration was also noted. Petitioner reported symptoms including constant low back pain radiating up his back into the bilateral buttocks and right ankle/foot pain with numbness and tingling. His symptoms would increase in both locations with standing and walking. Dr. Kornblatt indicated the MRI showed L4/5 disc desiccation with slight disk space narrowing and a moderate central right greater than left disc herniation with slight extrusion behind the superior body of L5 and no significant facet arthropathy. Following examination, Dr. Kornblatt diagnosed a central right L4/5 disc herniation with right lumbar radiculopathy and a healing left leg laceration. He opined Petitioner's prognosis was excellent as there was no clinical presentation which would indicate a need for surgery. He opined that Petitioner's lumbar complaints were related to his 7/15/17 work duties and that his treatment to date had been reasonable other than the facet injections "as the patient has never warranted a facet injection as he does not present with facet abnormalities or facet-mediated pain." He further opined that while Petitioner had reached MMI as to the left leg laceration, he had not yet reached MMI as to the low back. He indicated that following a recommended epidural injection and 2 to 3 weeks of work conditioning, Petitioner should undergo a functional capacity evaluation (FCE) and return to work. (Rx1).

There is an undated note in the records of Dr. Glaser where he responds to the report of Dr. Kornblatt. First, he indicated Dr. Kornblatt is an orthopedic surgeon that does not specialize in interventional pain management, and so his opinions need to be "evaluated in this light and compared to treatment recommendations of a board-certified Interventional Pain Management specialist." He disagreed that Petitioner's prognosis was excellent, indicating "Not needing surgery does not equal a good prognosis." He did agree that epidurals were appropriate,

but not that Petitioner would be at MMI following them. He opined Petitioner's ability to go to work conditioning would depend on his response to the injections. (Px3).

On 9/28/17, Dr. Glaser again noted no change in Petitioner's condition, again charged $2,846.88 for MetroTopicals A2, and again prescribed medial branch blocks. Sedentary duty was continued. (Px5; Px10).

On 10/11/17, Athletico issued a discharge report after 16 visits, noting Petitioner remained "in progress" with his long-term goals. It appears that the last actual therapy session took place on 8/29/17, as that was visit 16. Petitioner reported most of his symptoms were in the morning and that his low back eventually loosens up after moving around. On 8/22/17, Petitioner noted a spike in pain and his ability to move the prior Sunday after spending Saturday at the Air & Water Show and a friend's barbecue. (Px9).

On 10/26/17, Dr. Glaser's report states Petitioner's pain had increased (10/10) since 9/28/17 and that medial branch blocks still had not been approved. Again, Dr. Glaser prescribed MetroTopicals A2 ($2,846.88). (Px10). A virtually identical report was issued by nurse practitioner Cheryl Bruno. Then, there are notes from either the same date, 10/26/17, or 11/2/17 which appear to change the recommendation to L4/5 and L5/S1 epidurals. A separate note from 10/23/17 also prescribes the epidurals. A note holds Petitioner to sedentary duty. (Px3; Px5).

Dr. Glaser performed L4/5 and L5/S1 epidurals on 11/21/17. (Px3). On that same date, Petitioner signed a leasing agreement for a GameReady cold compression therapy device for two weeks. The Arbitrator did not note a prescription for this device in the 10/26/17 note of Dr. Glaser or NP Bruno, but there is a 11/21/17 note with an Instant Care Equipment Leasing that was signed by Dr. Glaser. (Px3).

Petitioner testified the epidural injections provided only temporary relief for two to three weeks. At this point, he testified he had pain in his low back and upper buttocks and into his legs. He said that physical therapy was helping.

On 12/28/17, Dr. Glaser's report indicates both that Petitioner reported his pain stayed the same following 11/21/17 lumbar epidural injections, and in the same paragraph states he had 40% relief and was pleased. Tramadol, Mobic and Cyclobenzaprine were again prescribed, along with MetroTopicals A2 ($2,846.88), as well as additional epidural. Sedentary duty was continued and Petitioner was referred to a neurosurgeon. (Px3; Px5; Px10). Dr. Glaser's records also contain a 1/29/18 note referring Petitioner to a neurosurgeon. (Px5).

Petitioner initially saw surgeon Dr. Salehi on 3/1/18, reporting a 6/1/17 initial injury when he felt low back pain lifting a heavy tote but was told to continue working. He reported a 6/14/17 incident where he was carrying a tote on his shoulder and stepping over a conveyor when he got a sharp pain that caused him to fall over, rolling his right ankle and cutting his left leg. He complained of tolerable low back pain at rest that was severe with activity. He denied any radiating pain or numbness. Neither therapy nor injections provided lasting relief. He denied any prior back pain. He noted mild ankle pain at times. There was no indication of abnormal findings on physical or neurologic examination. Dr. Salehi's review of the lumbar MRI films reflected single level degenerative disc disease at L4/5 without any loss of disc height, mild bilateral facet arthropathy and a disc herniation causing moderate bilateral recess stenosis. Dr. Salehi opined Petitioner had low back pain related to the work accident secondary to aggravation of disc disease/annular tear at L4/5. He opined Petitioner was a single level lumbar fusion candidate if his symptoms were intolerable but that he indicated his symptoms were manageable at that point. To prevent further aggravation Dr. Salehi recommended a functional capacity evaluation (FCE) after which permanent restrictions would be determined. In the meantime, he was held off work. (Px7).

Petitioner testified he was initially afraid to have surgery and wanted to continue conservative treatment, so he underwent the FCE. The 3/26/18 FCE noted an 86% consistency of effort and an 88% quality of effort but a 46% reliability of pain. The report then notes an inconsistent performance/unacceptable effort, and that the Petitioner's perceived limitations were markedly affecting symptom expression, consistency of effort, reliability of pain and quality of effort. It was determined that Petitioner demonstrated the ability to perform at the heavy physical demand level and could have performed "at markedly higher levels than willing during musculoskeletal and functional testing." While he gave good effort, his self-reported pain levels were not consistent with his pain behaviors and movement patterns observed during testing. This was based in part on higher pain ratings than would be expected given his heart rate and functional movement patterns. His pain was often self-rated at 10/10. It was noted Petitioner's main complaint was in his central lower back, and that his ankle was fine, and his neck was "just a little stressed." Waddell testing was negative. (Px9). He testified he was "pushed to the limit" during testing and had to go to the Roseland Community Hospital ER afterwards with severe pain.

On 4/5/18, Petitioner returned to Dr. Glaser. He reported his pain had increased since the December visit, that he had been to the ER twice since then and that he had decided to proceed with surgery. He also reported his pain was severely exacerbated by the FCE and he received Valium at the ER afterwards. Epidurals were still noted to be prescribed at L4/5 and L5/S1, and Mobic, Cyclobenzaprine and Norco were prescribed along with, again, MetroTopical A2 ($2,846). Dr. Glaser indicated Petitioner was to be on sedentary duty but also that he should be off work and could return to sedentary duty on 9/29/17. (Px3; Px5; Px10).

Epidurals were performed on 4/17/18 at L4/5 and L5/S1. (Px3; Px5). On 5/15/18, Petitioner reported his back pain remained the same but was less frequent. The report stated Petitioner had 90% relief of his radicular pain. Dr. Glaser then prescribed bilateral facet joint injections as well as refilled prescriptions, including, once again, MetroTopical A2. (Px10).

Following repeat L4/5 and L5/S1 epidural injections on 4/17/18, Dr. Glaser again ordered a GameReady device for two weeks. On 5/15/18, Glaser indicated Petitioner reported no change in his back pain following epidurals but 90% improvement in radicular pain. Bilateral facet injections were prescribed. He was held to sedentary duty. (Px3; Px5).

Petitioner returned to Dr. Salehi on 5/24/18 reporting typical back pain at a 5 out of 10 (5/10) level that would go up to 9/10, noting a recent visit to the ER due to pain. He had the FCE and indicated he now had intolerable pain and wanted to undergo surgery. He had no radicular symptoms. Dr. Salehi continued to recommend surgery, provided Petitioner quit smoking due to the risk of pseudarthrosis. Dr. Salehi indicated that approximately 7 to 9 weeks post-surgery Petitioner would be able to return to sedentary/light duty, and approximately 7 months post-surgery would be able to return to work per a valid FCE. In the meantime, he continued sedentary restrictions. (Px3; Px7).

Petitioner acknowledged at hearing that he remains a smoker but testified he has cut back on it in preparation for the surgery. Petitioner testified he had continued to receive benefits and TTD until approximately 5/9/18, and he hasn't received anything since.

On 6/11/18, Respondent obtained a utilization review (UR) with regard to the medical necessity of the surgery recommended by Dr. Salehi. Neurosurgeon Dr. Richardson certified the procedure as medically necessary and appropriate based on ODG guidelines, noting Petitioner had an extruded L4 disc and progressive pain despite conservative measures with minimal reduction of symptoms, and an indication in Salehi's 5/24/18 report that Petitioner's pain was intolerable. The Arbitrator notes the report was actually also signed off on by orthopedic surgeon Dr. Milos. (Px8).

On 7/11/18, Dr. Glaser's report indicates Petitioner's back pain had increased. It was noted the Petitioner had been in jail: "He has exacerbated his lower back pain. He also injured his right toe jumping off of a bed." His upper back pain had also increased. Dr. Glaser prescribed physical therapy and MetroTopicals N3 ($2,958.52). On 8/2/18, Petitioner again reported increased pain since 7/11/18. He also reported an increase in right foot pain. Bilateral facet injections, Mobic, Cyclobenzaprine and MetroTopicals N3 ($2,958.52) were prescribed. It appears a back brace was also ordered and physical therapy prescribed. Sedentary duty was continued. (Px3; Px5; Px10).

Petitioner was again evaluated by Dr. Kornblatt on 8/6/18. He noted Petitioner's updated treatment history and current complaints that included constant central low back pain and chronic right foot ache but with no radiating leg pain or numbness. Petitioner denied a neck injury but has noted upper back pain between the shoulder blades that had recently improved. Examination reflected less pain behavior findings and Dr. Kornblatt diagnosed lumbar degenerative disc disease, mechanical axial low back pain and cervicothoracic myofascial pain. He opined that "subjective complaints are supported by a lack of abnormal objective findings on physical examination as well as known L4/5 degenerative disc disease." He further opined that Petitioner's work injuries resulted in a central L4/5 disc herniation with radiculitis/radiculopathy, that the radicular symptoms had resolved and that the current lumbar and cervical conditions were unrelated to the work accident but rather to preexisting L4/5 degenerative disc disease as well as longevity of inactivity, deconditioned state and chronic pain dysfunction. He believed the accident caused a temporary aggravation of the preexisting condition at L4/5, and that it did not result in any cervical or thoracic injury. He opined that any treatment after the FCE would not be related to the work accident. The only treatment recommended for the low back was to be aerobically active and fit with a home exercise program and discontinuation of narcotic medication. He advised that Petitioner be restricted to medium physical demand level, stating "These restrictions are causally related to the work accident." As he believed Petitioner had reached MMI as to anything related to the accident, Dr. Kornblatt determined Petitioner had sustained a 6% whole person impairment pursuant to AMA guidelines. (Rx1).

Following this report of Kornblatt, Dr. Glaser again issued a response narrative which again is undated. He questions Dr. Kornblatt's diagnosis of lumbar degenerative disc disease as "not an adequate diagnosis." He also disputed the diagnosis of myofascial pain as something that by definition resolves with time, and that if symptoms do not so resolve "either a joint or a nerve is involved as injuries to those structures are the most common causes of chronic pain", and that Petitioner is suffering from pain from injured intervertebral joints. Given Petitioner was asymptomatic before the accidents, he opines that Petitioner's condition would not be related to preexisting degenerative disc disease. He goes on to state that there is no literature to support that a lack of objective findings on exam does not justify subjective complaints. He goes on to, twice, indicate that Dr. Kornblatt "should be ashamed."

Facet injections were performed on 8/21/18. (Px3; Px5). On 9/6/18, Dr. Glaser noted Petitioner's pain had decreased with injections 80% for about a week before the pain gradually returned. Mobic, Cyclobenzaprine and MetroTopicals N3 ($2,958.52) were prescribed along with repeat medial nerve branch blocks. Petitioner apparently also indicated 40% relief in his right foot. The work status note states: "Patient Not Working" with no indication of what his recommended work status was. (Px3; Px5; Px10).

Petitioner last saw Dr. Salehi on 9/18/18, testifying he still wanted to undergo surgery but was advised he couldn't return at that point because insurance wasn't authorizing the treatment. The doctor's report notes he stated he continued to have constant low back pain into the buttocks. He wasn't working and had been let go from his job. Dr. Salehi indicated he had mechanical back pain that was rendered permanently symptomatic by the accident and he continued to recommend surgery. He reviewed the report of Dr. Kornblatt and indicated

disagreement that the aggravation of Petitioner's condition was temporary since he had no prior symptoms and has had no resolution of symptoms, noting surgery had been previously approved and "it appears arbitrary" that it was now being denied. (Px7). Dr. Salehi issued a work note on 10/3/18 continuing Petitioner's restrictions on desk duty, noting he'd be re-evaluated on 11/7/18. (Px7). The Arbitrator notes there is a copy of this note in Px3 which has the date crossed out and has written in: "9/18/18 Corrected K.O." (Px3).

Medial branch blocks were performed on 10/2/18 at L2 to L5. (Px3; Px5). On 10/10/18, Dr. Glaser states Petitioner's low back pain decreased with the injections 45% while his upper back pain remained the same. Radiofrequency ablation from L2 to L5 was discussed. Petitioner reported pain relief by using ice. He was reporting 4/10 to 8/10 pain. Norco, Cyclobenzaprine and Mobic were refilled along with MetroTopicals N3 ($2,958.52). (Px10). Petitioner then saw Sharon Koys on 10/10/18, and she reported essentially the same information as Dr. Glaser had with a virtually identical report. (Px3; Px5).

At the last noted visit with Dr. Glaser on 11/13/18, Petitioner again reported increase back pain back up to 10/10 at its worst. MetroTopicals A2 was prescribed (2,846.88) this time. A note states "Patient is currently not working." (Px3; Px5; Px10).

Petitioner testified he has seen Dr. Glaser since that time but has not undergone any further injections since October 2018. He has prescribed a radiofrequency ablation (RFA) procedure, however Petitioner indicates he does not want further invasive treatments other than surgery so he can get back to work. Petitioner testified he is on public aid and cannot afford to return for treatment or to obtain medications, though he recently received a medical card and planned to obtain prescriptions through that.

Neurosurgeon Dr. Salehi testified via deposition on 11/13/18. He testified that Petitioner's neurologic exam was normal but there was mild loss of range of motion on physical exam. Given the lack of improvement with conservative treatment, Dr. Salehi's prognosis was likely ongoing back pain and he believed Petitioner had undergone adequate conservative treatment by the 3/1/18 visit. He advised him he was a one level fusion surgery candidate if his symptoms were bad enough, but at that time Petitioner opted for the FCE. Dr. Salehi believed Petitioner's mechanical back pain was due to an annular tear at L4/5. He noted at this visit Petitioner's "main" complaint was not his lower extremities. He testified that the fusion recommendation is dependent on Petitioner's pain level. He opined that while Petitioner may have had preexisting degenerative disc disease, he felt the accident aggravated the condition, noting the majority of the time this condition is asymptomatic. He testified the Petitioner's mechanism of injury supported causation, as he did not have prior symptoms and the symptoms correlated with the MRI findings. Petitioner indicated he had been let go from work at that time, but Dr. Salehi indicated he would have been at least capable of sedentary duty at that point. (Px6).

Dr. Salehi testified that when he saw Petitioner again on 5/24/18 it appeared he wanted to proceed with surgery. He had essentially the same complaints and Dr. Salehi advised he would need to take urine tests to show he quit smoking before he could undergo fusion given the risk of pseudarthrosis, advising that he could perform sedentary duty in the meantime and should undergo an FCE. Dr. Salehi reviewed Petitioner's FCE report and agreed the testing indicated he could do much more than sedentary duty, but he testified that the Petitioner nevertheless remained a surgical candidate, noting that heavier activities would be more likely to aggravate his symptoms. Dr. Salehi noted no other objective findings outside of the L4/5 annular tear to explain Petitioner's symptoms. At Petitioner's 9/18/18 visit, Dr. Salehi reviewed the report of Dr. Kornblatt. He noted Kornblatt agreed Petitioner had an injury and had a herniated L4/5 disc, and believed Dr. Kornblatt's determination that the aggravation was temporary didn't make sense without any factual basis, given Petitioner's complaints remained ongoing. He opined that if a patient's symptoms last beyond three months, an aggravation would no longer be considered temporary. Dr. Salehi further testified that 80 to 90 percent of patients with a herniated

disc respond to conservative care, consisting of time, therapy, injections and medication. If six months pass without improvement, surgery becomes an option. Dr. Salehi could not say why he issued the 10/3/18 note continuing Petitioner's restrictions without a visit. He continues to believe Petitioner should be limited to sedentary duty to avoid risk of reaggravation. (Px6).

Cross-examined, Dr. Salehi agreed he was not aware of Petitioner's lifting requirements at work. He also agreed that the surgical choice is based on the Petitioner's determination of whether his subjective symptoms are tolerable, and that on 3/1/18 he indicated his symptoms were tolerable. Asked about the FCE findings indicating behavioral factors, Dr. Salehi testified that Petitioner's complaints were consistent from visit to visit and the degree of pain, but acknowledged the complaints were subjective and Petitioner could exaggerate them. He found loss of range of motion on exam but acknowledged this also involved a subjective component. At the initial visit, the Petitioner hadn't complained of pain with lumbar palpation. He agreed with Dr. Kornblatt that Petitioner's neurologic exam was normal regarding radiculopathy, but he disagreed with Kornblatt's chronic pain dysfunction diagnosis, and indicated if his opinion was based on pre-accident records which reflected symptoms, Dr. Salehi would like to review them. Dr. Salehi testified that if the symptoms are mild, you don't want to offer surgery, but that a patient becomes a surgical candidate when they reach the point they cannot deal with it. On redirect exam, he testified that the Petitioner was capable of lifting something 70 or even 100 pounds, but that this could aggravate his condition and increase his pain. He testified that both he and Dr. Kornblatt agree that Petitioner's accident caused the L4/5 disc herniation. Dr. Salehi opined that the herniation came from the annular tear, and that its the annular tear that was aggravated by the accident and is what's driving Petitioner's pain. (Px6).

UR neurosurgeon Dr. Richardson was deposed on 4/5/19. He reiterated the opinion contained in his report. He noted Petitioner had an obvious damaged disc per MRI with partial obstruction of his central canal and was on the way to having significant spinal stenosis as well as bilateral nerve root canal stenosis, "so there wasn't much question. The poor man needed something done." He noted he reviewed only the MRI report, not the films. He testified Petitioner's symptoms are consistent with the MRI and physical exam findings. He'd had symptoms for a year or so without lasting improvement from multiple forms of conservative treatment. He testified that he practices in Louisiana and uses their workers' compensation guidelines, and he appeared unfamiliar with ODG guidelines on both direct and cross exam. He testified he has performed the recommended procedure himself. He testified the surgery recommended by Dr. Salehi is not an emergency, but that older literature indicates that if a nerve is compressed for over a year you could end up with permanent nerve damage. He was not certain why Dr. Milos also signed off on his report, or if Illinois required an Illinois doctor to sign off on an UR. (Px8).

On cross-examination by Respondent's counsel, Dr. Richardson testified he was not aware that the ODG guidelines referenced in his report indicate fusion surgery is not recommended for degenerative disc disease and disk herniation, noting if that is what the guidelines actually indicate: "That's absurd that ruptured discs don't require surgery." He testified that most people with chronic pain tend to overestimate their pain. Dr. Richardson testified that he reviewed the FCE and the post-FCE report of Dr. Kornblatt, acknowledging the FCE indicated Petitioner complained of significantly higher pain levels than would be expected, but testified: "I don't know who can tell you what to expect with pain." People with similar conditions can have varying levels of pain. While Dr. Kornblatt did note no radiculopathy or abnormal objective findings, he did note a loss of lumbar lordosis which is seen in people with organic back pain and is something that can't be faked. Dr. Richardson agreed there were no findings of radiculopathy with Petitioner, but testified that someone with spinal stenosis due to disc rupture may not have a positive straight leg raise test. Neither the FCE nor Dr. Kornblatt's opinions changed the fact that the MRI films were abnormal. While he didn't review the MRI films, Dr. Richardson testified he did see a very small thumbnail copy of film and evidence of significant disc and/or bone can be seen in the spinal canal. While he agreed that a person who aggravates a spine condition, returns to an asymptomatic

baseline and then has an altercation can re-aggravate the condition, Dr. Richardson testified that the Petitioner has not been asymptomatic since the work accident in this case. Dr. Richardson questioned Respondent's counsel's interpretation of "necessary" surgery, in that he agreed the Petitioner's life does not depend on the surgery, but that it would be necessary to be comfortable and to function and get back to work on a pain-free basis. (Px8).

On redirect, Dr. Richardson testified that if the Petitioner wants to be pain free and to return to work, he should have the surgery, which was recommended for back pain, not radiculopathy. He noted there are patients like Petitioner where the MRI shows a damaged disc but who have severe pain without a disc rupture and the pain is relieved by fusion or removal of the disc. People have various pain levels, and Dr. Richardson testified there are multiple reasons for complaining that may not be specific to back pain, such as using pain to manipulate their families, to gain sympathy, etc., and they may complain of 10 out of 10 pain which means they should be on a gurney to the hospital. He testified that after he answered the questions asked of him on the UR, the company that hired him added in other information and made the final edits. He testified he did not sign off on the report itself, but signed off on a questionnaire he completed. (Px8).

Orthopedic surgeon Dr. Kornblatt testified on 10/22/18. Regarding his 9/11/17 exam of Petitioner, he stated that he found Petitioner's complaints credible despite a normal physical exam. He reviewed both the lumbar MRI report and films. His diagnoses of central/right L4/5 disc herniation with right lumbar radiculopathy and the healing left leg laceration were causally related to the 6/1/17 and 6/15/17 work accidents. With regard to his 8/6/18 exam, Dr. Kornblatt testified he again found Petitioner's ongoing symptomatic complaints to be credible. He testified that he indicated that Petitioner was functioning at the medium physical demand level at that time and acknowledged the FCE evaluator indicated inconsistencies regarding the viability of Petitioner's pain and could function at the heavy demand level pursuant to the FCE. Dr. Kornblatt further testified that when he saw the Petitioner in August 2018, he believed the work aggravation of lumbar degenerative disc disease had resolved and the ongoing degenerative condition was not related to the accident. He noted treatment after the FCE would not be causally related to a work accident, and that the pre-FCE facet injections were not warranted. (Rx1).

Dr. Kornblatt opined that Petitioner was not a surgical candidate as he didn't present with neurologic complaints, his examination was objectively normal and he had one known level of degenerative disc disease "which in my opinion, is not an indication for any type of surgery." He agreed that such disease could be exacerbated by a physical altercation, noting it could also be exacerbated with no activity whatsoever. He believed Petitioner could have returned to work when he initially saw him, testifying: "I noted medium level type activity initially, but what I stated here certainly was not permanent." He believed he could lift 50-pound occasionally and 25 pounds frequently. In reviewing Petitioner's written job description, he noted the job duties fit within the restrictions he outlined. He opined Petitioner had reached MMI. Asked if this would still apply after he saw the Petitioner, the doctor testified that "it would be determined upon how he's doing." (Rx1).

On cross-examination, Dr. Kornblatt was asked what he would do, given his initial diagnosis, if Petitioner failed to subsequently respond to the therapy and epidurals he recommended, and he testified it would depend on the examination and MRI findings. Based on the MRI, "it would be highly unusual for him not to respond to conservative management" given the normal clinical exam, and "I think it's very hard to state that you're going to be aggressive with a patient whose exam is normal whether they have complaints or not." Whether the Petitioner's disc herniation had resorbed/resolved by the time of the 8/6/18 exam did not matter, what matters are the subjective complaints and exam findings. Had Petitioner presented with ongoing radicular complaints and findings he would have wanted to see an updated MRI. He testified that Petitioner had no such complaints or findings, and so repeat MRI was not needed because an ongoing presence of the disc would not warrant

surgery ("nobody in their right mind would do anything about it"). He did not believe Petitioner needed further treatment at that time, he would only have initially instituted restrictions due to Petitioner's deconditioning over time, but that these would be reduced within 6 to 8 weeks and eventually he most likely should be able to return to full activities. Dr. Kornblatt appeared to acknowledge he has performed fusion surgeries for patients with only a degenerative disc condition, but then indicated this was in cases of spinal fractures or instability. He would consider surgery for patients with radiculopathy to remove pressure from a nerve root. He didn't comment on whether he found pain behaviors as he had not been asked to do so, but indicated he saw no evidence of malingering with Petitioner. His opinion that Petitioner's preexisting condition was aggravated by the accident was based on the herniation and radiculopathy, but given the radiculopathy had dissipated, the temporary aggravation had resolved. He testified that other medical records indicating Petitioner continued to complain of radicular pain would probably not change his opinion. He could not comment on any current need for work restrictions since he hasn't seen Petitioner again. He testified that if Dr. Salehi thinks the Petitioner needs surgery he is wrong. He noted the FCE indicated Petitioner's consistency at 81%, and "that's pretty good", while noting that a lack of effort is a different story. (Rx1).

The Respondent obtained two URs in this case with Dr. Grattan. He testified that in coming to his conclusions, he used the Official Disability Guidelines (ODG). Dr. Grattan testified that he non-certified the initial cervical and lumbar (6/1/17 and 6/15/17) x-rays, the lumbar brace, the lumbar MRI, prescriptions for Robaxin, Prednisone, Flexeril and Provol, the bilateral facet injections, the sixteen session of therapy attended between 7/12/17 and 8/29/17, the Game Ready unit and the bilateral medial branch blocks. He also non-certified the Metrotopical A2 cream. He did certify per ODG six sessions of physical therapy, Naproxen, Keflex, Tramadol, Meloxicam, and the neurosurgical referral given on 9/12/17. He made his determinations based on the diagnosis he was provided with, back strain/ankle. The x-rays were non-certified based on there being no red flags or mechanism of injury that would be likely to cause a fracture, and there had been no conservative care performed at that point. Back braces are not used as first line treatment unless there is evidence of instability or spondylolisthesis. Lumbar MRI was also obtained prior to any conservative treatment and there were no neurologic symptoms. Robaxin, a muscle relaxer, was not certified because there was no documentation of muscle spasm on exam and Petitioner had not failed anti-inflammatory treatment. Prednisone is typically used for significant inflammatory conditions and Petitioner had no radicular symptoms. Provol is an herbal supplement that isn't in ODG and is not frequently used in common medical practice, so Dr. Grattan noted no explanation from the treater as to why this unusual supplement would be appropriate. On 8/1/17 there was no diagnosis or documentation of facet mediated pain to justify facet blocks, plus the current recommendation for such pain would be medial branch blocks. However, Dr. Grattan's testimony that medial branch blocks (9/28/17 and 10/26/17) were noncertified was difficult for the Arbitrator to understand other than Petitioner had undergone nonspecific prior injections that hadn't helped. The same reasoning applied to the 5/15/18 injections. While ODG does not address the GameReady unit, but Grattan testified that while advanced cold compression therapies do provide relief, they have never been shown to be more effective than a basic ice bag. As to Flexeril, he testified that the literature is sparse that muscle relaxants are helpful for chronic/subacute back pain and generally isn't used for longer than two weeks. The Metrotopical cream is not recommended for certification, as very few topicals have supporting studies, and where there are such studies it is typically for neuropathic pain. (Rx4).

On cross, Dr. Grattan testified that an Illinois physician signs off on his report, which is prepared based on his answers to questions. He was not asked to comment on the FCE or the neurosurgical referral. He agreed that x-ray are commonly performed at initial ER-type visits, and medications are often prescribed. A back brace can be beneficial, but in most studies isn't shown to work any better than a placebo. Whether a treatment can potentially be "beneficial" to a patient is not the same thing as determining if it meets the appropriate standard of care. He testified the MRI was not appropriate at the time it was prescribed, though it may have been later on.

Facet pain is determined by seeing if there is pain with facet loading, imaging showing facet arthritis or edema in the facet joints with an acute injury and lack of other potential sources of back pain, such as discogenic or radicular. Again, for this purpose, medial branch blocks would be the appropriate injections. If those work, the next step would be radiofrequency ablation (RFA). Facet joint injections are less accurate, as they have a greater volume of numbing medication and can impact other structures, so you can then overestimate facet involvement in the patient's pain. With topicals, again, in general studies show mild benefit at best versus placebo, and there are no randomized studies for the specific one used in this case. Dr. Gratton certified physical therapy from 7/3/17 to 7/16/17 but noncertified the therapy thereafter because the first 6 sessions provided no benefit and Petitioner was reporting 10/10 pain. He should have had some benefit in those first 6 sessions if it was going to provide relief. He also certified Naproxen, Keflex, Tramadol, Meloxicam and Norco. The neurosurgical referral was appropriate as Petitioner had already undergone conservative care without improvement. (Rx4).

Respondent also obtained a UR from pain management physician/anesthesiologist Dr. Hagle with regard to the reasonableness and necessity of the 4/17/18 injections, and he opined that they were not medically necessary per ODG, as they are appropriate for radiculopathy, not for stenosis or nonspecific low back pain, and he saw no documentation of radicular pain in the medical records consistent with nerve root compression as of the time the injection was prescribed on 4/5/18. MRI showed only mild foraminal narrowing. On cross, he agreed that an epidural can be both therapeutic and diagnostic, and if an injection is performed and provides significant symptomatic relief it is fair to say a pain generator has been identified. He agreed stenosis and/or a herniated disc can potentially cause nerve root impingement. He agreed that Dr. Glaser's 5/15/18 report stated that Petitioner had 90% relief of his radicular pain with the injection but no relief of axial back pain. He also agreed if prior medical records noted radicular complaints and signs of nerve compression on exam, a lumbar epidural would be a reasonable treatment. He agreed that he was not asked to provide a diagnosis in this case, or to make a determination of the reasonableness of the treatment based on the response to it. Dr. Hagle testified that pain from a facet joint would manifest primarily as axial low back pain, which could radiate to the buttocks and thigh, but should not go below the knee. (Rx6).

Petitioner testified he is not currently working but has contacted Respondent multiple times seeking to return and was turned down. He testified his previous TTD checks were often delayed, sometimes months at a time, and this put him behind on his bills and got him evicted from his residence. He moved in with his mother and sleeps on the couch, while his wife went to live with her mother. To his knowledge, he still has outstanding medical expenses. He testified he had no prior back, left leg or right foot injuries and was under no active treatment for his back prior to the accident date.

The written job description (Rx1) indicates a machine operator for Respondent must be able to physically stand for most of the working hours, must be exposed to cold temperatures, must operate a battery-operated pallet jack and must be able to physically lift 50 to 70 pounds.

On cross-examination, Petitioner agreed the original Applications for Adjustment of Claim he signed indicated he had only one dependent (Rx9). On redirect, he indicated he thought the question referred only to his biological child. He testified that after his benefits ended in May 2018, he ended up being evicted from his home in October 2015 and his wife and the kids then left the home and he went to go live with his mother. Petitioner testified that, of his stepchildren, one of the biological fathers died and the other has been in jail since the child was a one year old. He agreed he has not formally adopted the children but that they are a family – "I am married to their mother. That's our family."

As to the written job description for machine operator (Rx2), Petitioner disputed the document's statement that he had to lift up to 50 pounds, indicating it was not accurate and that the totes weighed 70 pounds. He testified

that his job orientation handbook from Respondent indicates that full gray totes should never weigh over 70 pounds, not 50 pounds. He initially could not recall if he told either Dr. Glaser or Dr. Salehi the weight of the totes he lifted at work, but then testified he said 70 pounds and did describe to them how he was injured at work. He did not provide them with a written job description.

On further cross-examination, Petitioner agreed he was aware his FCE indicated he could at least perform at the heavy work demand level and that it stated he provided inconsistent performance and unacceptable effort. He testified he did reapply for work with Respondent after the FCE, indicating he had reapplied twice in the six months prior to the hearing but he couldn't provide the exact dates he did so. He testified he has looked for work, "tried to find two, three", but no one would hire him due to his restrictions. He testified was ultimately terminated by Respondent, indicating he was supposed to come back to work but hadn't been cleared by his doctor to do as he remained restricted to seated duty. He denied being a union member, as he hadn't yet signed his papers to join after he returned to Respondent's employ after he had gone to school

As to Dr. Glaser's 7/11/18 report indicating he exacerbated his low back pain while in jail, Petitioner testified he told Glaser his back was hurting from sleeping on a hard bed with a thin mattress and he needed more medication. He agreed he told the doctor he hurt his right toe jumping off a bed. As to Dr. Kornblatt's second report indicating he was defending his wife when she was attacked, Petitioner denied being involved in an altercation in the January 2018 incident. Petitioner's testimony regarding this incident was not easy for the Arbitrator to understand, but he essentially indicated his wife was attacked and robbed, but that he was not involved. As to why he then told Kornblatt that he was defending his wife if he wasn't involved, Petitioner testified three women were jumping on his wife, two ran and a family member got the last one and his wife apart, and the three females lied and made a false police report to use the system against Petitioner as a weapon. He denied having any physical involvement in the incident.

Regarding the 11/13/18 report of Dr. Glaser indicating he had increased his activity, he testified that his treatment was no longer being authorized and he meant he was trying to perform the exercises he'd learned in physical therapy.

In the January 2018 altercation involving his wife, Petitioner reiterated that he was not physically involved. He testified that his wife didn't know the people who robbed her and after months passed, in May 2018, the police came to his house and arrested him and his wife based on a false report of one of the female attackers. He agreed fusion surgery had been prescribed for him prior to January 2018. He indicated he was advised by his doctors to perform a home exercise program given formal therapy had been denied. He testified that Dr. Salehi advised him not to lift anything over 40 pounds. He agrees he is capable of working in some capacity, but Respondent hasn't taken him back despite him reapplying three times, and that he hadn't received a TTD check in about a year.

After reviewing the records of Dr. Salehi, it was agreed that the first time he recommended surgery was in March 2018, which was two months after the alleged January 2018 altercation, not before.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on 6/14/17. The Petitioner testified that on that date he lifted a large tote full of chicken on his shoulder and as he was crossing the conveyor belt, he felt a sharp pain in his back causing him to fall and injure his back and right ankle and lacerate his left shin. He testified that he reported this to his supervisor, and Respondent presented no evidence to rebut this. The contemporaneous medical records from PIC were consistent. While the initial report on 6/15/17 indicated he hurt his back lifting the chicken, a more detailed history was noted on 6/21/17. The Arbitrator also notes with interest that the Petitioner had just returned back to work following a 6/1/17 accident which involved his low back.

As the Petitioner testified the incident occurred while he was working at a time he was scheduled to work, the injury occurred in the course of his employment. As to the "arising out of" element, the question is whether the Petitioner's risk of injury was increased due to his job duties. The Petitioner testified that his job as a machine operator is to monitor the sealing machines and if they are not working properly, to collect the chicken into large totes, to lift them up and onto his shoulder and to then bring them upstairs in order to run them through the machines again. He testified that these totes weighed approximately 70 pounds when filled. While the Respondent's written job description indicated the totes would weigh up to 50 pounds, the Arbitrator finds that whether the totes weighed 50 or 70 pounds is not relevant to this issue, as in either case the lifting and carrying of these totes would constitute an increased risk of injury within the meaning of the Illinois Workers' Compensation Act. Because lifting the heavy totes was a risk incidental to his work for the Respondent, it arose out of his employment with Respondent.

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's current lumbar condition of ill-being is causally related to his 6/14/17 work accident. The Arbitrator finds that the Petitioner's right ankle and left leg laceration conditions were also causally related to the 6/14/17 accident, but that these conditions both resolved prior to the hearing date.

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). Proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to an injury. Land and Lakes Co. v. Indust. Comm'n., 359 Ill.App.3d, 593 (2d Dist. 2005).

The Petitioner testified credibly that he had no injury or treatment to his low back or right ankle prior to 6/1/17. The Petitioner testified that on 6/1/17 he injured his back lifting heavy totes filled with chicken product. He reported the injury to his supervisor and was eventually sent to PIC. The Petitioner had consistent complaints of pain in his upper and lower back following this accident. (Px2). The Petitioner received conservative treatment at Physicians Immediate Care and was discharged to full duty on 6/12/17. On 6/14/17, the Petitioner injured himself again lifting heavy totes, this time indicating he had a twinge of pain that caused his leg to go out. He notified his supervisor of this new accident and was again sent to PIC.

Following the 6/14/17 accident, the Petitioner had consistent complaints of pain in his low back, right ankle and left shin and he was ultimately placed on seated work duties due to his injuries by Dr. Menon. Work restrictions were then continued by Dr. Glaser and Dr. Salehi. The Petitioner's restrictions could not be accommodated by the Respondent and he therefore remained off work. The Petitioner was able to perform his full duty work prior to June 1, 2017 and following his two accidents, he was unable to perform those same duties. These facts alone are sufficient to support a finding of causation based on a chain of events analysis.

The medical records in this case further support a finding or causation in this case. The initial 6/1/17 report from PIC notes Petitioner was lifting 70 pounds of chicken and throwing it over his shoulder, and that he denied any prior history of back injuries. On 1/15/17, following the second accident, the Petitioner returned to PIC and the doctor noted he returned to full duty on a Monday and then on Tuesday was lifting chicken and felt back pain.

Dr. Salehi testified that the Petitioner's current lumbar condition was causally related to the work accident given he exhibited no prior symptoms, had a consistent mechanism of injury and had symptoms which correlated to the MRI findings at L4/5. Respondent's Section 12 examiner Dr. Kornblatt also diagnosed the Petitioner with a central L4/5 herniated disc and testified that the diagnosis was causally related to the 6/1/17 and 6/14/17 accidents. He also testified that he found the Petitioner's low back pain complaints were credible and he saw no indications of malingering. While Dr. Kornblatt, in his 8/6/18 report opined that the work incident resulted in a temporary aggravation of a pre-existing condition L4/5 degenerative disc disease condition, he based this on his determination that an initial radiculopathy diagnosis had resolved, leaving only the degenerative disc disease.

The Arbitrator initially notes that his diagnosis of radiculopathy was questionable given the lack of any significant radicular complaints by the Petitioner and the lack of any neurological findings by either Dr. Salehi or Dr. Kornblatt on exam. Secondly, the fact that a radiculopathy condition may have resolved does not mean that the Petitioner's ongoing low back symptoms did not remain causally related to the work accidents, whether due to their causing an L4/5 disc herniation or aggravating a preexisting degenerative disc disease condition at that level. The Arbitrator finds the opinions of Dr. Salehi in this regard to be more persuasive than those of Dr. Kornblatt in terms of the relationship of the ongoing condition, while also noting that both doctors agreed that his initial post-accident lumbar condition was causally related. There simply is no indication that the Petitioner's low back symptoms ever resolved after initially occurring contemporaneously to the accidents. Dr. Salehi's opinions are further bolstered by the opinions of surgeon Dr. Richardson, who performed a UR at the request of the Respondent. Both Dr. Salehi and Dr. Richardson agree that the work injuries resulted in a herniated disc at L4/5 and that a lumbar fusion procedure is a reasonable procedure relative to treating the Petitioner's ongoing lumbar pain complaints.

The Arbitrator does note, however, that the right ankle condition appears to have resolved with no significant sequelae. While Dr. Glaser's reports note ongoing right ankle complaints, there really was no focus to theses and the Petitioner did not appear to suffer anything more significant than a right ankle sprain/strain as a result of the 6/14/17 work accident. Further, as noted in more depth below, the records and treatment of Dr. Glaser are suspect in this case.

The left leg laceration was noted in the initial records to be fairly superficial, and there does not appear to have been any functional disability resulting from this injury following the healing of the laceration.

The Arbitrator is not swayed by the Respondent's arguments that a physical altercation and/or jail time activities of the Petitioner somehow resulted in a discontinuation of the causal relationship of the low back condition to the 6/14/17 accident. Respondent produced no credible evidence that the Petitioner was physically involved in the alleged altercation, what that involvement may have been and whether it had any impact whatsoever to the Petitioner's lumbar spine. The Petitioner testified that he was not involved in a physical way with any altercation that may have occurred in January 2018. The fact that this may have been mentioned to Dr. Kornblatt does nothing to prove by the preponderance of the evidence that there was any impact to the Petitioner's low back. While there was also an indication that the Petitioner may have injured his toe jumping from a bed while incarcerated, again this does not indicate in and of itself that his lumbar condition was impacted. The Respondent referred to a note from Dr. Silver which states that in June of 2018 he was in jail and exacerbated

his back pain, however this is the totality of this evidence. The Arbitrator acknowledges that there are some discrepancies in the story surrounding the altercation the Petitioner's wife was involved in and the fact he jumped off a bed while in jail given that he had a low back condition, but in no way do these incidents lead to the conclusion by any preponderance of the evidence that these constituted intervening incidents that somehow broke the chain of causation between the 6/14/17 work accident and the Petitioner's lumbar condition at L4/5. A herniated L4/5 disc was confirmed via an objective MRI prior to this time, and the symptoms for which Dr. Salehi recommended surgery in March 2018 were not significantly different than those which existed prior to January 2018.

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's medical care has been reasonable and necessary to treat the 6/14/17 work accident, with the exception of various treatments and medications instituted by Dr. Glaser, and that the Respondent has not paid for all appropriate charges. It appears from the Arbitrator's review of Px1 that virtually all of the unpaid charges relate to the treatments and prescriptions of Dr. Glaser

The treatment instituted by PIC and Dr. Salehi, including the lumbar MRI and physical therapy, were reasonable and necessary in the Arbitrator's view based on the preponderance of the evidence. While Dr. Grattan's UR report indicated that ODG did not support the x-rays that were initially taken via PIC nor the medications prescribed, and that the lumbar MRI obtained was premature, the Arbitrator finds that the x-rays were of minimal charge and are commonly performed at initial emergency-type visits following an accident that may involve the spine, and the fact that the MRI may have been somewhat premature per ODG does not automatically mean the procedure was not reasonable, particularly given the hindsight of the finding of an L4/5 disc herniation. The charges of Dr. Glaser for office visits on 7/14/17 ($313.00), 8/17/17 ($125.00), 8/31/17 ($125.00), 9/28/17 ($125.00), 10/26/17 ($186.00), 12/28/17 ($125.00), 5/15/18 ($125.00), 6/2/18 ($125.00), 7/3/18 ($100.00), 7/11/18 ($125.00), 9/6/18 ($125.00) and 10/10/18 ($125.00) are found by the Arbitrator to be reasonable and necessary by the Arbitrator pursuant to Section 8(a), and the charges are awarded pursuant to this Section and Section 8.2 of the Act.

The treatments instituted via and by Dr. Glaser are another matter altogether. The Arbitrator notes that board-certified neurosurgeon Dr. Salehi himself testified that further conservative treatments after 3/1/18 were unnecessary. The Arbitrator further notes that Dr. Glaser treated the Petitioner conservatively between 7/14/17 and 11/13/18. For this period of treatment, via five separate "providers" (Elmwood Park Same Day Surgery, Instant Care Equipment Leasing, Metro Health Solutions, Windy City Anesthesia and Pain and Rehab Specialists of Greater Chicago), Dr. Glaser's visits and prescriptions rang up a grand total of $128,663.10 in charges. In the Arbitrator's experience with hundreds of workers compensation claims involving spine treatment, these charges are absolutely excessive by any reasonable measure. This is significantly borne out via the UR's obtained by Respondent.

These charges include repeated charges in the neighborhood of $7,000 each for a two-week rental of a GameReady cold compression device (via Instant Care), which the UR report indicates has no significant increase in efficacy than that of a simple ice bag. The Arbitrator must repeat: upwards of $7,000 for each prescribed two-week period of use. The device was charged for on 8/1/17 ($6,886.30), 11/21/17 ($6,825.00) and 4/17/18 ($7,507.50) and the charges totaled $21,218.80. The Arbitrator finds that the weight of the evidence in this case makes it abundantly clear that these prescriptions for the GameReady cold compression devices are

patently unreasonable, unnecessary and excessive in cost pursuant to Section 8(a) of the Act for the intended purpose, and these charges are denied. Pursuant to Section 8.2 of the Act, neither the Petitioner nor the Respondent are liable for the costs of these products.

Additionally, Dr. Glaser, in addition to prescribing multiple oral medications which include opiates, prescribed "Metrotopical" creams, for which he was charging the Respondent upwards of $2,846.88 per month. According to Dr. Grattan's UR report and testimony, Metrotopical cream is not recommended for certification, as very few such topicals have supporting studies, and where there are such studies it is typically for neuropathic pain. There is no evidence in this case that the Petitioner was suffering from neuropathic pain. In addition, the Arbitrator notes that the costs of these creams are excessive on their face. The reports of Dr. Glaser make it quite clear that any claimed improvement in the Petitioner's condition was short-lived, as evidenced by the March 2018 surgical recommendation of Dr. Salehi. Pursuant to Px1, these charges totaled $27,184.42 (Metro Health). The Arbitrator finds that the evidence in this case convincingly indicates that the Metrotopical creams prescribed by Dr. Glaser were unreasonable, unnecessary and of significantly excessive cost pursuant to Section 8(a) of the Act, and the charges for these products are denied. Pursuant to Section 8.2 of the Act, neither the Petitioner nor the Respondent are liable for the costs of these products. If any portion of these charges are based on the prescription of oral medications, that portion would be the responsibility of the Respondent.

Dr. Glaser performed and charged for a series of various types of injections. This includes the charges of Dr. Glaser himself (Pain Specialists), an anesthesiologist (Windy City) and a surgical facility (Elmwood Park). For facet injections performed on 8/1/17, Dr. Glaser charged $2,792.00 and the facility charged $20,406.63. Based on the UR report of Dr. Grattan, these charges are denied pursuant to Section 8(a) of the Act. Similarly, facet injections performed by Dr. Glaser on 8/21/18 ($2,792.00 by Dr. Glaser and $21,800.21 by the facility) are denied as well. No surgeon in this case has indicated that facet injections were reasonable and necessary in this case, and Dr. Grattan indicated that these injections would not be favored over medial branch block injections, which Dr. Glaser also prescribed and performed. Dr. Kornblatt opined that there was no basis for the facet injections. In the latter case of the injections, the Arbitrator also notes that surgery had already been prescribed, and, as noted above, Dr. Salehi testified that further conservative treatments after 3/1/18 were unnecessary.

Dr. Glaser performed lumbar epidural injections on 11/21/17 and 4/17/18. With regard to the former, the charges included $3,878.00 from Dr. Glaser, $11,502.53 from the facility and an unknown amount from the anesthesiologist, as a letter in Px1 indicated the charges had already been paid by Respondent. The Arbitrator finds that the 11/21/17 epidurals were reasonable and necessary under Section 8(a) of the Act, and this is supported by the opinions of Dr. Kornblatt.

A second set of epidurals was performed on 4/17/18, for which the charges included Dr. Glaser ($3,878.00), the surgical facility ($12,573.56) and the anesthesiologist ($2,571.00). Based on the opinions of Dr. Salehi and UR reviewer Dr. Hagle, these charges are denied as unreasonable and unnecessary treatments pursuant to Section 8(a) of the Act. Pursuant to Section 8.2 of the Act, neither the Petitioner nor the Respondent are liable for the costs of these products.

Finally, Dr. Glaser performed medial branch blocks on 10/2/18. The charges for this procedure involved $2,792.00 from Dr. Glaser and $31,645.92 from the surgical facility. These charges are denied. While Dr. Grattan opined that medial branch blocks should be performed instead of facet injections if the theory is that there is pain resulting from the facets, this procedure took place well after Dr. Salehi had prescribed surgery and well after he indicated that conservative treatments were no longer applicable.

The Petitioner also submitted billing from Injured Workers' Pharmacy totaling $653.45, all prescribed by Dr. Glaser. This includes Tramadol and Norco between 7/19/17 and 11/15/18. (Px12). The Arbitrator finds these prescription medications to be reasonable and necessary pursuant to Section 8(a) of the Act, and Respondent is liable for same pursuant to Sections 8(a) and 8.2 of the Act.

Dr. Glaser at one point, in response to the last report of Dr. Kornblatt, stated that a board-certified spine surgeon apparently had no business opining as to proper pain treatments for a spine condition, and that the doctor "should be ashamed" of his opinions in this case. The chutzpah, for lack of a better word, of this pain physician using such language in criticizing a board-certified surgeon in this case is completely uncalled for in the Arbitrator's view. After charging or recommending treatments the charges for which exceeded $125,000 for conservative measures that appear to have provided no significant improvement whatsoever to the Petitioner's condition, many of which have questionable efficacy at best at highly excessive costs, and which were prescribed by no other physicians in this case, the only party in this case that should be ashamed is Dr. Glaser himself.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the surgical treatment recommended by Dr. Salehi, consisting of an L4/5 lumbar fusion, is reasonable and necessary treatment pursuant to Section 8(a) of the Act. As such, the Respondent is liable and shall authorize same.

This issue was made significantly more difficult by issues of credibility involving the Petitioner in this case. This includes an essentially invalid FCE, which includes issues related to TTD, the altercation involving Petitioner's wife and his subsequent incarceration. The Arbitrator has considered all of these issues, but the bottom line in this case is that there is objective evidence of an L4/5 disc herniation that is causing a level or spinal and foraminal stenosis, and no evidence of any similar prior symptoms before 6/1/17. Additionally, the Arbitrator notes the opinions of Dr. Salehi and Dr. Richardson in favor of the recommended fusion surgery, as well as the opinions of Richardson and Dr. Kornblatt indicating they saw no evidence of malingering or manipulation on the Petitioner's behalf in this case. It is relevant to the Arbitrator that both of these opinions were also obtained at the request of the Respondent. The Arbitrator would caution the Petitioner that the goal after surgery is to obtain the best possible outcome for his lumbar spine, and that being involved in altercations of any sort, particularly ones that could result in situations of incarceration, are not in the best interests of his long term health.

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

The Petitioner claims entitlement to TTD from 6/7/17 through the 4/25/19 hearing date. The Respondent indicates it paid TTD totaling $17,774.16 for the period from 6/7/17 through 5/9/18. The Arbitrator finds that the Respondent reasonably terminated TTD as of 5/9/18.

The basis for this determination rests significantly on the FCE findings. While it is true that Dr. Richardson and Dr. Kornblatt indicated that the FCE findings were not as bad as the report may have made them out to be in terms of the Petitioner's effort, the FCE report is nevertheless clear that the Petitioner was capable of working at a level significantly above what he displayed at the FCE. The evidence in the record indicates that light duty had been made available to the Petitioner initially for a period of time. This supports a finding that light duty was, in

fact, available with Respondent depending on the level of work he was capable of. While the FCE was not able to truly specify this, it is also true that this was due in large part to the Petitioner's own actions. He essentially cannot cause in inaccurate result in the FCE setting and then complain that no light duty was available when the determination of this issue was dependent on those same inaccurate results.

On the other hand, the Respondent cannot talk out of both sides of its mouth. Evidence has been presented of the Petitioner seeking to reapply for a job with Respondent. It is unclear to the Arbitrator if the Petitioner has been terminated from his employment with Respondent or not. If the Petitioner has in fact been terminated, the facts reflect that he has not been returned to work in a completely unrestricted capacity. In such case, according to current case law, the Petitioner would be entitled to TTD as of the termination date through the date of hearing.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Respondent has presented reasonable defenses in this claim, which have been outlined in detail above, both in terms of credibility issues with Petitioner and reasonable disputes regarding treatment protocols. For these reasons, penalties and fees are denied.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent's TTD credit is $17,774.16 based on benefits paid prior to hearing.

WITH RESPECT TO ISSUE (O), THE NUMBER OF DEPENDENT CHILDREN, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner has failed to prove that he has more than one dependent under the age of 18. The only evidence of dependence that was provided by Petitioner is that he lives with his wife's two children, that their biological fathers were either deceased or incarcerated, and that he claims the children on his tax returns as dependents. This is simply not enough, in the Arbitrator's view, to find that the children are Petitioner's dependents under the Act.

No information was elicited as to who pays the expenses of the children. No information was elicited as to whether the tax returns are filed jointly with his wife or solely on behalf of Petitioner himself. No information was elicited on whether his wife works or whether it is solely her earnings that pay for the expenses of her children. The Petitioner has acknowledged that he has not adopted the children. While he provided an explanation after the fact, the Petitioner did not claim more than one dependent on his initially filed Applications for Adjustment. In order to claim these children as his dependents, the Petitioner needed to provide significantly more detailed information with regard to whether these children were financially dependent upon him, and he has failed to do so by the preponderance of the evidence. The Arbitrator finds that the Petitioner had one dependent under the age of 18 at the time of the 6/14/17 accident.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF JEFFERSON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cody Summers,

Petitioner,

vs.

NO: 11 WC 45381

20IWCC0539

Petco Petroleum Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical bills, temporary total disability ("TTD"), and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. The Commission finds Petitioner met his burden of proving he sustained accidental injuries that arose out of and in the course of his employment on October 6, 2011. The Commission further finds Petitioner sustained permanent disabilities due to the October 6, 2011, work incident. On the date of accident, Petitioner was directly exposed to gas and fumes when the crew with whom he was working accidentally ruptured an underground gas line. The following day he sought medical treatment after experiencing symptoms including shortness of breath and lightheadedness. Dr. Jamal, Petitioner's treating physician, ultimately diagnosed Petitioner with an inhalation lung injury and reactive airways. The results of a stress test Petitioner underwent due to his ongoing symptoms on November 8, 2011, were normal. A myocardial perfusion study was also normal. On November 14, 2011, Dr. Jamal discharged Petitioner from care and cleared Petitioner to return to his normal job without any restrictions. Petitioner has sought no additional medical treatment relating to this work accident since that final visit with Dr. Jamal.

During the hearing, Petitioner testified that he continues to experience breathing problems and his daily life continues to be affected by residual symptoms. Petitioner testified that he works on his family farm and his daily chores can be difficult depending on which particles are in the air. He testified that humidity as well as seasonal issues during farming season trigger shortness of breath episodes. Petitioner testified that cold air, fumes, and dust also trigger shortness of breath

episodes. Petitioner testified that he continues to use an inhaler when he experiences shortness of breath. While he did admit to suffering from sinus issues prior to the work incident, Petitioner testified that he never previously experienced shortness of breath. Petitioner continues to smoke approximately one pack of cigarettes each week.

After carefully considering the totality of the evidence, and analyzing the five factors pursuant to Section 8.1b(b) of the Act, the Commission finds Petitioner sustained a 4% loss of use of the whole person. Petitioner credibly testified that he continues to occasionally experience shortness of breath episodes. However, his condition required limited and very conservative treatment. The work injury occurred on October 6, 2011, and Petitioner achieved MMI and was discharged from care on November 14, 2011. The results of both the stress test and the myocardial perfusion study Petitioner underwent following the work incident were normal. Petitioner's treating doctor cleared him to return to his regular job without any restrictions. Although Petitioner did not return to his original job, he immediately began working as a welder. This position involved a lot of grinding of materials. Petitioner testified that the particles in the air would bother him; however, he continued in this position for three years and only left the position due to his incarceration in October 2014. Petitioner's occasional bouts of shortness of breath have not prevented him from continuing in his normal occupation or from performing his usual duties on the family farm. Furthermore, Petitioner has not sought any additional medical treatment for his work-related injury since November 14, 2011.

For the foregoing reasons, the Commission finds Petitioner sustained a 4% loss of use of the whole person as a result of the October 6, 2011, work injury.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 19, 2019, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner temporary total disability benefits of **$319.00**/week for **5-4/7** weeks commencing **October 7, 2011** through **November 14, 2011**, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services of **$20,325.90**, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent partial disability benefits of **$319.00**/week for **20** weeks, because Petitioner's injuries caused **4%** loss of use of the whole person, as provided for in §8(d)2 of the Act.

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

20IWCC0539

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020

d: 8/4/20
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUMMERS, CODY Case# **11WC045381**
Employee/Petitioner

PETCO PETROLEUM CORP
Employer/Respondent

20 I W CC0539

On 8/19/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0479 MUELHAUSEN & STEFANI
LAWRENCE STEFANI
745 McCLINTOCK SUITE 315
BURR RIDGE, IL 60527

0000 RUSIN & MACIOROWSKI LTD
TERRY SCHROEDER
2506 GALEN DR SUITE 104
CHAMPAIGN, IL 61821

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

Cody Summers
Employee/Petitioner

v.

Petco Petroleum Corp.
Employer/Respondent

Case # **11** WC **45381**

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 **Mt. Vernon**, on **2/8/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/6/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,720.00**; the average weekly wage was $**360.00**.

On the date of accident, Petitioner was **26** 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** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $20,325.90, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $319.00/week for 5 4/7 weeks, commencing 10/7/11 through 11/14/11, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, the Respondent shall pay Petitioner permanent partial disability benefits of $319.00/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Michael K. Nowak, Arbitrator

8/15/19
Date

FINDINGS OF FACT

The Petitioner is 33 years old and testified that on October 6, 2011 he was employed as a pipefitter and laborer for Respondent. Respondent is in the oil business and Petitioner's duties involved working in the oil fields, digging trenches in the ground and laying pipe for various substances which include oil, gas and salt water.

Petitioner testified that on October 6, 2011, he was a member of a crew working at a job site at Twin Bridges. His shift was 7:00 a.m. to 3:00 p.m. The work on that date involved installing new pipeline underground. Salt water was to go through this line after installation. The crew included Petitioner, Lee Warner, Charles Maroon and Charles Smith. Petitioner testified that Charles Smith was the crew leader and operator, and that Lee Warner and Charles Maroon were laborers, similar to Petitioner. The job of installing underground pipeline involved digging and working in a trench. Charles Smith was operating a track hoe which is used to dig dirt and make the trench line for the pipe. The trench was approximately four feet deep and six to eight feet wide. Petitioner testified that at approximately 1:00 p.m., Charles Smith, while digging with the track hoe, inadvertently ruptured an existing gas line which was also in the trench. Lee Warner and Charles Maroon were working in the trench at the time of the rupture. Petitioner testified he was next to the company truck which he states was 15 to 30 feet from the trench. Petitioner explained that the truck needs to be close to the trench area for quick accessibility if tools are needed, or in the case of an emergency, such as what happened.

Following the rupture, Petitioner observed fluids coming from the gas line and noticed that Lee Warner and Charles Maroon were "covered head to toe". Petitioner stated he noticed a "sulfuric eggy smell, like a rotten egg".

Petitioner testified that Respondent had an office approximately a mile and a half to two miles from the job site. Phil Wells, who is now deceased, was the head supervisor at that time. Petitioner contacted Wells from the truck to advise of the ruptured gas line. Wells arrived on the scene from the nearby Petco facility and sent Lee Warner and Charles Maroon back to the Petco office to clean up. Petitioner states that Warner and Maroon were gone for approximately 45 minutes.

Petitioner testified that a ruptured gas line presents a very hazardous situation and the priority is to repair it quickly. This involves cutting and cleaning the pipe and putting in a clamp to stop the flow of oil and gas. Phil Wells called the small poly crew who brought the tools to fix the line. Petitioner testified that Charles Smith stayed on the track hoe to keep dirt away from the punctured gas line. He stated that he and Phil Wells got in the ditch and repaired the ruptured gas line and that 35 to 40 minutes elapsed from the time of the rupture to its repair. During that period, he states that the sulfuric rotten egg smell remained. Petitioner testified that he and the other members of the crew were wearing hydrogen sulfide monitors which did not activate. He stated that a nearby worker named Aaron Theory, who was on the mowing crew, walked up to the trench following the rupture and recalls that Theory's monitor did signal. The mowing crew was responsible for mowing the paths to allow Petitioner's crew to lay the pipeline down.

Petitioner testified that following the rupture, he noticed symptoms which included shortness of breath, nausea and being light headed. These symptoms persisted the remainder of the day and into the following day.

On Friday, October 7, 2011, Petitioner was scheduled to work at 7:00 a.m. On that morning, he called Phil Wells and informed him he had not been feeling well since the gas line rupture. He proceeded to the emergency room at Fayette County Hospital.

Lee Warner gave a recorded statement on January 27, 2012 **(Resp. Ex. 5; Deposition Ex. 1)** and testified by deposition on January 27, 2016 **(Resp. Ex. 5)**. Warner confirmed that Charles Smith ruptured the gas line, and that he and Charles Maroon were in the trench at the time. He states there was an eruption of gas and oil. He testified that Petitioner was by the truck getting tools when the rupture occurred. In his recorded statement of January 27, 2012, Warner stated the truck was approximately 15 to 20 feet from the trench and gas line rupture. **(Resp. Ex. 5, Deposition Ex. 1, p. 15)**. However, in his deposition of January 27, 2016 he stated that the truck was 50 to 60 feet away. **(Resp. Ex. 5, p. 10)**. Warner confirmed that both he and Maroon were covered in oil and gas, and that he noticed the odor of gas in the air. He testified that he was wearing a hydrogen sulfide monitor which did not activate. He confirmed that a ruptured gas line presents a dangerous situation, and the priority is to repair it quickly to stop the flow of oil and gas. Both he and Maroon were sent back to the yard to shower and change clothes. He testified that they were gone 45 minutes to an hour and that Petitioner remained on the site. He was not sure what happened on the job site during that period but recalls that he and Maroon assisted in repairing the pipe upon their return.

Charles Smith, like Warner, gave a recorded statement on January 27, 2012 **(Resp. Ex. 6)** and testified by deposition on January 27, 2016. **(Resp. Ex. 4)**. Smith confirmed that he ruptured an existing gas line while operating the track hoe. He acknowledged that Warner and Maroon were in the trench at the time, got covered in oil and salt water, and were sent back to the office to clean up and change clothes. He states that Petitioner was by the truck when the rupture occurred, and the truck was 50 to 60 feet away from the trench. Smith also noticed the smell of gas in the air following the rupture. He acknowledged that, when a gas line ruptures, it is a priority to repair the line and stop the flow of oil and gas into the air. He states that this is necessary to keep it from damaging the land and causing damage to any person. The longer the situation exists, the greater the risk. He testified that none of the hydrogen sulfide monitors activated.

Smith confirmed that Warner and Maroon were gone approximately 45 minutes after being sent into the office to clean up. Smith presents conflicting accounts of what transpired next to repair the rupture. On direct examination, he testified that "to the best he can remember", Lee Warner and Charles Maroon repaired the pipe upon return to the site of the rupture. **(Resp. Ex. 6; p. 10)**. However, on cross examination, Smith testified that it was he who got in the ditch to repair the ruptured pipe. **(Resp. Ex. 6, pp. 20 & 21)**. He states that the repair took approximately 30 minutes. He testified that Petitioner remained in the area that entire time. **(Resp. Ex. 6; p. 21)**

On October 7, 2011, Petitioner arrived at Fayette County Hospital at 9:35 a.m. **(Pet. Ex. 3)** He reported being exposed to hydrogen sulfide yesterday from working in the oil field. He complained of difficulty breathing, cough and bilateral wheezing. X-ray of his chest was normal. He was diagnosed with asthmatic bronchitis, was treated with bronchodilation inhaler and taken off work.

From October 8, 2011 through October 12, 2011, the symptoms continued, and Petitioner returned to Fayette County Hospital on October 12, 2011. **(Pet. Ex. 5).** Petitioner again reported symptoms which included difficulty breathing, cough and rib pain following inhalation of gas at work. High resolution CT Scan of the chest and repeat chest X-ray were performed and were unremarkable. The physicians at Fayette County Hospital recommended transfer from Fayette County Hospital to Barnes-Jewish Hospital in St. Louis.

Petitioner was transported by ambulance to Barnes-Jewish Hospital. The EMS report reflects shortness of breath and cough following exposure to hydrogen sulfide gas while working in the oil field. **(Pet. Ex. 4).** He was admitted to Barnes-Jewish from October 12, 2011 through October 13, 2011. **(Pet. Ex. 6).** He reports a history of gas exposure following a ruptured line at work. He had complaints of shortness of breath and chest pain. Right rib x-ray was negative. The primary diagnosis was "toxic effect of hydrogen gas".

Petitioner received follow up treatment from Dr. Asad Jamal from October 24, 2011 through November 14, 2011. **(Pet. Ex. 7).** Records reflect continuing complaints of difficulty breathing with coughing and wheezing following inhalation of fumes at work. Dr. Jamal diagnosed toxic inhalation lung injury with reactive airways and chest pain and continued Petitioner on Broncho dilating medication. Cardiac stress test of November 8, 2011 was normal. On November 14, 2011, Dr. Jamal returned Petitioner to full duty work as tolerated on November 15, 2011.

Petitioner did not return to work with Respondent and testified to working as a welder from November 15, 2011 through October 15, 2014 with continuing episodes of shortness of breath.

From October 15, 2014 through October 6, 2017, Petitioner was incarcerated. He testified that episodes of shortness of breath continued. While incarcerated, he tried to run to stay fit and healthy, but was unable to do so due to the breathing difficulties.

Petitioner testified that the episodes of shortness of breath currently continue. They are precipitated by triggers which include humidity, cold air, fumes and dust, and physical exertion. He uses albuterol inhaling treatment as needed. He is currently not working, but spends time helping on his grandfather's cattle farm. He continues to experience shortness of breath performing heavy activities on the farm.

Petitioner testified he never had issues with shortness of breath prior to the October 6, 2011 gas line rupture incident and has sustained no other injuries to his lungs. He recalls having a head cold with some sinus issues in the period prior to October 6, 2011, but did not experience symptoms of difficulty breathing, wheezing and lightheadedness which occurred following the gas line rupture.

Dr. Jeffrey Coe examined Petitioner on May 16, 2012 and testified by deposition on August 7, 2015. **(Pet. Ex. 2).** Dr. Coe is a board certified specialist in occupational medicine. Dr. Coe concluded that Petitioner suffered a lung injury in his workplace on October 6, 2011 from inhalation of hydrogen sulfide. He explained that the injury is referred to as reactive airway dysfunction syndrome which results in bronchospasm and shortness of breath. It causes direct injury to the airways and to receptors in these airways causing them to become inflamed and more sensitive to the environment with repeated episodes of bronchospasm after a single exposure. He states that the

lung condition has reached a permanent state, and Petitioner continues to have airway hyper-responsiveness and hypersensitivity to anything that could cause irritation.

Dr. Coe testified that hydrogen sulfide is a gas with well-known toxic properties. It is a by-product of chemical processes also of crude oil or chemical refining processes. Exposure usually occurs through inhalation. The gas has a strong, pungent, rotten egg type of smell. He explains that workers in oil and gas drilling are at a high risk of exposure, and a ruptured line would cause hydrogen sulfide to be emitted into the air. **(Pet. Ex. 2)**

Dr. Coe obtained a history of Petitioner working in a trench to repair a ruptured oil line and the hydrogen sulfide monitor signaling. Dr. Coe testified that the hydrogen sulfide monitor's purpose is to detect potentially toxic levels of the dangerous gas and it is set to signal at a certain exposure level. He further states that it is well recognized that an individual could experience pulmonary symptoms from hydrogen sulfide exposure where the level of exposure is not at the level where the monitor would signal. Dr. Coe testified that, even if Petitioner was not actually in the trench, but was in the nearby area of the rupture, that was sufficient exposure to result in pulmonary symptoms. **(Pet. Ex. 2)**

Dr. Glennon Paul examined Petitioner on April 18, 2013 at the request of Respondent. **(Resp. Ex. 2)** Dr. Paul concluded that Petitioner has probable asthma, intrinsic in etiology, which may have been temporarily worsened by exposure to hydrogen sulfide gas. He performed pulmonary function studies which revealed mild to moderate obstruction with reversibility compatible with a reactive airway disease, such as asthma. He recommended anti-inflammatory drugs such as inhaled steroids and a rescue inhaler. Dr. Paul noted that symptoms have greatly improved since the hydrogen sulfide exposure on October 6, 2011 and should continue to improve.

Dr. Paul authored a supplemental report dated June 17, 2013 in which he was provided the January 27, 2012 recorded statement of Charles Smith. **(Resp. Ex. 3)** Dr. Paul notes that Smith says that Petitioner was "nowhere in the area" during the break of the pipe. Based on Smith's statement, Dr. Paul finds that it is very unlikely the hydrogen sulfide exacerbated his asthma. He further states that "if Mr. Smith is right, Petitioner suffered from an exacerbation of asthma secondary to an upper respiratory tract infection.

CONCLUSIONS

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

It is undisputed that, on the October 6, 2011 accident date, Petitioner was a member of a crew laying pipeline underground. It is further undisputed that Charles Smith ruptured a gas line while digging with a track hoe and that oil and gas were emitted. All witnesses agreed that there was a smell of gas and rotten eggs. Although there are factual disputes regarding the events that transpired following the rupture, the evidence supports that Petitioner remained in the area following the rupture and was exposed to the gas that was emitted from the ruptured gas line. He experienced symptoms which included shortness of breath, cough and lightheadedness which caused him to seek emergency care at Fayette County Hospital the following day on October 7, 2011.

Based on the above, and the record taken as a whole, the Arbitrator finds that on October 6, 2011, an accident occurred that arose out of and in the course of Petitioner's employment for Respondent.

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

The chain of events supports causal relationship. There was immediate onset of pulmonary symptoms following the rupture of the gas line and Petitioner's exposure to hydrogen sulfide. These symptoms caused Petitioner to seek emergency care the following day on October 7, 2011 at Fayette County Hospital, with a return to Fayette County Hospital on October 12, 2011 and a subsequent transfer to Barnes-Jewish Hospital where he was admitted. There is no evidence of any treatment prior to the October 6, 2011 rupture of the gas line. Further, the Arbitrator relies on the treating medical records, the opinion of Dr. Coe and the original opinion of Dr. Paul in finding a causal relationship.

The October 7, 2011 emergency room of Fayette County Hospital record reflects complaints of difficulty breathing, productive cough and bilateral wheezing following exposure to hydrogen sulfide working in the oil fields yesterday. The EMS report of October 12, 2011 reflects complaints of shortness of breath and cough following exposure to natural gas. The records of Barnes-Jewish Hospital reflect a primary diagnosis of "toxic effect of hydrocarbon gas". The records of Dr. Asad Jamal reflect toxic inhalation lung injury. The treating records in their entirety consistently support the onset of pulmonary symptoms following the gas exposure.

The opinions of the respective experts obtained by both Petitioner and Respondent also support a causal relationship. Dr. Coe is of the opinion that the lung injury was the result of hydrogen sulfide exposure. Dr. Paul, in his initial report, found that the exposure to hydrogen sulfide worsened Petitioner's probable asthma.

Dr. Paul later changed his opinion based on Charles Smith's statement in which he says Petitioner was "nowhere in the area" following the rupture. This opinion is not persuasive. Both Petitioner and Mr. Warner confirmed that Petitioner was at least standing beside the open trench where the rupture occurred. The Arbitrator finds the statement of Mr. Smith that Petitioner was "nowhere in the area following the rupture is not credible.

There is a factual dispute regarding events occurring between the ruptured line and it's repair. There are conflicting accounts of who repaired the rupture. It is undisputed that Lee Warner and Charles Marroon were sent into the office to clean up and change clothes following the rupture and were gone approximately 45 minutes to an hour. Warner recalls that he and Marroon assisted in the repair after return to the job site. Petitioner testified that he and Phil Wells went into the ditch to repair the rupture. Charles Smith disagreed. However, Smith's testimony and recollection are suspect considering on direct examination he stated that Lee Warner and Charles Marroon repaired the rupture, but on cross examination he testified that he got in the ditch to repair the ruptured pipe.

Despite the differing accounts of what transpired, it is clear that Petitioner remained in the area the entire time. Dr. Coe testified that it was not necessary that Petitioner was actually in the trench, but being in the area was sufficient exposure to cause pulmonary symptoms. He further states that it is well recognized that some individuals will experience symptoms from the hydrogen sulfide exposure where the level of exposure is not at the level where the hydrogen sulfide monitor will signal.

All witnesses agree that the smell of gas permeated in the air following the rupture. Petitioner had the immediate onset of pulmonary symptoms which caused him to seek emergency care the following day. It simply defies logic to speculate that these symptoms are not related to exposure to a gas which is well known to cause those exact symptoms.

Based on the above, and the record taken as a whole, the Arbitrator finds that a causal connection exists between Petitioner's current pulmonary condition of ill-being and the gas line rupture of October 6, 2011.

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

Issue (K): What temporary benefits are in dispute?

The Respondent's only objection to the claimed medical and temporary total disability is based on accident and causal relationship issues which have been resolved in Petitioner's favor.

Based on the above, the Arbitrator finds that Petitioner was temporarily totally disabled from October 7, 2011 through November 14, 2011, for a period of 5-4/7 weeks.

The Arbitrator further finds that medical bills in the amount of $20,325.90 **(Pet. Ex. 1)** are reasonable and necessary and causally related to the accident of October 6, 2011. Respondent shall pay said bills pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall get credit for all amounts previously paid by Respondent.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a pipefitter/laborer working in the oil fields at the time of the accident. Petitioner has no work restrictions resulting from this injury. However, the job involves heavy work laying and repairing pipeline and working outdoors in the oil fields. The Arbitrator notes Petitioner's testimony that episodes of shortness of breath are triggered by humidity, cold air and physical exertion. Because of heavy labor duties which require Petitioner to work in all types of weather conditions. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 26 years old at the time of the accident and, as a younger person, will likely continue to work with the effects of his pulmonary injury and

may feel those effects for a longer time then an older person. 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 direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The medical records corroborate that Petitioner sustained a gas exposure at work resulting in shortness of breath, coughing and wheezing. Petitioner was diagnosed with an inhalation lung injury. He continues to experience episodes of shortness of breath which are precipitated by various triggers which include humidity, cold air, fumes and dust, household products such as bleach, and physical exertion. Dr. Coe states that Petitioner developed a lung injury usually referred to as reactive airway dysfunction syndrome which causes direct injury to the airways and to receptors in these airways causing them to become inflamed and more sensitive to the environment with repeated episodes of bronchospasm after a single exposure. He states that the condition is permanent. Petitioner required nebulized bronchodilating medicines to open up his respiratory passages. Dr. Jamal diagnosed inhalation lung injury with reactive airways. Petitioner continues to use an Albuteral inhaler as needed for the episodes of shortness of breath he experiences. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stanley Malik,

Petitioner,

vs. NO: 17 WC 30799

Draper & Kramer, **20IWCC0540**

Respondent.

DECISION AND OPINION ON REVIEW

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

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

20IWCC0540

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

DATED: SEP 2 1 2020
TJT:yl
o 9/1/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MALIK, STANLEY
Employee/Petitioner

Case# **17WC030799**

DRAPER & KRAMER
Employer/Respondent

20IWCC0540

On 2/5/2018, 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 1.62% 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:

1938 ALEKSY BELCHER
RANDALL T MANOYAN
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0000 HOLECEK & ASSOCIATES
LAUREN ZIMMER
PO BOX 64093
ST PAUL, MN 55164

20IWCC0540

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STANLEY MALIK
Employee/Petitioner

v.

DRAPER & KRAMER
Employer/Respondent

Case # **17** WC **30799**

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 **Arbitrator Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **December 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [ ] 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 **5/18/2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,587.02**; the average weekly wage was $**991.74**.

On the date of accident, Petitioner was **64** 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 is entitled to a credit of $**153.23** under Section 8(j) of the Act.

ORDER

Because the Petitioner failed to prove that he suffered an accident arising out of and in the course and scope of his employment with the Respondent, benefits are denied. The Respondent did not act in an unreasonable or vexatious manner in denying this case, therefore, no penalties or attorneys' fees 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

02-01-18
Date

FEB 5 - 2018

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STANLEY MALIK,)
)
Petitioner,)
)
v.) Case Number 17 WC 30799
) Arbitrator Carlson
DRAPER & KRAMER.)
)
Respondent.)

FINDINGS OF FACT

The Petitioner testified with the assistance of an interpreter, claiming he felt more comfortable speaking in Polish. T. 59. He testified is 64 years old and that he moved to the United States in 1987. T. 8. He testified that he worked as a maintenance repair worker for Draper & Kramer at 540 North State since 2012. T. 9. The Petitioner testified that his job consisted of maintenance tasks throughout the building, including preparing apartments for tenants, performing work orders and maintaining the swimming pool. T. 11. To maintain the pool, the Petitioner would check and adjust the chemical levels of the pool, which took between 10 and 30 minutes during which time the pool remained open to residents. T. 57-58. To perform this task, the Petitioner stated that he would do a visual inspection of the pool on the 9th floor, then go to the 8th floor to adjust the chemical levels. T. 24-25.

The Petitioner testified that he used a stairwell when completing this task. T. 25-26. He testified that the stairwell was used by building workers and was open to residents. T. 29, 47. He testified that "very often" homeless people were looking for shelter on the

stairs, having used the parking area to gain access to the stairwell. T. 29, 47. The Petitioner testified that he had previously seen cardboard, food remains, papers, newspapers and human waste in the stairwell. T. 30.

The Petitioner testified that on May 18, 2017 he went to the pool and visually inspected it before using the stairwell to go to the 8th floor. T. 23-26. He testified that as he was going down the stairs, he "probably stepped on something or put my leg on something, so my foot got twisted and I lost my balance and because I slipped and lost the balance, I went – I fell, and I wanted to brace myself, so I extended my arm and with the whole force of my body fell on that arm." T. 26.

The Petitioner testified that he was not carrying anything at the time of his fall and that he did not notice any human waste on his shoes after the fall. T. 46, 48. He testified that he did not look if there was anything on the floor that caused him to slip because he was in pain. T. 48.

When asked during the hearing for more detail relative to the cause of his fall, the following exchange occurred between the Petitioner and his attorney (T. 62):

> Q: Now with regard to the fall that you suffered in the stairwell that day, you testified that you believe that there was some sort of slippery substance on one of the stairs that day, right?
> A: Yes, there's a possibility.
> Q: But would it be fair to say that your fall happened so quickly and the result of your fall was so painful, that it didn't really occur to you to checkout the area in which you slipped on?
> A: Of course, yes.

Later, on cross examination, the Petitioner admitted that he did not know for certain if there was a substance on the floor that caused him to fall, but stated that "I've been walking on these stairs several years, nothing happened, so it must have been some kind of reason." T. 67-68.

Following the incident, the Petitioner experienced pain in his right shoulder. T. 27. He reported the occurrence to his supervisor, Steven Zolan. T. 31. The Petitioner testified that he did not report any water, debris or waste on the stairs to Mr. Zolan. T. 48. He did not report any defect on the stairs or any cause for his fall. T. 49.

The Petitioner sought treatment from Union Health Services, UIC Medical Center, Illinois Masonic, ATI Physical Therapy and Dr. Chudik of Hinsdale Orthopedic. T. 31-38. During this time, the Petitioner also received treatment for an unrelated heart condition. *Id.* The Petitioner testified that his shoulder condition required surgery and he wished to undergo the same. T. 39, 41.

On cross examination, the Petitioner testified that he communicated at work in English and that all work orders were written in English. T. 43. He admitted that he was able to answer questions during his testimony at the hearing prior to the question being translated into Polish. *Id.* He testified that he communicated in English with his all but one of his doctors during his treatment for his shoulder injury and for his unrelated cardiac condition. T. 51-52. The Petitioner testified that he communicated with the Traveler's claim handler investigating his claim in English. T. 52.

The Petitioner testified that he was directed by Mr. Zolan to seek treatment at Union Health Services, but later admitted that Union Health Services was his primary care doctor he was required to see for his union health insurance. T. 32, 50-51.

The Petitioner testified that he came under the care of Dr. Chudik (Hinsdale Orthopedics) based on a referral from a friend. T. 54. He testified that he provided Dr. Chudik with a history of his accident and his complaints and that he understood the importance of being truthful to his doctor. T. 55. He testified that he did not tell Dr. Chudik

that he miss stepped or rolled his ankle at the time of the fall, even though the statement was contained in Dr. Chudik's October 20, 2017 and November 1, 2017 reports. T. 54-55. The Petitioner testified that he continued to trust Dr. Chudik despite Dr. Chudik's reports containing statements that he attributed to the Petitioner which the Petitioner denied providing. T. 55-56.

Testimony of Steven Zolen

Steven Zolen testified that he is the Chief Engineer of Grand Plaza Apartments, which is managed by Draper & Kramer. T. 69. As Chief Engineer, he manages about 14 maintenance professionals whose job it is to maintain the two tower apartment building. T. 70. Mr. Zolen testified that he managed the Petitioner, who worked for the Respondent as both a C janitor and an A janitor. T. 70. Mr. Zolen testified that he communicated with the Petitioner in English and that the Petitioner was "very fluent" in English. T. 74.

Mr. Zolen explained that C janitors performed general janitorial and cleaning work, while A janitors completed work orders and performed maintenance on the buildings. T. 71. While performing tasks throughout the building, both C and A janitors were able to use the elevators or one of the four stairwells to transverse the building. T. 72. Janitors are not required to rush to complete tasks. T. 82. Mr. Zolen testified that the workers "are all union. They're not like turtles, you know, they work at a normal pace." T. 81.

Mr. Zolen testified that on May 18, 2017, the Petitioner was working as an A janitor and one of his daily activities was to check the chemical levels of the pool. T. 74. This was a routine task that was performed twice daily (once in the morning and once in the afternoon) and was not emergent. T. 74, 82. To perform this task, the Petitioner was required to go to the pump room located on the 8th floor to check the pool's heating,

chlorine, PH levels and maintain a log as required by the Illinois Department of Health. T. 74, 79. The log was written in English. T. 79. All of the items used to complete this task were stored in the pump room so there was no reason to carry any items while on the way to the pump room. T. 79-80.

To perform this task, some of the A janitors use a stairwell to get from the 9th floor to the 8th floor. The 9th floor was the amenity floor of the buildings (which included the pool) and the 8th floor has a parking garage and the pump room for the pool. T. 72. There is a gate in the middle of the 8th and 9th floors, which requires a key for individuals who are going up the stairs, but no key is required to descend the stairs. T. 72, 87-88, 94-95. Mr. Zolen testified that the stairwell are cleaned constantly on a daily basis. T. 76. The stairwell is well-lit, with two LED lights on each side. T. 76. The stairs are made of a stamped steel to provide traction and have handrails. T. 76-77.

The stairwell was used by maintenance professionals, the dock professional, LAZ parking security and was open to residents. T. 76-78. Mr. Zolen testified that homeless people sometimes take shelter in the stairwell when the weather is cold, although they normally stay on the 3rd or 4th floors. T. 78. Mr. Zolen testified that some of the workers used the 8th floor stairwell frequently for smoking breaks. T. 92.

Mr. Zolen testified that the Petitioner called him on May 18, 2017 and reported that he slipped and fell on the stairs. T. 74-75. The Petitioner did not report any substance, water, debris or defect on the stairs that caused him to fall. T. 75, 95. No reports or complaints were made relative to the condition of the stairs that day by either residents or workers. T. 77.

On cross examination, Mr. Zolen testified that the Petitioner does his job, but did not work as quickly as some other guys on the team. T. 83-84. While the stairwell was not only used for emergencies, Mr. Zolen testified that in the case of an emergency, all tenants and guests in the building could use the stairwell to exit the building and no key would be required for them to descend the stairs. T. 97.

Testimony of George Acosta

George Acosta testified that he is an investigative case manager for Travelers Insurance. T. 98. He testified that he has worked in this capacity for a little over a year and a half. T. 105. Mr. Acosta testified that his job entails investigating claims, speaking to the employee and employer, reviewing medical records and determining whether the claim is compensable and deserving of Workers' Compensation benefits. T. 99. Mr. Acosta testified that he has found claims to be compensable before and likewise has found claims that he feels that he has a good faith basis to deny. T. 99-100. He testified that his compensation at Travelers does not impacted by his compensability decisions. T. 100.

Mr. Acosta testified that he was given the opportunity to work on the Petitioner's case when it was sent to Travelers Insurance. T. 100. Mr. Vasquez testified that he spoke with the Petitioner on two or three occasions after the claim was reported. T. 100. He testified that these conversations were conducted in English over the phone and that the Petitioner never requested a translator during their discussions. T. 100. During their initial interview, Mr. Acosta testified that the Petitioner told him that he fell down the stairs at work, but did not know how the incident occurred. T. 102. Mr. Acosta testified that the Petitioner told him that he either tripped over his own feet or missed a step to fall down and cause his injury. T. 102. Mr. Acosta asked the Petitioner if there was any defect on the

steps to cause the fall and that the Petitioner stated that there was not. T. 103. Mr. Acosta further asked the Petitioner if he was carrying anything at the time of the fall and the Petitioner stated that he was not. T. 103.

Mr. Acosta testified he that called the Petitioner in June of 2017 to communicate a denial of the claim, as the Petitioner's fall did not arise out of and in the course of his employment. T. 103-104, 112. Mr. Acosta testified that the Petitioner had the opportunity to provide additional information about his fall, but did not do so at that time. *Id.* Mr. Acosta then sent a letter to the Petitioner on June 15, 2017 reiterating this denial. RX 2.

Medical Records

The Petitioner's medical records documenting his right shoulder treatment were admitted into evidence at hearing. None of these medical records include an accident history that notes any substance, water, debris, human waste or defect present on the stairs that caused the Petitioner to fall. Medical records from Union Health Services for the Petitioner's treatment on May 18, 2017 stated that the Petitioner "slipped and fell while going down the stairs." PX 2. He then went to the University of Illinois Emergency Department where he reported "slipping on stairs at 4:30 pm and catching self with his hand, pain to shoulder during incident, more severe since then with any movement of the shoulder." PX 4. Neither records contain any information regarding any substance, water, debris, human waste or defect present on the stairs at the time of his fall. PX 2, PX 4.

The Petitioner's treating surgeon, Dr. Chudik saw the Petitioner on two occasions: October 20, 2017 and November 1, 2017. PX 1, RX 3. In both reports, Dr. Chudik writes: "Patient states that he was walking down the stairs to the pump room for the pool when he miss stepped or rolled his ankle causing him to fall down the steps and onto his right arm."

PX 1, RX 3. Like his other medical records, Dr. Chudik's records do not contain any information regarding any substance, water, debris, human waste or defect present on the stairs at the time of his fall. PX 1, RX 3.

CONCLUSIONS OF LAW

As to Issue C, did an accident occur that arose of and in the course of the Petitioner's employment by the Respondents?

To recover workers' compensation benefits, the Petitioner must prove, by a preponderance of credible evidence, that his injuries arose out of and in the course of his employment. *Illinois Bell Telephone Co. v. Industrial Commission,* 131 Ill.2d 478, 546 N.E.2d 603 (1989). Because the Petitioner's accident occurred at his workplace, the accident was sustained in the course of his employment. The issue in this case is whether the Petitioner's accident "arose out of" his employment with the Respondent. Based on the following reasons, the Arbitrator finds that it did not.

For an accident to "arise out of" the Petitioner's employment, it must be caused by a risk associated with the employment. There are three kinds of risks that the worker may have been exposed to: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls, and (3) neutral risks with no particular employment or personal characteristics. *Illinois Consolidated Telephone Co. v. Industrial Commission,* 314 Ill. App.3d 347, 732 N.E.2d 49 (2000). Risks directly associated with the claimant's employment are those to which the general public is not exposed, such as tripping on a defect at the employer's premises, falling on slippery ground or performing some work related task that contributes to the risk of falling. *Id.*

To meet his burden of proof, the Petitioner must show more than an inability to explain why he fell. He must present evidence by which a reasonable inference can be

drawn that his accident was caused by an employment related risk. "Circumstantial evidence can only support an inference which is reasonable and probable, not mere possible." *Mann v. Producer's Chemical Co.,* 356 Ill.App.3d 967, 974, 827 N.E.2d 883 92005). "Where evidence that allows for the inference of the nonexistence of a fact just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise and conjecture, and the inference cannot reasonably be drawn." *Carter v. Arazon,* 332 Ill.App.3d 948, 961, 774 N.E.2d 400 (2002).

The Petitioner testified at hearing that he did not see any substance, water, debris, human waste or defect present on the stairs at the time of his fall which caused the occurrence. He testified that there was merely a "possibility" that "something" on the ground caused his fall. In fact, during his testimony, the Petitioner stated on numerous occasions that he "did not check" if there was anything on the floor that caused his fall and that he believed that there was a "possibility" that something caused him to fall, based on the fact that he had never fallen on the steps before. Based on this testimony, the Arbitrator finds that the Petitioner failed to prove that his fall resulted from a risk associated with his employment by a preponderance of the credible evidence. Further, the Arbitrator further concludes that any award of workers' compensation benefits in this case would rest on speculation and conjecture, given that the Petitioner could only testify to possibilities as to what may have caused his fall.

In finding that the Petitioner's accident did not arise out of his employment, the Arbitrator notes that the Petitioner was not exposed to an increased risk as the stairwell was open to the general public. An injury resulting from a "neutral risk," defined as a risk to which the general public is equally exposed, does not arise out of the employment. *First*

Cash Financial Services v. Industrial Commission, 367 Ill. App.3d 102 (2006). "By itself, the act of walking across a floor at the employers' place of business does not establish a risk greater than that faced by the general public." *Illinois Consolidated Telephone Co. v. Industrial Commission,* 314 Ill. App.3d 347, 732 N.E.2d 49 (2000). Here, the Arbitrator finds that the Petitioner failed to establish that he was exposed to any hazard on the stairwell and that he further failed to show that he was exposed to a risk greater than the general public was able to use the stairwell on the date of the accident.

The Arbitrator notes that the area where the Petitioner fell is open to the general public, as both the Petitioner and supervisor Steven Zolen testified that the stairwell was used by maintenance workers, the dock professional, LAZ parking security and building residents and guests. In addition, the Petitioner testified that homeless people were "very often" in the stairwell for shelter. Undisputed evidence further showed that there was a gate in the stairwell which required a key to enter the stairwell going up the stairs, but that no keys were required to descend the stairs.

The Arbitrator further notes that the task that Petitioner was performing, checking the chemical levels of the pool, did not require him to carry any objects as he moved from the 9th floor to the 8th floor. As Mr. Zolen testified, the employees would check the chemical levels of the pool twice daily, but there not specific times when the task had to be completed and the task was not emergent. The Arbitrator finds that the Petitioner was not required to rush or hurry while performing his job duties and that the maintenance professionals worked at a normal pace.

The Arbitrator notes the similarities between this case and *First Cash Financial Services v. Industrial Commission*, 367 Ill. App.3d 102 (2006). In *First Cash*, the claimant

was a bank teller who slipped and fell in an employee bathroom. *Id.* She testified at hearing that she did not know what caused her to fall or observe anything on the floor. *Id.* The arbitrator noted that there was no evidence presented to show that the bathroom floor was free of hair, dust, debris, powder, make-up, tissue, oil, water or other possible substances. *Id.* The arbitrator in *First Cash* found that the claimant suffered a compensable work accident and awarded benefits. *Id.* This decision was affirmed by the Commission and confirmed by the Circuit Court. *Id.* On appeal, the Appellate Court reversed, noting that the claimant failed to prove that the risk of falling was work related. *Id.* The Appellate Court found that that the burden of proof at arbitration was incorrectly shifted to the respondent to disprove the existence of a defect on the floor. *Id.* Ultimately, the Appellate Court ruled that the claimant, who had the burden of proving that her injury arose out of her employment, presented no direct evidence to explain the cause of her fall, as she did not know why she fell. *Id.* The decision in *First Cash* notes that the circumstantial evidence in the case could not show more than a mere possibility that the floor was dirty at the time of the accident and that the condition of the fall was the cause of the claimant's fall. *Id.*

Here, like in *First Cash*, the Petitioner testified multiple times that he did not know if there was any substance on the floor that caused his fall. He stated that he did not check to see if any substance was present after the fall, rather, he believed that there was a "possibility" that something was present because he had not fallen on the stairs previously. The Petitioner testified to previously seeing cardboard, food remains, papers, newspapers and human waste in the stairwell, although he did not explain when he allegedly saw these objects and did not provide testimony on the condition of the stairwell on the date of the accident. In contrast, Respondent witness Steven Zolen provided testimony that the

stairwell was clean and in good condition on May 18, 2017 and testified that no complaints were made relative to any debris or defect in the stairwell on the date of the fall. The fact that the Petitioner had previously used the stairs without issue does not make it any more likely that a substance was present at the time of the fall. In the case at hand, just like in *First Cash*, it is at least equally possible that there was nothing on the floor to cause the Petitioner to fall.

Accordingly, the Arbitrator finds the Petitioner failed to prove, by a preponderance of the credible evidence, that he sustained an accident arising out of and in the course of his employment.

As to Issue F, is the Petitioner's current condition of ill being causally related to the injury?

The Arbitrator finds the Petitioner failed to prove, by a preponderance of the credible evidence, that he sustained an accident arising out of and in the course of his employment. Based on this finding, the Arbitrator opines that the Petitioner's right shoulder injury that he sustained as a result of the slip and fall on May 18, 2017, is not causally related to any compensable work accident or injury.

As to Issue J, has the Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator finds that the Respondent has paid for all appropriate charges for all reasonable and necessary medical services as the Petitioner failed to prove by a preponderance of the credible evidence that he sustained an accident both arising out of and in the course of his employment. Because the Petitioner failed to prove a compensable work accident under the Illinois Workers' Compensation Act, he is not entitled to payment of medical benefits by the Respondent for treatment to his right shoulder.

As to Issue K, what temporary benefits are in dispute?

The Arbitrator finds that the Petitioner is not entitled to total temporary disability benefits for the period of time he was unable to work (May 19, 2017 through June 4, 2017, or 2-3/7 weeks) as he failed to prove by a preponderance of the credible evidence that he sustained an accident both arising out of and in the course of his employment. Because the Petitioner failed to prove a compensable work accident under the Illinois Workers' Compensation Act, he is not entitled to payment of TTD benefits by the Respondent for treatment to his right shoulder.

As to Issue M, should penalties or fees be imposed upon Respondent?

The Arbitrator notes that the Petitioner filed a Petition for Penalties and Fees under Sections 16, 19(K) and 19(L) on the afternoon of December 12, 2017, less than two days before the agreed trial date of December 14, 2017. The Arbitrator finds that the Petitioner's slip and fall injury was reported shortly after the incident on May 18, 2017. After the incident was reported, a claim file was timely created at Travelers Insurance Company and the case was assigned to the Investigative Case Unit. There, the claim handler (George Acosta) was in contact with the Petitioner and spoke to him directly to gather information about the claim.

After speaking to the Petitioner, gathering evidence from the employer and reviewing the Petitioner's medical records, Mr. Acosta sent the Petitioner a letter on June 15, 2017 informing him that the claim was denied as the slip and fall was not caused by a risk associated with the Petitioner's employment. The Arbitrator finds that the Respondent had a good faith basis to deny this claim and that the denial of benefits was not unreasonable or vexatious. Accordingly, the Arbitrator denies penalties or attorneys' fees to the Petitioner.

As to Issue N, is Respondent due any credit under 8(j)?

The Arbitrator finds the Petitioner failed to prove, by a preponderance of the credible evidence, that he sustained an accident arising out of and in the course of his employment. In the alternative, if the payment of medical bills is awarded, the Arbitrator notes that Petitioner's medical bills from ATI Physical Therapy reflect a group insurance payment in the amount of $153.23. PX 5. The Arbitrator further notes that the Petitioner testified that he had group insurance through his union. The Arbitrator awards 8(j) credits for any payments made by the Petitioner's union group insurance plan to the Respondent.

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

Reginald Crosby,

Petitioner,

vs. NO: 12 WC 23988

20IWCC0541

Loretto Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 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.

20IWCC0541

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

DATED: SEP 21 2020
TJT:yl
o 9/15/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

CROSBY, REGINALD Case# **12WC023988**
Employee/Petitioner

LORETTO HOSPITAL **20IWCC0541**
Employer/Respondent

On 2/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1218 LAW OFFICES OF MARK SCHAFFNER
205 N MICHIGAN AVE
SUITE 2560
CHICAGO, IL 60601

1109 GAROFALO SCHREIBER HART ETAL
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
CORRECTED ARBITRATION DECISION

Reginald Crosby
Employee/Petitioner
v.
Loretto Hospital
Employer/Respondent

Case # **12** WC **023988**

An *Application for Adjustment 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 **July 7, 2017** and **October 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/4/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment regarding the petitioner's left arm.

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: **$65,969.18** and the average weekly wage, pursuant to Section 10, was **$1,209.14**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**4,865.48** for TTD, $**0** for TPD, $**0** for maintenance, and $**8,801.62** for other benefits, for a total credit of $**13,667.10**.

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

ORDER

Claim for Compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 4, 2012 and failed to prove a causal connection between his work activities for Respondent and the condition of ill-being regarding his left shoulder.

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 7, 2018
Date

ICArbDec p. 2

FEB 7 - 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a Floor Tech, stripping and waxing floors. In this job, Petitioner would apply stripper to a floor, operate heavy machinery to break up the finish on the floor, set fans out to dry the floor and wax floors. This was a part-time job that Petitioner worked for about 4-1/2 years before the date of the alleged accident of April 4, 2012. Petitioner was also employed by the CTA as a Rail Janitor at this time. When Petitioner worked the rail janitor job, he would sweep the train, check for debris, check for graffiti and clean the elevators. He also moved and emptied trashcans.

Petitioner is right handed. Before April 4, 2012, Petitioner never had problems with his left arm. He had no prior medical treatment regarding his left arm. He was working full duty and able to perform all his work activities for Respondent (including the stripping machines) and his job at the CTA at that time.

When Petitioner applied for employment with Respondent, he was working full-time at the CTA. He had started working for the CTA in 1998. When Petitioner applied at Respondent, he met with an individual named Larry Battle. He thought that Battle was a director of different departments with the hospital. He interviewed with Battle for the job. Petitioner completed his written application for employment wherein he alleged he stated, "I work for the Chicago Transit Authority." It was determined that Battle was not an employee of Respondent, but was, in fact, an employee of another entity (HHS). Battle acted in a manner as if he worked for Respondent in that he scheduled work shifts, gave instructions, and handed out paychecks during the one year he worked on Respondent's premises, supervising the floor techs. There was no evidence elicited regarding to whom Battle reported or if he was an agent for Respondent. Petitioner did arrange a shift change with Battle when his shift was changed at the CTA. The job application that Petitioner filled out at Respondent sets forth that he was employed by the CTA. Other than the written job application, Petitioner did not identify any person employed by Respondent to whom he gave information that he worked for the CTA and was paid by the CTA at the time of his alleged accident.

Petitioner was paid at an hourly rate of $10.50 to $11.00 per hour at Respondent. The Parties stipulated that Petitioner's Average Weekly Wage at Respondent was $196.87. Petitioner's wage records from the CTA job for the year preceding April 4, 2012 were admitted as PX 1.

On April 4, 2012 Petitioner was working at Respondent, stripping and waxing the cafeteria floor. Petitioner and Robert Reeves moved and stacked tables as a part of this job. The tables weighed between 50 and 80 pounds each. The tables are round. Petitioner was on one side of the table and Reeves was on the other. To flip the table, Petitioner would grab it with both arms and turn it over. Petitioner's left arm would go up with the table to flip it over. Petitioner finished his job duties at Respondent on April 4, 2012, which included flipping the tables back over after he completed the floor. He did not notice anything was wrong at that time. Everything was normal.

The following morning when Petitioner got up, he noted a sharp pain in his left shoulder. He took Ibuprofen and it calmed the pain down some. Petitioner was not scheduled to work at Respondent the next day. He was next scheduled to work at Respondent on Saturday night, April 7, 2012. He had worked for the CTA on April 4. Petitioner testified that he was scheduled to work at the CTA on April 5, but he was in too much pain and took off work. On April 6, 2012, he went to Loyola Hospital Emergency Room for treatment. He was concerned, because of pain radiating into his chest, that he might be having a heart attack. Petitioner testified that he was asked about his job activities and he told Loyola representatives that he had been lifting heavy furniture at Loretto Hospital. The records from Loyola regarding the April 6, 2012 ER visit do not confirm this

testimony. The chief complaint is Chest Pain-Left sided chest pain started today, has had left shoulder pain since Sunday and pain has now radiated into left chest. The nurses' notes show Petitioner thought his left shoulder pain which started Sunday was related to lifting from work. The ER doctor recorded a history of left shoulder pain since Sunday. "He is a janitor for the CTA and thought he was doing too much lifting with trash cans. Did not feel a pop/tear. No specific inciting trauma or event. Has continued throughout this week. Today started going into his left chest." Petitioner denied giving this history at Loyola. April 6, 2012 was a Friday. April 4, 2012 was a Wednesday. The preceding Sunday was April 1, 2012. Petitioner received an appropriate work-up at Loyola, and heart attack was ruled out. Left shoulder x-rays revealed glenohumeral degenerative changes, dystrophic calcifications (possible calcific tendinitis) and no fracture or dislocation. The ~~physical exam did not reveal swelling, but painful movement and tenderness in the shoulder was noted.~~ Petitioner was discharged and instructed to follow-up with his PCP, Dr. Bridgid Steele. He was given pain medication during the ER visit and discharged with scripts for hydrocodone, acetaminophen Norco and docusate sodium. The diagnosis was left shoulder pain and chest pain. (PX 3, RX 4) Petitioner testified Loyola told him he had probably pulled or torn a muscle in his shoulder.

On April 7, 2012, Petitioner reported the injury to Mr. Reeves, his supervisor at Loretto. Petitioner did not report an accident or injury to the CTA. Petitioner denied he was acting in an effort to protect his position at the CTA in not reporting an accident. Petitioner filled out an accident report at Respondent and gave it to Mr. Griffin on April 9, 2012.

Petitioner was seen by Dr. Bridgid Steele on April 12, 2012. The history was of a left shoulder injury last week. The patient was lifting tables and mopping the floor at work on 4/4/2012. Immediate symptoms were immediate pain and immediate swelling. The physical exam by Dr. Steele revealed no swelling or deformity. with soft tissue tenderness and reduced range of motion. The assessment was shoulder sprain and tendon injury. An MRI was ordered and an orthopedic referral was made. (PX 3)

On April 24, 2012, Petitioner was seen by Dr. Douglas Evans on the orthopedic referral. The history was that the patient described moving tables at work and flipping tables over multiple times during the day. The next day he noticed a sharp pain in his shoulder. He describes the pain as anteriorly, posteriorly and laterally. He has pain with any movement around his shoulder. The physical exam revealed tenderness, decreased range of motion and several positive orthopedic tests (Hawkins', Jobe's, Speed's and O'Brien's), the significance of the positive tests was unknown because any motion of the joint produced pain. The x-ray from the ER was said to show severe degenerative changes with loose fragments and the MRI showed severe arthritis with loose bodies, diffuse labral tearing and a partial tear of the supraspinatus tendon. Dr. Evans' impression was left shoulder severe glenohumeral arthritis with loose bodies. Dr. Evans thought that the patient aggravated his arthritis with the work incident. Therapy, anti-inflammatories and a possible injection were recommended. Petitioner declined the injection because of his Type II diabetes. (PX 3)

Petitioner received treatment from a number of physicians at Loyola, including pain management, therapy and an EMG (negative for cervical pathology. Petitioner also received a cortisone shot in his shoulder, which, he says, made the pain worse. (PX 3)

Ultimately, Dr. Rees prescribed a shoulder replacement. This surgery took place on July 29, 2013. The history provided to the doctors subsequent to the 4/6/2012 emergency room visit were consistently about moving tables at Loretto on April 4 and experiencing pain in his shoulder on April 5 after waking up in the morning, although an APN at Gottlieb Hospital noted the history of moving a table and feeling a pop in his shoulder at work. (PX 3)

Petitioner continued with physical therapy at Loyola after his left shoulder replacement. He testified that therapy did not provide pain relief and surgery did not provide pain relief. He returned to work with the CTA on December 19, 2013, and was also released to return to work by Dr. Rees on December 20, 2013. Petitioner returned to see Dr. Rees about his difficulty with his shoulder, and Rees prescribed six more months of physical therapy. Petitioner testified that his pain has never changed since the accident.

Petitioner testified there was nothing that he could do to relieve his pain. He has constant pain. He does not take NSAIDs because of concerns regarding his kidneys. He can't lift his left arm beyond the plane of his shoulder. He does not work his normal job at the CTA, but no medical restrictions have been imposed on him. He continues to sweep the platforms, mop the elevators, and "pull" the garbage, sometimes with a co-worker if he believes the garbage is "too much." Petitioner's pay at the CTA has increased since the accident, due to a CBA.

Petitioner received a letter from Respondent advising that his employment at Loretto was terminated as of July 12, 2012. (PX 10) He conceded on cross-examination that he was told he could reapply for work at Respondent, but stated he had not. The petitioner described the limited movement he has with his left arm. Nevertheless, his income from the CTA has increased since his arm surgery.

Petitioner's last visit with Dr. Rees was on May 30, 2014. Petitioner has left shoulder pain that sometimes radiates into his neck. He has difficulty with overhead reaching and reaching behind his back. The impression was "Fair Result s/p primary left shoulder arthroplasty." The outcome is not optimal despite good radiographs and a full course of physical therapy. Dr. Rees referred Petitioner to Dr. Garbis to see if they were missing something regarding the shoulder. Dr. Rees did note that Petitioner had substantial arthritic change prior to the work injury and this may be the best result. Cervical pathology was ruled out as the cause for Petitioner's complaints. Petitioner's last physician visit regarding his shoulder was with Dr. Garbis at Loyola on August 8, 2014. Options of a manipulation under anesthesia, revision TSA and possible reverse TSA were discussed. Petitioner has not had any medical care regarding his left shoulder after the 8/8/2014 visit with Dr. Garbis. (PX 3)

Dr. Benjamin Goldberg, an orthopedic surgeon, reviewed the medical records and examined Petitioner on September 7, 2012, pursuant to Section 12 of the Act at the request of the Respondent. Dr. Goldberg concluded that Petitioner had severe preexisting arthritis unrelated to his alleged work injury. Dr. Goldberg also noted that Petitioner performed in a non-physiologic manner upon examination and performed inconsistently when compared to video surveillance. Dr. Goldberg did not endorse causal connection. He did not endorse a TSA procedure, based upon the non-physiological findings on the exam. (RX 1)

Petitioner was examined by Dr. Craig Westin on March 21, 2016, at the request of his attorney. Dr. Westin reviewed medical records, but not the Loyola ER records from 4/6/2012. Dr. Westin's diagnosis was left shoulder arthrosis status post left shoulder total arthroplasty. Persistent pain of unknown cause, most likely periscapular scarring. Dr. Westin endorsed causation as a result of the industrial exposure that occurred on April 4, 2012. The patient had preexisting advanced left shoulder arthritis that was aggravated by turning the tables to accomplish his mopping task April 4, 2012. It is not clear why the painful condition became intolerable that particular day. "he said he often turned the tables to get his job done, but after that day at work, the pain never left. Dr. Westin concluded that Petitioner was limited to no overhead activity with his left upper extremity and no pulling or pushing in excess of 10 pounds. (PX 4)

Petitioner claimed TTD from July 29, 2013 (the day of the TSA procedure) through December 19, 2013 (he returned to work at the CTA on December 20, 2013) and TPD from April 8, 2012 through August 8, 2014. Respondent paid $4,865.48 in TTD and $8,801.62 in other benefits. (ArbX 1) Petitioner claimed medical expenses in the amount of $86,524.90 for the time period of 9/4/2012 – 8/8/2014. (PX 2) Respondent denied TTD and medical benefits, based on Dr. Goldberg's report, as of 9/30/2012. (RX 2)

Respondent submitted video surveillance of Petitioner from June and July of 2012. Petitioner is seen wearing a sling at times and he is seen to use his left arm at various times. He is seen to move his left arm in an unrestricted manner, to an extent. He is not seen extending his left arm over his shoulder and is not seen reaching behind his back. (RX 3)

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT AND ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 4, 2012 and failed to prove a causal connection between his work activities on April 4, 2012 and his current condition of ill-being regarding his left shoulder. The claim for compensation is, therefore, denied.

The finding on the issue of accident is based upon several factors. First, the record establishes that Petitioner had to flip 8 or 10 tables (so, perhaps 16-20 flips?) on April 4, 2012. Petitioner testified that he felt normal after this activity. He woke up with a sharp pain in his left shoulder on April 5, 2012. There was no specific incident or onset of complaints that can be associated with Petitioner's work activities for Respondent on April 4, 2012. The history at the Loyola ER is inconsistent with Petitioner's testimony at trial and the subsequent histories that Petitioner gave. Petitioner testified that he informed the Loyola ER staff that he had been lifting heavy tables at Loretto. The history recorded by the Loyola ER nurse and the ER physician is that Petitioner associated his pain with doing too much lifting of heavy trashcans at the CTA. Petitioner also gave the ER staff the history of left shoulder pain since Sunday (4/1/2012) and the onset of left chest pain on 4/6/2012. The Arbitrator places great weight on the initial history which places the onset of left shoulder pain to be on Sunday, April 1, 2012

(not the claimed accident date of April 4, 2012) and relates the complaints to work at the CTA, not Petitioner's work for Respondent. Petitioner's testimony that he told the ER staff about his April 4, 2012 work activities at Respondent on April 6, 2012 is found to be not credible. "It is presumed that a declaration to a treating physician as to one's condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Commission, 2 Ill. 2d 590, 602 (1954) Based upon the ER records from Loyola of April 6, 2012 and the opinions of Dr. Goldberg, Petitioner does not prevail on the issue of accident.

As to the issue of causation, the Arbitrator finds Dr. Goldberg's opinion that Petitioner's shoulder condition is not causally related to an injury and is due to his arthritis condition to be most persuasive. It best comports with the evidence adduced, especially given the history reflected in the April 6, 2012 ER records. Dr. Westin's opinion is not controlling because of the Arbitrator's finding regarding accident, above, and the fact that he did not review the April 6, 2012 ER documents, per his report.

WITH RESPECT TO ISSUE (G), WHAT WERE PETITIONER'S EARNINGS, AND ISSUE (O), CONCURRENT EMPLOYMNENT AS A PART OF THE WAGE ISSUE THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner's Average Weekly Wage was $1,209.14. This amount is determined by adding the stipulated AWW of $196.87 for Petitioner's employment by Respondent to the AWW calculated for Petitioner's concurrent employment with the CTA of $1,012.27.

Petitioner's employment with the CTA was disclosed on Petitioner's employment application. Respondent is charged with knowledge of Petitioner's employment by the CTA as of his date of hire, which was before the injury. Petitioner's unrebutted testimony and PX 1 establish concurrent employment. Petitioner's wages from the CTA are properly included in the AWW calculation for Petitioner, pursuant to §10 of the Act.

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, ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment by Respondent on April 4, 2012 and has failed to prove a causal connection between his current condition of ill-being regarding his left shoulder and his work activities for Respondent, the Arbitrator needs not decide the above issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
[ ] Affirm with changes	[X] 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

Rebecca Patton,

Petitioner,

vs. NO: 11 WC 34624

St of IL/DOC Stateville and Michael Frerichs as State Treasurer and Ex-officio Rate Adjustment Fund,

20IWCC0542

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 21, 2019, is hereby affirmed and adopted.

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

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

DATED: SEP 2 1 2020
TJT:yl
o 7/28/20
51

Thomas J. Tyrrell

Maria E. Portela

20IWCC0542

DISSENT

I disagree with the Majority's decision. Based on the evidence presented, I would find that Petitioner failed to prove that she is permanently and totally disabled under §8(f) of the Act and would remand the case to the Arbitrator for the Petitioner to participate in a vocational rehabilitation assessment and rehabilitation plan, if appropriate. Although Dr. Jeffrey Coe, an occupational medicine specialist, issued a medical opinion that Petitioner was permanently and totally disabled, none of her treating surgeons provided a similar opinion. In fact, Petitioner's treating primary care physician, Dr. Magee, offered a contrary opinion when he completed several Illinois Department of Central Management Services (CMS) Authorization for Disability Leave and Return to Work forms. (PX5) On the forms dated June 14, 2018, and January 21, 2019, Dr. Magee documents that Petitioner had limitations in standing, climbing, bending, and stooping as a result of her right knee total replacement, revision surgeries, and that she had limited range of motion. However, Dr. Magee also documented that Petitioner is ambulatory and a Class 4 Physical Impairment pursuant to the Federal Dictionary of Occupational Titles, defined on the form as "Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity." Question number 7(d) on both of the referenced CMS forms, under the section "Extent of Disability," requires the physician to answer, "In your opinion is patient permanently and totally disabled for employment?" Dr. Magee checked the box "No." (PX5)

The record contained no evidence of a diligent but unsuccessful job search or that there were no jobs available for an individual in the claimant's circumstances. I would remand the case for a vocational rehabilitation assessment and so that Petitioner could participate in vocational rehabilitation for the reasons explained below.

> To prove an employee is totally and permanently disabled, the Illinois Supreme Court held: The finding of a permanent medical disability does not, however, resolve the question of whether an employee is totally and permanently disabled within the meaning of section 8(f) of the Workmen's Compensation Act (Ill. Rev. Stat. 1975, ch. 48, par. 138.8(f)). As noted above, the degree of the disability is dependent upon the extent to which the medical disability has impaired the employee's earning capacity or ability to work...
>
> For the purposes of section 8(f), a person is totally disabled when he cannot perform any services except those for which no reasonably stable labor market exists. (*C. R. Wikel, Inc. v. Industrial Com.* (1977), 69 Ill. 2d 273, 278; *South Import*

> *Motors, Inc. v. Industrial Com.* (1972), 52 Ill. 2d 485, 489.) Conversely, if an employee is qualified for and capable of obtaining gainful employment without seriously endangering health or life, such employee is not totally and permanently disabled. *Jefferson Electric Co. v. Industrial Com.* (1976), 64 Ill. 2d 85, 92-94; *Cebulski v. Industrial Com.* (1971), 48 Ill. 2d 289; *Perry Coal Co. v. Industrial Com.* (1931), 343 Ill. 525, 529.
>
> The focus of the Commission's analysis is on the degree to which the employee's medical disability impairs his employability. In arriving at its determination, the Commission must consider the employee's age, experience, training and capabilities. (*Consolidated Freightways, Inc. v. Industrial Comm'n.* (1976), 64 Ill. 2d 312, 320; *Springfield Park District v. Industrial Com.* (1971), 49 Ill. 2d 67, 73.) The initial burden of proving the extent of the disability is on the employee to show that, as a result of a work-connected injury, he is unable to perform or obtain regular and continuous employment for which he is qualified.

E. R. Moore Co. v. Industrial Comm'n., 71 Ill. 2d 353, 361-363, 376 N.E.2d 206, 209-210 (1978). In the subject case, the Petitioner has not sustained her burden of proving that as a result of her injury she is medically unable to perform or obtain regular and continuous employment. In fact, unlike the Petitioner in *E.R. Moore*, the Petitioner in the subject case has a high school diploma, two years of junior college and was in the United States Coast Guard reaching the rank of E2 after two years. Petitioner compared her rank as to "something like an apprentice." T. 62. She was honorably discharged. The Petitioner testified that she is able to use a computer, read and respond to emails. T. 64. Given those factors, the Petitioner has not sustained her burden of proof.

I also disagree with the Majority that in this case, the burden should shift to the Respondent to prove that a reasonably stable labor market exists for this Petitioner. The Majority notes that under *Ceco v Industrial Commission*, "where a doctor testifies that a Petitioner is permanently and totally disabled, even if a general practitioner, and even with conflicting opinions, the burden shifts to Respondent to show that some kind of suitable work is regularly and continuously available to the Claimant." However, there are two important distinctions between *Ceco* and the subject case. In *Ceco*, two doctors opined that Petitioner was not capable of working; a physician specializing in traumatic surgery and the family physician testified on claimant's behalf. Second, the Petitioner in *Ceco* had a ninth-grade education in Mexico and conversed primarily in Spanish. Petitioner was employed as a welder for five years prior to the injury, and a witness for Respondent testified that retraining was inappropriate. *Ceco Corp. v. Industrial Comm'n.*, 95 Ill. 2d 278, 288, 447 N.E.2d 842, 846 (1983).

In this case, Dr. Coe's opinions regarding Petitioner's job eligibility, by his own admission, are not within his expertise and conflict with Petitioner's treating primary care physician. Dr. Coe's opinion regarding Petitioner's ability to work was qualified, by his own testimony, "with the understanding that I am not a vocational rehabilitation specialist—that's a separate specialty..." PX21, 71-72.

Petitioner testified that she is homebound by pain once or twice a week yet testified her pain increases are dictated by weather or "like if there's water out there." T. 66. Dr. Coe also testified that Petitioner's cognitive abilities were affected by her narcotic medication, however, Petitioner testified she has completely weaned off of all opioid medication. She testified that she spoke with Dr. Magee, her general practitioner, and was approved for medical marijuana to control her pain. T. 69-71. There was no medical opinion given what, if any affect, her new pain control methods would have on her ability to perform sedentary work. Thus, I disagree that by offering Dr. Coe's opinion that Petitioner has sustained her burden of proof. I find Dr. Coe's opinion unsupported by the evidence and accorded little weight. *See, e.g.*, *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, 14 N.E.3d 16 (2014). (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Finally, Dr. Coe also based his opinion on factors that are not road blocks to every type of job, i.e. Petitioner's walking tolerance and the need to change positions. There are ride shares to help with transportation, and many jobs that can be performed remotely, however, a vocational rehabilitation consultant is in the best position to determine whether a stable labor market exists commensurate with Petitioner's education and training and Petitioner offered no such evidence. When asked if Petitioner had attempted to look for other jobs, Petitioner testified "Well I filled out some paperwork for the Department of Corrections. I didn't physically look for the job. They sent like leads to me....January, February, March,... '18. I want to say it stopped about March, maybe April...I never made it to an interview." T. 95.

The Petitioner's testimony, lack of a job search effort, coupled with the medical evidence and Dr. Magee's opinion that Petitioner is capable of performing sedentary work, are all indicators that the claimant is capable of employment and an opinion regarding whether or not a reasonably stable labor market exists for the Petitioner should be left to a certified vocational rehabilitation counselor. Therefore, I would remand the case to the Arbitrator for a vocational rehabilitation assessment and plan, if appropriate

Kathryn A. Doerries

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PATTON, REBECCA
Employee/Petitioner

Case# **11WC034624**

20IWCC0542

ST OF IL DOC STATEVILLE AND MICHAEL FRERICHS AS STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE RATE ADJUSTMENT FUND
Employer/Respondent

On 3/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0924 BLOCK KLUKAS MANZELLA & SHELL
MICHAEL D BLOCK
19 W JEFFRSON ST
JOLIET, IL 60432

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAR 21 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

20 IWCC0542

- [ ] 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

REBECCA PATTON
Employee/Petitioner

Case # 11 WC 34624

v.

Consolidated cases: ____

STATE OF IL DOC STATEVILLE and
MICHAEL FRERICHS AS STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE RATE ADJUSTMENT 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 **GREGORY DOLLISON**, Arbitrator of the Commission, in the city of **NEW LENOX**, on **02/08/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] 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 **08/12/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,122.84**; the average weekly wage was **$1,194.67**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.00**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $424,517.09, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner temporary total disability benefits of $796.45/week for 123 weeks, commencing 8/13/2011 to 6/17/2012 (44 and 1/7 weeks), 3/5/2014 to 7/1/2014 (16 and 6/7 weeks), and 8/19/2015 to 10/26/2016 (62 weeks), as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**796.45**/week for life, commencing **10/27/16**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

3/21/19
Date

MAR 2 1 2019

FINDINGS OF FACT:

Petitioner, Rebecca Patton ("Petitioner"), testified that she was hired in 1996 to work as a correctional officer for the Illinois Department of Corrections at the Stateville Correctional Center ("Stateville") in Crest Hill, Illinois. She testified that she has continually worked as a correctional officer at Stateville since her date of hire.

Petitioner testified that on August 12, 2011, she was 46 years old and was assigned to "tower duty" in Tower Number 9. She began working tower duty approximately four years prior in 2007. Petitioner's typical work hours were 7:00 a.m. until 3 p.m. She was allowed a 30-minute break for lunch and a 15 minutes break that she typically would not take, or work into her lunch.

Petitioner testified that Tower 9 was an octagon shaped structure with eight large windows and two doors that sat atop a 30-foot wall. Petitioner testified that in order to reach Tower 9, she would be transported via a mobile transport unit. After being dropped off by the mobile transport unit, Petitioner would walk towards an entrance at the base of the 30-foot wall. Petitioner testified that the ground outside the entrance to Tower 9 was unpaved. Specifically, it was a mix of grass, gravel, and dirt. Petitioner testified about the unique way that correctional officers would enter the tower. First, she would wait for the officer in Tower 9 to lower down a milk crate to the entrance at the base of the 30-foot fall. Inside the milk crate was the only key to the entrance. Petitioner would retrieve the key from the milk crate to open a four-foot doorway at the base of Tower 9. The door would lock behind her. Petitioner testified that upon entering the base of the 30-foot tower, she first had to step down two feet to the ground below, which was also an unpaved, dirt surface. Then she would walk towards the staircase and climb up 33 stairs to the top of the wall. Once atop the wall, she next had to climb up 9 steps on a ladder to reach the top of Tower 9, where there was a catwalk with two access doors.

Petitioner testified that Stateville was a jail housing convicted felons and, as such, following protocol and maintaining security was of the utmost importance. With regard to Tower 9, she testified that one did not want the key out of the tower any longer than necessary, as it is a safety concern. She described the process of lowering down the key in a milk crate to the relieving officer as "hurried," noting that the relieving officer has to assume surveillance duties and the officer being relieved has to leave the prison promptly. Petitioner further testified that returning the key in the milk crate was considered part of her duties, otherwise it would be a security breach.

In general, Petitioner testified that tower duty included constant surveillance of the prison area. She also said tower duty was an armed position, and officers had their choice of two guns: a twelve-gauge shotgun or Remington mini-14 rifle. With regard to Petitioner's specific job duties on a typical day, she testified that she was required to constantly surveil both the inner and outer perimeter of Stateville. This included surveilling for aircraft, overlooking the sally port (described as a gate allowing ingress and egress between the jail and surrounding community), surveilling the recreational yard, roads around the prison, the Northern Reception Center (a separate IDOC prison site outside but adjacent to Stateville), and the movement of any people within her perimeter. Petitioner testified that because of the placement of the windows, she had to stand most of the day to perform her surveillance duties, moving window to window, which was monitored by the prison warden. Petitioner stated that walking window to window, coupled with physically standing to perform surveillance, would be 5 hours out of a typical 7 ¼ hour day. Petitioner also testified that at various points throughout the day she would receive security calls ("SCIs") over her radio, that there would be movement in her perimeter (e.g. of prisoners, at the sally port, etc.) and she would then be required to select a firearm, go onto the catwalk, and provide an armed escort.

Petitioner testified that at the end of a shift, she would wait for the mobile transport unit to arrive with her relieving officer and complete the aforementioned process of lowering the milk crate to her relieving officer but in reverse. After he came up, she went down. Petitioner testified that upon reaching the base of the 30-foot tower, she had to use her left hand to pull the door towards her to ensure that the handle was lined up. If not, the handle would not drop and she would not be able to leave. Petitioner testified that she would then have to turn and twist her body while coming up from a squat and use her right hand to place the tower key in a milk crate at the same time.

Petitioner testified that on a typical day, she would make four trips up and down the Tower. Initially, upon arrival to Tower 9 at the beginning of her shift. Next, coming down for her lunch. Once again, ascending the steps and ladder upon completing her lunch break. And, lastly, a final descent and exit at the end of her work day.

Petitioner testified as to her normal work day. First, she would park approximately one block away from Stateville, walk to a check point, and undergo a pat search before entering the jail. Next, she would walk approximately one-half block and stand for roll call, which lasted approximately 15 minutes. Thereafter, Petitioner would walk one block to a pickup point where a mobile transport unit would drive her to Tower 9. Upon reaching Tower 9, Petitioner would undergo the aforementioned process of waiting for the key in the milk crate, stepping down two feet from the four-foot tall doorway, and ascending 33 stairs and 9 ladder rungs. Upon entry, she would perform an equipment and inventory check with the on-duty officer before relieving him/her of their duties. Then, she would exit Tower 9 onto the catwalk to watch the officer, who was just relieved, put the key in the milk crate after locking the door. Thereafter, she would hoist up the milk crate into the tower, radio the operator to check-in and confirm she relieved the prior shift, begin her logbook, and then finally begin her aforementioned surveillance of the prison.

Petitioner testified that she had two prior knee injuries. First, in approximately 2001, Petitioner sustained a right knee injury during an inmate assault for which she did not have any specific medical attention for her right knee aside from a trip to the infirmary, ice, and rest. Second, Petitioner sustained a left knee injury at some point in the late 1990's at a construction site at the prison for which she underwent approximately two weeks of physical therapy. Petitioner testified that both of these injuries were minor.

Petitioner testified that she did not miss any time at work between approximately 2001 and August 12, 2011, due to her knees. She also testified that after her 2001 knee injury and August 12, 2011, she did not sustain any other knee injuries, did not make any medical appointments for her knees, did not receive any medical treatment for her knees, and was not diagnosed with a either a medial or lateral meniscus tear in either knee. Moreover, Petitioner testified that she worked full duty and did not make any medical appointments to see a doctor while working tower duty in Tower 9.

Petitioner testified that on August 8, 2011, she noticed that her right leg was sore, swollen, and puffy. She noticed the symptoms on the front of her knee, approximately three inches below to three inches above her knee, but not at the medial part. Petitioner testified that her knee symptoms were odd because typically she would have enough rest over the weekend and she would not have any knee issues. Petitioner testified she was involved in some activities, including walking, shopping, and visiting with friends. Her normal weekend routines included grocery shopping, laundry, and other household chores. She testified that she did have a gym membership some time earlier, but she did not visit very often. When she did, Petitioner would use the sauna, hot tub, and swimming pool.

Petitioner testified that because of her knee symptoms, she spoke with the workers' compensation liaison, Kelly Ledford, during her lunch break to see if she could get her knee looked at in conjunction with her

old knee claim. Petitioner provided that the next day, Ms. Ledford informed her that she would need to file a new claim because her old claim was over thirteen years old. Petitioner stated that she did not file a new claim because she was just planning on applying ice at home and seeing a general practitioner, and there was no new injury.

Petitioner testified that she continued to work full duty and did not seek any medical treatment between August 8 and August 12, 2011. She testified that her knee felt essentially the same during this period with pain being 2/10. Petitioner testified that she was not under any specific medical treatment and did not have a regular primary care physician because she was in "good health."

Petitioner testified that at approximately 2:55 p.m., on August 12, 2011, the mobile unit was arriving with Petitioner's afternoon shift relief. She notified the shift commander that the 3-11 needed permission to enter. At that time, she let the key down in the milk crate. After her relieving officer took the key, she raised the milk crate up and waited for him to ascend the stairs and ladder to go over their equipment. Petitioner stated that once that was complete, she descended the ladder without issue. Similarly, she descended the 33 stairs without issue and began to let herself out to exit the tower from the base of the stairs where there was the approximately two-foot step up and out. Petitioner related that she pulled the door with her left hand to close the door and got into a position where she could engage the handle, as the door had to be lined up. Petitioner stated that because the door is only four feet tall, she was exiting from a squat and she turned and twisted as she came to a full standup position to put the key in the basket, the last action to perform while exiting Tower 9. Petitioner testified that while exiting with her foot planted, she pivoted and heard a pop and felt excruciating pain in her right knee and laid on the ground. The relieving Officer inquired if she was ok, and she said no and waited for the mobile unit. The Officer from the mobile unit arrived, assisted in picking her up and drove her directly to her car. Petitioner testified that this was not the normal procedure. Rather, she would normally be dropped off at the check point and from there she would walk to her car.

Petitioner testified at the time of her accident, she lived approximately five to six minutes away from the jail. She drove herself home only using her left foot. Later that evening, her daughter drove her to St. Joseph Medical Center. The Provena St. Joseph Medical Center records show an initial history involving a right knee injury which occurred approximately 3:00 p.m. prior to arrival. Patient reported that while standing, she turned with her right foot planted. She noted that there was a pop in the right knee with subsequent pain in the medial aspect of the right knee and no other reported complaints. Her reported pain was 9 out of 10 (Pet. Ex. 1 at 13) Right knee x-rays revealed mild narrowing of the medial joint space compartment, small suprapatellar joint effusion, small patellar and femoral osteophytes, and small marginal enthesophytes. The radiologist's impression was mild degenerative changes. (Id. at 15) Petitioner's diagnosis was knee pain with possible meniscus injury. (Id.at 13) She received a brace, crutches, and a pain prescription with instructions to see an orthopedist. (Id. at 13-14)

On August 15, 2011, Petitioner completed a Workers' Compensation Employee's Notice of Injury Report. (Resp. Ex. 1) According to the report, Petitioner reported the incident "happened at the base of Tower [transportation correctional officer] took me to car." Petitioner conveyed that she was "exiting Tower leaving for the day" and that she was "turning to walk away from Tower, a cracking sound occurred, and I was unable to support myself on [the] right knee."

On August 22, 2011, Petitioner saw Dr. Cooke of Cooke Medical as a new primary care patient. (Pet. Ex. 2, p. 13). Petitioner testified that this was her first doctor visit since approximately 2002. She gave a history of a prior right knee injury over thirteen years ago. She reported doing well until two weeks ago and presented with right knee aching, swelling, pain with ambulation, and popping. Petitioner's reported mechanism of injury was that she turned and felt a pop with swelling, was seen at Provena St. Joseph's and they

felt it was a meniscal tear. After an exam with positive findings, the doctor made an orthopedic referral to Dr. Primus. (Id. at p. 14)

On September 2, 2011, Petitioner underwent an initial evaluation with Dr. Gregory Primus (Pet. Ex. 4, pp. 3-5). At that initial visit, Petitioner's chief complaint was right knee pain due to an injury while at work August 12, 2011. Dr. Primus described the mechanism of injury as twisting during a turning motion. On exam, Petitioner had a positive McMurray's test along the medial joint line in the meniscal exam, and the patellofemoral exam revealed pain with patella femoral compression, as well as crepitus. Dr. Primus diagnosed 1.) knee pain; 2.) chondromalacia patellae; 3.) meniscus tear; and 4.) medial meniscus tear. Dr. Primus ordered an MRI to rule out a meniscal tear and prescribed elevation, partial weight bearing with a brace, activity limitations. Dr. Primus also "... explained that going up and down stairs can place 2 times one's body weight across the parellofemoral joint. Standing from a squat can place 8 times one's body weight and Meniscal internal derangement..." (Id. at p. 4)

Petitioner underwent the prescribed MRI of the right knee on November 1, 2011. The study revealed a complex tear involving the body and posterior horn of the medial meniscus. Also identified was mild chondromalacia of the patellofemoral joint, degenerative osteophytosis and cartilage thinning involving the medial compartment. (Pet. Ex.4 at p. 335)

Petitioner returned to Dr. Primus on November 11, 2011. After reading the MRI, which he indicated showed evidence of a medial meniscal tear and medial condyle wear with contusion, the doctor assessed chondromalacia patellae and meniscal tear. Surgery was prescribed. (Id. at pp. 7-8)

On December 7, 2011, Dr. Primus performed 1.) right knee arthroscopic partial medial meniscectomy; 2.) abrasion arthroplasty of the lateral femoral condyle and chondroplasty of the patella facet; and 3.) diffuse synovectomy with debridement at South Suburban Hospital. The post-operative diagnosis was 1.) right knee medial meniscal tear; 2.) chondromalacia; 3.) diffuse synovitis and arthrofibrosis; and 4.) partial ACL rupture. Chondromalacia found at the medial compartment was noted to be a mild grade 2. (Pet.'s Ex. 3F)

Post-surgery, Petitioner followed with Dr. Primus on December 13, 2011. Petitioner complained of some numbness and tingling on the superior and medial portions of her knee. Petitioner also reported pain in the back of her knee and she was ambulating with one crutch on a regular basis. Dr. Primus prescribed physical therapy. (Pet. Ex. 4 at pp. 9-10) By January 10, 2012, Petitioner reported improvement with her right knee. At this visit she also reported symptoms of increasing pain in her left knee due to overcompensation. Dr. Primus ordered a full course of physical therapy and indicated the left knee would be watched and observed to see if it would improve with therapy. (Id at pp. 11-12) Petitioner began physical therapy at Chicago Center for Sports Medicine on January 16, 2012. (Id at 17)

On February 14, 2012, Dr. Primus recorded right knee improvements and similar left leg overcompensation complaints. The doctor continued his physical therapy prescription and ordered work condition/hardening. (Pet. Ex. 4, pp. 13-14) Petitioner underwent work conditioning/hardening through March 9, 2012. (Pet. Ex. 4 pp. 21-25) The Work Conditioning Discharge Summary dated March 9, 2012 states Petitioner had difficulty due to weakness and subjective reports of lower extremity pain and fear of reinjury. Also noted was examination findings of increased inflammation and decreased range of motion. The evaluator opined that Petitioner was capable to function at light to medium work level. It was reported that Petitioner demonstrated an overall questionable effort due to inconsistency amongst objective measurements. Also reported was that Petitioner did not demonstrate all of the essential job functions to return to work as a Correctional Officer. (Id. at 25-26)

Petitioner next saw Dr. Primus on March 12, 2012. An examination revealed decreased swelling. She demonstrated moderate pain to palpation especially around the portals. Petitioner also had pain with patellofemoral compression. Dr. Primus ordered ten additional sessions of work hardening. (Id. at 139) At her visit On March 19, 2012, Dr. Primus noted that due to Petitioner's failure to improve and progress in work hardening and her extensive degree of grade three changes of her cartilage, Visco supplementation injections would be appropriate. On April 11, 2012, Dr. Primus, Petitioner reported increased pain and swelling. The doctor prescribed a steroid injection to decrease inflammation prior to proceeding with the Visco supplementation injection. (Id. at 140)

After undergoing eight sessions of physical therapy through April 27, 2012, at Accelerated Rehab (Pet. Ex. 7), Petitioner next saw Dr. Primus on May 18, 2012. Petitioner continued to complain of numbness and tingling. Dr. Primus administered a steroid injection. (Id. at 141) The doctor administered a repeat steroid injection on June 1, 2012. Dr. Primus reiterated that Petitioner was a good candidate for a series of Visco supplementation. Dr. Primus anticipated that Petitioner would be able to return to work full duty on June 18, 2012. (Id at 144-146)

Petitioner testified that she returned to work full duty on June 18, 2012. Petitioner also stated that Dr. Primus administered another injection that day. Petitioner returned to Dr. Primus on July 16, 2012 reporting worsening symptoms. Petitioner provided that she was experiencing pain on the medial and posterior aspect of the knee. The doctor noted that she had returned to work noticing increased swelling in both feet and legs at the end of the day. She reported that her pain was limiting her overall function and she was concerned that she was going in reverse. Dr. Prius continued work hardening. The doctor reiterated that Petitioner was a good candidate for a series of Visco supplementation. Petitioner was also referred to pain management for a TENS unit for pain relief. Her full duty work authorization was continued. (Id. pp. 150-152)

Petitioner underwent a Section 12 examination, at her attorney's request, with Dr. Sherwin Ho on March 25, 2013. According to Dr. Ho, Petitioner reported that on August 12, 2011, she was at work, and while standing and turning with her right foot planted, she noted a pop and sudden pain in her right knee. Petitioner reported that her pain was in the medial aspect of her right knee. Petitioner denied any prior history of injury to the right knee. After performing and reviewing the medical records from Dr. Cooke and Dr. Primus, Dr. Ho diagnosed medial compartment and patellofemoral arthritis, right knee, and post partial medial meniscectomy. Dr. Ho opined that the cause of the medial meniscus tear was the work injury sustained on August 12, 2011, as described by Petitioner. His future prognosis was that Petitioner would likely to continue to require treatment for her knee including corticosteroid and Visco supplemental injections on a semi-annual basis as needed for the pain. Dr. Ho felt Petitioner would also benefit from further treatment to compensate for the loss of her medial meniscus, such as a custom fit valgus derotation brace, and future surgeries. (Pet. Ex. 16)

On April 18, 2013, Petitioner returned to Dr. Cooke with complaints of pain and swelling in the right knee. Petitioner described her symptoms as moderate in severity and worsening. Her symptoms were made worse with standing or walking, worsening at the end of each work day and improved by rest. An MRI of the bilateral knees was ordered, and Petitioner was to follow up with an orthopedic surgeon. (Pet. Ex. 2, pp. 313-315)

Dr. Ho testified via deposition in this mater June 21, 2013. Dr. Ho testified he is the Director of Sports Medicine at the University of Chicago, being board certified in orthopedic surgery and the sub-specialty of sports medicine. (Pet. Ex. 18, p. 4) Dr. Ho discussed the findings of Dr. Primus's December 7, 2011, surgery where Petitioner had a medial meniscal tear, chondromalacia, synovitis, arthrofibrosis and a partial ACL tear. (Id. at 6). Dr. Ho was presented with the following hypothetical question:

> "Let's assume that on August 12,2011 she was working at Stateville for the State of Illinois which entailed going up and down stairs, up and down thirty stairs four times a day. Her workday is 7:00 to 3:00. She's required to stand all day to look out of the tower or substantially most of the day, because she must constantly surveil all the areas within her view...She must be able to stand or walk long periods of time. Occasionally she holds a shot gun or a different similar kind of gun called a mini 14. So working the 7:00 to 3:00 shift, at 2:55 PM she descends the 33 stairs, she reaches the bottom of the stairs, her legs to her are tired and sore. She is either about to place or just has placed keys in a return basket. She turns, her right leg collapses, a co-worker sees her, carries her to a van and drives her to her car and then she goes in to Provena St. Joe's emergency room, follows up with Dr. Cooke who refers her to Dr. Primus, and then she has the course of treatment which you've reviewed." (Pet. Ex. 18 pp. 7-8)

In response to that hypothetical, Dr. Ho opined that he was aware of the injury and what was found at time of surgery as well as on MRI. He testified "...we know the knee collapsed. We know that's a pretty bad injury to tear or practically tear your ACL, to tear the meniscus in the way that it was torn, and to damage the articular surface cartilage. Even if there was some pre-existing damage, the way Dr. Primus describes the injury in the operative report tells me that this is a knee that has sustained a significant traumatic injury. We know what the injury was. She turned, her knee buckled on her..." Dr. Ho testified that Petitioner had to be caught off guard, as the knee had to collapse on her completely for her to sustain this type of injury. He added "...she just had to be tired and her muscles had to just be fatigue...We're talking specifically about her quadriceps and her patellafemoral joint." He testified that if this had occurred eight hours after starting work and that she was on her feet and doing the stairs, that would explain why her knee gave out on her. The doctor further explained that pivoting was the direct causative factor of the knee injury, but the buckling is what caused the damage to her knee. (Id. pp. 10-14)

Dr. Ho explained that when Dr. Primus took her to the surgery, he was cleaning up the meniscal tear, the partial ACL tear, the cartilage damage in her knee, et cetera. The doctor indicated that the more important tear was what is termed a radial tear of the medial meniscus. Dr. Ho explained that the radial tear is a less common tear and its' pattern is only seen with trauma, i.e., with a twisting or giving way injury such as Petitioner's. He added that radial tear is one that renders a meniscus non-functional. Dr. Ho further explained that although it is a simple tear, it does more in terms of making the meniscus non-functional than, for example, a horizontal cleavage tear, where a lot of the cushioning mechanism of the meniscus is preserved. On the other hand, a radial tear takes away a lot of the cushioning characteristics. (Id. pp. 14 – 16)

Dr. Ho further testified that there are four grades of chondromalacia; Petitioner had some grade 2 medial chondromalacia of the patella at surgery which is pretty common in a woman of her age and physical characteristics (Id. at 16). In terms of follow up care, the doctor provided that a simple less involved or less traumatic injury, such as a simple meniscal tear, often times would not require injections postoperatively. (Id. pp. 16-17)

Dr. Ho then testified about the permanency of Petitioner's injury. He noted that x-rays taken at the time of the examination showed nearly complete loss of the medial joint space of the upper knee and moderate osteophytes formation which is permanent and will require treatment in the future. Dr. Ho proposed an osteotomy to unload the medial compartment, and if that is not ultimately helpful, then a knee replacement. Dr. Ho also testified that the treatment to date was reasonable and necessary and causally related to the accident of August 12, 2011. (Id. pp. 18 – 19)

On cross-examination, Dr. Ho testified that a medial meniscus tear can be both a chronic or an acute injury. In this matter, he identified Petitioner's injury as acute on chronic, with an acute tear on top of chronic changes. (Id. at 21)

Petitioner followed with Dr. Cooke on July 22, 2013. Dr. Cooke noted Petitioner continued with right knee pain complaints. During an examination, Dr. Cooke recorded that she had full range of motion with occasional popping. Also noted was some pain with bending as well as mild swelling. Petitioner was to follow up with her orthopedic surgeon. (Pet. Ex. 2 at 316)

Petitioner underwent the prescribed repeat right knee MRI on July 31, 2013, at South Suburban Hospital. The MRI, which was compared with Petitioner's prior November 2011 MRI, revealed extensive degenerative maceration of the medial meniscus, moderate diffuse chondromalacia, and a large medial joint osteophyte and overall progression of the degenerative changes. (Pet. Ex. 3, at 70)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Brian Cole on January 16, 2014. In his report dated same, the doctor recorded that Petitioner reported that on the date of the alleged accident, she came down the stairs of one of the watchtowers in the prison and twisted her right knee. According to Dr. Cole, Petitioner noted that there was nothing unusual about the situation and she did not fall. "She was on the stairs, she essentially stood, tuned, and "heard a pop" and then had worsening of her right knee pain thereafter." Dr. Cole noted that Petitioner's right knee had been bothering her immediately prior to the injury. He also noted that Petitioner had a previous problem with right knee dating back to 13 years ago. Dr. Coe chronicled medical records he reviewed which included Dr. Primus' clinical notes and the deposition of Dr. Ho. After reviewing the medical records and performing an examination, Dr. Coe's impression was significant advanced preexisting degenerative joint disease of the right knee with concurrent comorbidity of obesity. Dr. Cole indicated that a total knee replacement is the only definite step to bring Petitioner to an end point of treatment. The doctor stated, "I cannot categorically say that her need for the replacement was related to the injury date in question. She had an ongoing well-established level of osteoarthritis radiographically that was advanced. She is obese. Her mechanism of injury was so benign that I cannot definitely say that it changed the natural course of her knee whatsoever. Furthermore, she conveys to me she was hurting even before the injury (immediately before for that matter) and was under the care of a physician." Dr. Cole added that Petitioner had "some level of twisting injury, August 2011, not categorically responsible for claimant's need for care at this point." Dr. Coe opined that Petitioner could return full duty work, albeit with some discomfort. (Resp. Ex. 2)

Petitioner saw Dr. Cooke on January 29, 2014, complaining of bilateral knee pain without swelling to the left knee but some to the right. Petitioner reported an increase in pain since the cold weather with extreme temperatures. Petitioner referred back to Dr. Primus for intraarticular steroid injection. (Pet. Ex. 2, pp. 317-318)

Petitioner saw Dr. Primus on March 4, 2014. At that time, she underwent an injection to the right knee. (Pet. Ex. 4 at 394)

O April 8, 2014, Dr. Cole authored a Section 12 addendum report. According to the doctor, he reviewed addendum records, dated March 25, 2014. He opined that Petitioner's need for care of the knee was not related to her job duties. The doctor stated, "Granted, the repetitive ascending/descending of stairs might or could worsen the symptoms of osteoarthritis in a symptomatic knee; however, I cannot say this is anything "above and beyond" what might or could just as easily happen at home...I cannot draw a causal connection between her repeated walking up and down stairs at work and her current condition." (Resp. Ex. 3)

Petitioner saw Dr. Primus on May 9, 2014 with continual right knee symptoms as well as a left knee clicking and popping. Dr. Primus prescribed a right total knee replacement. (Pet. Ex. 4, pp. 474-

475) Petitioner testified that the prescribed surgery was not authorized. She remained off work from March 5, 2014 through July 1, 2014, returning to work the following day.

Petitioner continued treating with Dr. Primus through the end of 2014. On November 7, 2014, she underwent bilateral knee steroid injections. (Id. at 519) Petitioner underwent another set of bilateral knee injections on December 5, 2014. (Id. at 524) By January 9, 2015, Dr. Primus continued his knee replacement recommendation. (Id. at 529)

Petitioner testified that on June 9, 2015, she witnessed a motor vehicle accident near the end of Respondent's driveway. Petitioner stated that while assisting one of the individuals involved, her buckled and she "ended up" in a bush. She stated, the knee "just gave way."

Petitioner saw Dr. Cooke on June 10, 2015 Petitioner reported that she was at work on June 9, 2015 when she attempted to assist someone who was in a motor vehicle accident near Stateville. Petitioner reported that while helping the individual, she tumbled into a ravine and fell on top of a thorn bush. Petitioner had to be assisted out of the ravine by a co-worker. Petitioner was complaining of generalized soreness and stiffness all over. She was able to ambulate but had significant discomfort. Petitioner was diagnosed with a blunt musculoskeletal trauma after a 10-12 foot fall. Tylenol prn was prescribed. (Pet. Ex. 2 at 56)

Petitioner saw Dr. Primus on June 30, 2015 reporting worsening symptoms. Petitioner reported that she was ready for surgery. Dr. Primus prescribed total knee replacement surgery. (Pet. Ex. 4, pp. 530-531)

On August 19, 2015, Dr. Primus performed a right knee arthroplasty for a preoperative diagnosis of right knee degenerative osteoarthritis and acquired genu varum (Pet. Ex 3g) He further performed an open reduction and internal fixation of an intraoperative medial tibial plateau fracture. In the operative notes, the doctor described that "…[d]uring this procedure, based on the vibration of the cutting jig, this is where we believed the extenuation of the tibial cut was made leading to the crack and fracture..." Thus, a third post-operative diagnosis was iatrogenic tibial plateau fracture which occurred during surgery (Id), leaving Petitioner with plating and screws situated directly underneath an artificial knee. After surgery, Petitioner received home healthcare from Advocate.

According to Petitioner, five weeks later, on September 23, 2015, she had a slip and fall hobbling down the stairs at her apartment building. Thereafter, Dr. Primus performed a right knee incisional closure with irrigation and debridement, and a manipulation under anesthesia. The postoperative diagnosis was traumatic right knee incision dehiscence. (Pet. Ex. 4A, pp. 25-29) Dr. Primus then referred Petitioner for pain treatment to Dr. Aashan at Northwest Suburban Pain Clinic. (Pet. Ex. 4A)

Petitioner saw Dr. Ahsan, a pain management specialist, on October 22, 2015. She complained of pain in her right knee extending to her right thigh and foot, as well as right leg stiffness. Dr. Ahsan indicated Petitioner suffers from chronic postoperative right knee pain. The doctor prescribed fentanyl patches, muscle relaxants, and Lyrica. (Pet. Ex. 11, pp. 4-9)

On January 13, 2016, Petitioner presented to MidAmerica Orthopedics where she saw Dr. Sarkis Bedikian for a second opinion. Petitioner reported difficulty bending the right knee along with severe pain and swelling. After obtaining an x-ray and performing an examination, Dr. Bedikian felt Petitioner had instability, likely related to component malposition, specifically the tibial component. The doctor was also concerned she had a wound dehiscence, underlying infection along with arthrofibrosis. Dr. Bedikian recommended a right knee revision. (Pet. Ex. 12, pp. 6-7)

On March 14, 2016, Dr. Bedikian performed a right total knee revision with a diagnosis of right knee arthrofibrosis and instability. (Pet. Ex. 14g) Petitioner testified that she had improvement following this procedure. She indicated there was no more rocking of the implant, less pain and swelling, her black and blue went away and she had more ability to bend her knee.

On May 10, 2016, Dr. Bedikian noted that although Petitioner reported making strides, she was frustrated by her overall lack of progress. The doctor noted that he was concerned with her over all lack of flexion at six weeks post surgery. Although she was able to get to 65 degrees, same was nowhere closer to 90 degrees. The doctor prescribed right knee manipulation. (Pet. Ex. 12 at 9) The procedure was carried out on May 23, 2016 for a postoperative diagnosis of right knee arthrofibrosis (Pet. Ex. 14h)

Petitioner followed with Dr. Bedikian on July 13, 2016. The doctor noted Petitioner's right knee flexion reached a plateau at 70 to 75 degrees. Also noted were her complaints of significant pain and swelling. Dr. Bedikian recommended a repeat manipulation of Petitioner's knee. (Pet. Ex. 12 at 13) The recommended procedure was completed on July 28, 2016. (Pet. Ex. 14I)

On August 3, 2016, Dr. Bedikian noted that Petitioner did not achieve additional range of motion following the manipulation. He also noted that she had plateaued in her physical therapy. The doctor provided that only way to possibly improve her stiffness and decreased her pain would be another surgical procedure which would include removing the femoral implant and implanting a hinged knee prosthesis. (Pet. Ex. 12 at 15) Petitioner elected not to undergo any further surgeries at that time. Petitioner testified that she hopes to avoid undergoing any further medical treatment.

Records submitted show Petitioner last saw Dr. Bedikian on October 26, 2016. At that time, Dr. Bedikian informed Petitioner that there was no good solution for her problem. He again provided the surgical option to revise the right knee to a hinged prosthesis which required sacrificing her collateral ligaments. After noting Petitioner was scheduled to see a new pain management physician, Dr. Bedikian indicated she could return on an as needed basis. (Id. at 19)

Petitioner saw Dr. Malhotra with Expert Pain Physicians on October 27, 2016 the following day (Pet. Ex's: 15, 15a). Dr. Malhotra treated Petitioner through May 11, 2018. It appears that Petitioner had significant pain complaints, required significant narcotic medication. Per warnings in the records and Petitioner's testimony, she weaned of the narcotics and legally became certified to take medical marijuana which she did in various forms. (Pet. Ex. 22) She also had therapy at Antares in Burr Ridge, and testified that the therapist there assisted her in making the switch from opioids to marijuana.

At her request, Petitioner underwent a Section 12 examination Dr. Jeffrey Coe on July 25, 2017. In his report dated same, Dr. Coe opined that Petitioner sustained an injury to her right knee that caused a tear of the right knee medial meniscus, right knee synovitis and aggravated preexistent degenerative arthritis causing both acute and chronic knee pain. The doctor felt that a causal relationship existed between Petitioner's current right knee and left knee symptoms and state of impairment and the incident occurring at work with Respondent on August 12, 2011. He further indicated that "...in my opinion, based on the totality of [Petitioner's] knee symptoms and her poor outcome from multiple right knee surgical procedures...[Petitioner] is permanently and totally disabled from gainful employment...due to the condition of her lower extremities." The doctor added that Petitioner would require continual treatment in the form of pain management. (Pet. Ex. 19)

Petitioner testified that she has not worked since her first total knee replacement of August 19, 2015. Petitioner also testified that no orthopedic or pain doctor to date has released her to return to full duty work. Physician's Statements submitted through January 21, 2019, show she could do some type of sedentary work. (Pet. Ex. 5)

Petitioner testified that she has a high school diploma and took two years of general studies courses at Joliet Junior College. She has served in the United States Coast Guard for two years reaching the rank of E2, with job duties including being a deck hand and grounds keeper, before going into corrections. Petitioner testified that she has no specific computer skills aside from performing e-mail.

Petitioner testified that she actively sought sedentary work between approximately January and April 2018 with the Illinois Department of Corrections, which sent her job leads. Petitioner testified that she applied for several jobs, but never made it to the interview stage.

At the time of trial, Petitioner testified that her knee can "lay her out" from anywhere between several hours to a week. She explained that changes in barometric pressure cause her knee to throb and ache and that the pain was not sudden or sharp. Petitioner described the feeling like a "charlie horse" that will not ever release. Both the onset and duration of these symptoms are unpredictable.

Petitioner testified that presently she uses several different methods to treat her symptoms. For example, Petitioner said she uses heating pads, an electric ice machine, and "toggle" method she learned at Alteras to roll out the muscles in her legs. Additionally, she testified that she spends on between $300.00 to $400.00 per month on medical marijuana to treat her pain symptoms. If none of these tools work, she will stay home.

Petitioner testified that she has difficulty bending her knee, she has restricted range of motion, and when she moves forward it feels like her toes will grab the ground, and she will have to physically swing her hip in order to walk. Petitioner testified that she felt her right knee injury and resulting medical treatment caused her to have an altered gait, altered leg length, and worsened hip pain. Petitioner testified that she has never had a left leg surgery.

With regard to her current mobility, Petitioner testified that she utilizes a combination of a scooter, a walker with wheels, or a cane depending the circumstances. Petitioner testified that she purchased these items herself. Following the accident, the lowest her pain level ever was 6 out of 10 following the initial surgery.

Petitioner testified that her medical bills have been paid via her HMO group health insurance.

In Support of the Arbitrator's Decision regarding "C" (Accident Arising out of it and the course of the employment), the Arbitrator finds the following:

Petitioner worked as Correction Officer performing "tower duty" at Stateville Penitentiary from approximately 2007 until her August 12, 2011, date of accident. For some time prior to Petitioner's date of accident, she was assigned to Tower 9. To reach Tower 9, Petitioner had to climb 33 stairs and 9 ladder rungs. Petitioner testified she would typically go up and down the stairs and ladder rungs four times per day. Petitioner's job duties required constant surveillance of the prison and surround grounds through eight large windows in the octagon shaped Tower 9. Although a chair was provided, Petitioner testified that she could not perform her job duties in a seated position. Petitioner testified that she would stand approximately 5 hours out of her 7 ¼ to 7 ½ hour work day and would often be carrying a heavy weapon. She readily admitted to two minor, prior work accidents, one involving each knee, over 10 years before. The treatment to her right knee was simply going to the infirmary, icing and resting, while she did have some physical therapy on the left knee. Neither required surgery. She did not have any medical treatment for either of her knees between approximately 2001 and her date of accident. Although she was considering the possibility of seeing a doctor for 2/10 pain, she was continuously performing full duties which were stressful on her knees. The post-accident medical imaging and observations at surgery confirm Petitioner's pre-existing condition in her knees consisted of mild degenerative changes. The medial meniscus and all tears, as well as the chondral injury, were acute.

At the end or her work shift, Petitioner's duties required that she take the only key to Tower 9 downstairs with her. After she descended 9 ladder rungs and 33 steps, the last act necessary to exiting was to unlock the door in Tower 9 and pivot to place the key into a tethered milk crate lowered down by her relieving officer while coming out of a squat due to the fact the only exit was a four-foot tall door. Placing the key into the milk crate after locking the door was the last act Petitioner was required to exit Tower 9. If she did not perform this act, it would be considered a security breach because the door to a guard tower would be unsecure. Petitioner testified that this process was done hurriedly since the officer on top could not perform surveillance while waiting for the milk crate.

Petitioner planted her foot and she twisted her knee, causing immediate and severe pain. Petitioner's testimony regarding configuration of Tower 9 and the process of hurriedly coming out of a squat due to a unique configuration to place the key in a milk crate to catch her ride back was unrebutted. In addition, the initial medical records of Dr. Primus, the first orthopedist that she saw, discussed both the mechanical forces of descending that many stairs, and those from coming up from a squat, the latter being 8 times a person's normal weight. Thus, she was required to pull the door closed, and then from a semi-squat go thru the opening, return the key, and leave. It was while she was coming up from the squat and depositing the key that she twisted and hurt her knee in the performance of her duties.

Respondent denied benefits in this claim arguing that Petitioner was not exposed to a greater risk than the general public. However, the Arbitrator finds Petitioner's right knee injury arose out of a peculiar risk incidental to her duties as a correctional officer in the direct performance of "tower duty" at Tower 9 at Stateville.

The rule is that injuries resulting from a risk distinctly associated with employment, *i.e.*, an employment-related risk, are compensable under the Act. 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. When a claimant is injured due to an employment-related risk, it is not necessary to perform a neutral risk analysis. *Young v. Illinois Workers' Compensation Comm'n*, 2014 Ill. App. (4th) 130392WC, ¶23.

Here, Petitioner's right knee injury was sustained while performing actual work duties incidental to her job as correctional officer working tower duties at Tower 9. Specifically, Petitioner was required to place the only key to the door at Tower 9 into a tethered milk crate while exiting to meet the mobile transport unit (e.g. her work-provided ride within the prison). These facts, coupled with the unique configurations of Tower 9 outlined above (e.g. the four-foot opening that was two-feet above the ground at the base of the tower) forced Petitioner to squat and twist to accomplish this task. So, while under *Young*, no neutral risk analysis is to be done, if such an analysis was performed, there would be an increased risk greater than experienced by the general public.

The Arbitrator relies on *Steak 'n Shake v. Illinois Workers' Comp. Comm'n*, 2016 IL App. (3d) 150500WC in support of his decision. In that case, the Court awarded benefits to a fast food manager who injured herself while wiping town tables, noting that the claimant credibly testified that her job duties were to keep the flow of customers moving in an efficient manner. Respondent provided no rebuttal evidence. The Court reasoned the claimants injures resulted from a risk distinctly associated with her employment because the record established that Petitioner was injured engaging in an activity that the employer might reasonably have expected her to perform in the fulfillment of her job duties. Unlike *Steak 'n Shake*, Petitioner's motion of

exiting a squat while turning to return the Tower 9 key to the milk crate was actually part of her job duties and unequivocally expected of her. Even if this motion was not considered part of her actual job duties, it was certainly an activity her employer might have reasonably expected to perform in fulfilment of her job duties due to the configurations of Tower 9.

There are several other bases to support a finding Petitioner's accident arising out of and in the course of the employment, the first of which would not require a neutral risk analysis going to the issue of risks to the general public. In *Caterpillar v. Industrial Commission*, 215 Ill. App. 3d 229 (1991), a case was presented to the Arbitrator claiming specific accident, and on review the Commission found the case compensable on the basis of repetitive trauma, a theory that had not been raised at arbitration.

The Appellate Court held that pleadings and proceedings in Workers' Compensation cases are informal and designed to achieve a right result, and that the Commission must decide the case on evidence presented and on the merits of the case and not be restricted to the Claimant's Application for Adjustment of Claim. *See Caterpillar*, 215 Ill. App. 3d 229 (1991). In that regard, multiple theories of compensability exist through the records and testimony of Drs. Primus, Ho, and Coe. Even Respondent's Section 12 Examiner, Dr. Cole, opined that the records he reviewed reflected an accident and the effect of the stairs on a person's knee.

At the time of Petitioner's accident in 2011, it could legitimately be argued that pivoting on a leg and twisting a knee, in the absence of anything more, was a neutral risk and not compensable. Since then, however, the Appellate Court has come down with the cases of *Mytnik v. I.W.C.C.*, 2016 Ill. App. (1st) 152116 WC and *Young v. I.W.C.C*, 2014 Ill. App. (4th) 130392 WC.

In *Young*, a claimant was an inspector who was in the process of checking some parts, and while reaching for a spring clip, he felt a snap or pop in his shoulder. The Court discussed the three categories of risks, being risks distinctly associated with employment, personal risk, and neutral risks, having no particular employment or personal characterizes. It held, as Respondent asserts here, that neutral risks do not arise out of the employment unless the employee was exposed to a risk to a greater degree than the general public. The Commission had held that reaching down for an item was not a risk beyond what she would experience as a normal activity of daily living. The Appellate Court held that where a Claimant is injured due to an employment related risk, distantly associated with his or her employment, it is unnecessary to perform a neutral risk analysis. A neutral risk has no employment related characteristics. Where a risk is distinctly associated with the claimant's employment, it is not a neutral risk. Thus, the Court held the injury arose out of his employment.

So, too, in *Mytnik v. I.W.C.C*, supra, the claimant was an assembler who claimed that he would be bending and reaching, and as a result injured his back. The Commission denied the claim, finding varied and inconsistent histories regarding the incident. The Court held that in analyzing risk, the first step was to determine whether the injuries arose out of an employment related risk. It reaffirmed the rule on when risk is distinctly associated with employment. There, as here, the claimant was performing duties. Even if the claimant herein were only hurrying to the mobile transport officer, with nothing more, that would be within her duties.

A case directly on point to the facts herein is *Luloh v. Federal Express*, 18 I.W.C.C. 0189. There, Petitioner was performing her normal job duties as a Federal Express delivery person when her left foot planted on the ground and her left knee twisted. Unlike here, there was nothing abnormal about the ground. The Commission found Claimant was in the foreseeable performance of duties. At the time of the occurrence she was not carrying anything, and she was not in an unusual hurry, nor was there any defect on the ground. In the case at bar, Petitioner was locking a door and returning a key to a milk crate and then exiting in a confined and unusual configuration with a dirt and gravel surface both inside and outside of the doorway. The facts here are much stronger than *Luloh*. In following *Mytnik* and *Young*, the Commission noted in *Luloh* that the Appellate

Court found the risk the claimant was exposed to was necessary for the performance of her job duties at the time of the injury, and that those two cases were applicable to the knee injury in *Luloh*, which had the same mechanism of injury as here. Following those cases, it is clear that Petitioner herein was injured while performing her actual job duties of descending the stairs, with a key presumably of insignificant weight, locking the door, leaving with a squat through a lower exit, and returning the key to a milk crate for the officer on top to hoist. Moreover, these actions were done hurriedly for security reasons. The place of the injury itself presented an unusual and confined situation where a squat was required in order to exit.

Even if one were to consider Respondent's claim of no increased risk, Petitioner would prevail. While it is clear that it was twisting of the knee which caused the torn medial meniscus, requiring surgery, as explained by Dr.'s Ho and Coe, the contributory events both leading up to and existing at the time of the injury are atypical for the general public. In the context of *Sisbro v. Industrial Commission*, 207 IL 2d 193 (2003), where an employee physical structures, even if diseased, break down under the stresses of usual employment, it is an accident arising out of an in the course of the employment.

In *Sisbro*, an employee merely stepped down from a truck, and his ankle collapsed in part due to a pre-exiting disease. In *Jones v. Power Maintenance Constructors*, 13 I.W.C.C. 0403, where an employee was required to kneel and contort in a confined space, and suffered a meniscal tear, the claim was found compensable. Here, the undisputed evidence of Dr. Primus is that coming up from a squat produced eight times the forces on the knee of simply carrying usual weight and this was required due to the small opening through which Petitioner had to pass. She testified her legs would be fatigued at the end of the day. Dr. Ho, with expertise in biomechanics, explained which leg muscles would be weakened and how this could cause the leg to collapse. So even assuming Petitioner was not performing her duties at the time of the accident, although clearly she was, the injury sustained was not a risk typical to the general public, and represents an increased risk by reason of the previous performance of her job duties which required not only standing and walking but carrying a weapon, the stairs, and the configuration of the exit area.

Finally, as a repetitive trauma theory to the case, the evidence is likewise clear that Petitioner was on her feet, moving from window to window at the top of a tower, standing 5 working hours per day, while carrying a heavy weapon, with its additional force on her legs for literally years before the incidents in question; her best recollection was she went up and down the stairs most days at lunch. Upon returning to work following her first surgery, she lacked the cushioning of a normal meniscus, and by MRI the medial compartment broke down from what were minimal pre-injury changes consistent with her age. Her repetitive work activities were clearly stressful on the damaged knee and contributory, although it was the specific accident which acutely damaged the meniscus.

Of note, Dr. Cole actually agreed with Dr. Primus. While Dr. Cole did not quarrel with, or even discuss Dr. Primus' initial office note on the effects of coming out from a squat, in Respondent's Exhibit 3, he stated: Granted, the repetitive ascending/descending of stairs might or could worsen the symptoms of osteoarthrosis in a symptomatic knee; however, I cannot say this is anything "above and beyond" what might or could just as easily have happened in the home." However, in the very next sentence he goes on to state that his assumption that she was under a physician's care prior to this onset at work. While admittedly Petitioner had some significantly less symptoms beforehand, Dr. Cole supports a repetitive trauma theory, although the primary cause was the specific accident and surrounding circumstances. Accordingly, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment with Respondent.

In Support of the Arbitrator's Findings regarding "F" (Causal Connection) the Arbitrator finds the following:

See the Arbitrator's findings and conclusions regarding "C" accident arising out of *supra*. Both the chain of events and the medical testimony strongly support causal connection. While Petitioner clearly had symptoms preceding the incident described by her as 2/10, she appeared at St. Joseph Medical Center the evening of the accident with a pain level severity of 9/10, on a typical 1 to 10 scale. Petitioner's testimony and the medical records support a consistent mechanism of injury, namely, that she turned with the right foot planted and immediately noticed a pop, followed by pain in the medial aspect of the right knee. Although the emergency room doctor read the right knee x-rays at that time as negative, the radiologist read the them as showing mild degrative changes. The impression was a possible medial meniscus tear, which from the facts of the case would clearly be acute. At the initial visit to Dr. Primus, she then gives the history of the injury while at work August 12, 2011, with the mechanism of injury. Dr. Primus read his own x-rays, showing that the medial compartment revealed mild medial compartment joint space narrowing, medial femoral and tibial osteophyte formation, and no evidence of sub-chondral sclerosis. The lateral compartment was normal, and the patella femoral joint was normal with a central tracking patella, except for a medial patellar osteophyte and lateral patellar osteophyte, consistent with the St. Joseph Medical Center reading of the x-rays. Clearly, at the time of her injury by the imaging, Petitioner was not suffering from any advanced osteoarthritis in the knee, but did suffer a torn medial meniscus which was later found on MRI, and for which Dr. Primus did surgery December 11, 2011. At that surgery, which was four months post-accident, he only found grade II changes in the medial compartment.

Dr. Ho testified that the medial meniscal tear was a radial tear, which would have been post-traumatic, and is also the type of tear that causes aggravation and acceleration of medial compartment osteoarthritis which can lead a total knee replacement. Dr. Primus also felt the surgeries were work related, as the records reflect in that he sought workers' compensation approval for his surgeries, which in this case were not forthcoming. Dr. Ho explained that radial tears of the medial meniscus are only seen with trauma and that there are worse than some other types of tears because they take away the cushioning. Prior to then, Dr. Ho testified she only had early arthritis consistent with her age.

Dr. Coe testified that going up and down stairs, or squatting, causes an eccentric out of balance force on the knee which causes increased risk. (Pet. Ex., p. 20) Dr. Coe also explained what Dr. Primus reported that meniscal tears can cause articular cartilage damage. The articular cartilage is a smooth glossing tissue on the surface of a joint, richly supplied with blood which produced fluid and a small surface to let the joint glide and slide. Once it is torn, it does not heal itself, but it scars over and never heals back to a smooth normal cartilage. With respect to Petitioner, she suffered an internal derangement of the knee with tearing of the meniscus, joint lining inflammation, synovitis, and an injury to the articular cartilage, which are all significant injuries. At the first surgery some of the shock absorber and spacer were removed from the knee, causing increased pressures within the knee, and she was found to have articular cartilage damage. So, over the course of the next few years she had accelerated breakdown within her right knee ultimately leading to her right knee replacement surgery which was very complicated and required multiple follow up surgical procedures and associated chronic pain. Dr. Coe expressed a clear understanding of the accident, that as part of the tower work, that the last step was below grade, she is stepping upward with a key with an awkward movement in a narrow or confined space which was part of her work activity. (Id. at 81) He understood that prolonged walking or lifting could fatigue legs. (Id. at 87 – 88) He also testified that the mild degenerative arthritis changes which showed up on x-rays done on the date of the accident would not even cause a doctor to prescribe an MRI. (Id. at 97 – 98) He also opined that the medial meniscal tear was a new acute injury (Id. at 98), as did Dr. Ho. Dr. Coe also testified that the major breakdown, the biggest identifiable change in her right knee is that the area of the site of the meniscal tear, with the significance being that the meniscal tear was a factor in the medial compartment breakdown, which collapsed further fairly quickly, leading to knee replacement surgery within a relatively short period of time and then a whole series of unfortunate complications. (Id. at 99-100)

The Arbitrator finds the records and testimony of Drs. Primus, Ho and Coe convincing, and adopts their findings and opinions. Dr. Ho and his opinions on mechanism of injury are reasonable and convincing. The

Arbitrator has also considered the Section 12 examination and subsequent report of Dr. Brian Cole, Respondent's Exhibits 2 and 3. Initially, the Arbitrator notes that Dr. Cole's opinions are less than persuasive as he was not furnished with Petitioner's complete medical records. For example, his summary of the medical records led him to the conclusion: "Medical records demonstrate a fact pattern conveying the claimant had some level of injury at work that lead to a continued need for care with Dr. Primus." His language in his summary was: "I cannot categorically say that her need for this replacement is related to the injury in the question."

Dr. Cole was furnished with Dr. Ho's Independent Medical Exam and his deposition, yet Dr. Cole does not at all contest the causal relation between the accident and the medial meniscus tear, nor the ACL tear. The medial meniscus tear was the causative agent for the subsequent breakdown of the medial compartment. His exam was January 16, 2014, approximately two and one-half years following the accident. He agreed that Petitioner required a total knee replacement and took x-rays that day showing "nearly complete medial joint space loss in the right knee, medial to the ephemeral compartment." It also showed mild to moderate changes in the lateral and paternal femoral compartment. Dr. Cole, without having the benefit of the initial imaging either at the Emergency Room or by Dr. Primus, the operative findings of Dr. Primus, or the records outlined supra, assumed that Petitioner previously had significant pre-existing medial compartment degenerative changes. In fact, she did not. As previously stated, at surgery four months later she had grade 2 changes out of 4 at the medial joint consistent with her age; by the time she saw Dr. Cole her medial joint changes had accelerated to the extent she required a total knee two and one half years post injury, while the lateral, unaffected compartment and the patella femoral joint compartment had not advanced to any significant degree, if at all, being only mild to moderate at the time of his exam.

Dr. Cole opined Petitioner did require a total knee replacement. Dr. Cole simply wasn't provided with the initial hospital records showing Petitioner's pain at that stage to be 9/10, nor the medical records describing the injury in detail, including twisting her knee while coming up from a squat in an area with unusual configuration, or that the x-rays as of the date of her injury and initially by Dr. Primus only showed her degenerative condition to be mild. Nor does it appear that Dr. Cole had Dr. Primus' operative report from December 7, 2012, only having a post-operative clinical note. Had Dr. Cole had the operative report he would have known that the medial compartment degenerative findings as of that time were not advanced, but rather only grade 2, as Dr. Ho testified.

Factually, Petitioner went from minor right knee complaints before her injury, with minimal degenerative changes noted on imaging, to requiring a total knee replacement within two and one-half years. The MRI from July 31, 2013, showed progression from the mild changes which existed at the time of injury to advanced changes in a relatively short period of time at the exact site of the injury, the medial compartment.

Expert opinions must be supported by facts and are only as valid as the facts underlying them. *Gross v. I.W.C.C., 2011 Ill. App. (4th) 100615WC*. That Court also held that an expert opinion is only as valid as the reasons for the opinion. In this case, Dr. Cole in his initial report was handicapped by a lack of necessary information at his initial Independent Medical Examination, specifically medical records demonstrating the opposite of the basis of his opinion and showing Petitioner only had mild degenerate changes prior to the accident in question.

Subsequently, Dr. Cole three months later was provided additional medical records (Resp. Ex. 3). He states "I reviewed your addendum records, dated March 25, 2014, regarding causality." The doctor did not list what additional records were furnished or he reviewed, and the Arbitrator will not speculate in that regard. However, his only opinion in the subsequent report was that he would not draw a causal connection between her repeated walking up and down stairs at work and her current condition. Dr. Cole did not comment on the total facts surrounding Petitioner's injury, which were stated in a hypothetical question to Dr. Ho at the deposition which Dr. Cole purported to have reviewed.

Evidence submitted show Petitioner had a relatively normal medial compartment of her knee at the time of her accident with only mild degenerative changes, and changes in the lateral and patellar femoral compartment, yet the latter two compartments remained insignificant to the time of Dr. Cole's exam, while the medial compartment, following the medial meniscus surgery for a radial tear and resulting loss of cushioning need for, deteriorated at a very accelerated rate. She went from mild changes to a need for a total replacement in 30 months.

Regarding Petitioner's left knee, the only opinions and evidence are that of Dr. Coe, Pet. Exhibit 19. The Courts and the Commission has routinely found compensable overuse injuries to the contralateral extremity where an individual injures on extremity and during the course of treatment through overuse in favoring that injured member, suffers a deteriorating condition on the contralateral side. *See Michael Healey v. University of Illinois*, 09 I.W.C.C. 1267 (contralateral shoulder condition compensable due to overuse); *Body Elec. Co. v. Dec*, 356 Ill. App. 3d 851 (1st Dist. 2005) (the Commission "has seen many instances where the contralateral side has developed symptomology which required more aggressive treatment simply because the claimant has had to bear weight or rely on it almost exclusively); *Steven Benyon v. Perillo BMW*, 08 I.W.C.C. 121 (petitioner forced to compensate for right wrist injury by relying on left wrist and found left wrist condition causally connected to right wrist injury). Ultimately, Petitioner had six right knee surgeries. Petitioner testified that her medical treatment caused her overcompensation with her left leg and hip. Dr. Coe's report at page 8 reflects that Dr. Primus considered left knee replacement surgery during treatment as well, and Dr. Coe opined at page 15 of his report that Petitioner had left knee joint margin tenderness, and stiffness of the left knee in flexion. Dr. Coe testified that Petitioner's left knee symptoms were caused by overuse of the left side due to continuous right knee symptoms related her August 2011 work injury and subsequent surgeries (Pet. Ex. 21, p. 53). While these left knee symptoms were minimal compared to the associated weakness of her right knee, thigh, and calf muscular atrophy following her multiple surgeries, with limitation in right leg weight bearing, both the chain of events and the records of Dr. Primus and the testimony of Dr. Coe support that Petitioner's left knee has advanced to the point where consideration of a total left knee arthroplasty may be required as well. The Arbitrator finds a causal nexus exists with respect to the conditions of ill being in both knees and the medical treatment described in the records and in Dr. Coe's narrative report.

In Support of the Arbitrator's Findings regarding "K" (Temporary Total Disability/Maintenance), the Arbitrator finds the following:

The temporary total disability periods of August 13, 2011 through June 17, 2012, and March 5, 2014 through July 1, 2014, reflect the initial healing period to and following the medial meniscal surgery, and for the second period following Dr. Primus exam of March 4, 2014, where x-rays taken at his office were interpreted as showing near bone on bone medial compartment narrowing. He performed a right knee steroid injection, a Synvisc injection and use of a hinged right knee brace, and took her off work. On May 9, 2014, he prescribed right total knee replacement. On May 23, 2014, he found the same regarding the right knee and now left knee medial and lateral joint margin tenderness and patella femoral tenderness due to overuse. Petitioner returned to work July 2, 2014, which she did until her right total knee arthroplasty performed by Dr. Primus August 19, 2015. Unfortunately, at surgery the tibial plateau was fractured and required plating with screws in addition to the artificial prosthesis. Her limited ability to ambulate led to an additional surgery on September 25, 2015, following a fall at home on stairs when she was approximately four weeks post-surgery. Petitioner continued with Dr. Primus, who referred her to a pain specialist, Dr. Ahsan, who prescribed fentanyl patches, muscle relaxers, and Lyrica. He also noted Petitioner's left knee pain. Petitioner also had physical therapy while seeing Dr. Ahsan and thereafter, January 13, 2016, she was seen by an orthopedic specialist, Dr. Bedikian. Dr. Bedikian performed right knee surgery March 14, 2016, observing at surgery severe arthrofibrosis, right knee process instability and medial laxity. The doctor performed a revision right knee arthroplasty with scar tissue release, requiring home health care. On May 23, 2016, Petitioner had a right knee manipulation procedure due

to lack of flexion post-operatively. Again, with the diagnosis of post-operate arthrofibrosis. On July 28, 2016, Petitioner underwent a repeat right knee manipulation by Dr. Bedikian, with the results being she was unable to flex beyond 70-75 degrees. On August 3, 2016, motion remained limited, and the only likely improvement would be removal of the processes and implantation of a new, hinged processes with a risk that it might not increase motion. This surgery was declined by Petitioner. On August 26, 2016, Dr. Bedikian noted no improvement, and referred her to pain management, which she sought the next day with Dr. Malhotra. It appears that at this point orthopedic treatments had concluded with Petitioner, and all that remained was pain management, including, initially, a significant opioid prescription. Accordingly, the Arbitrator finds the date of MMI as the date Petitioner completed treatment with Dr. Bedikian, October 26, 2016. Thus, the Arbitrator finds Petitioner temporarily and totally disabled for a period of 123-3/7 weeks, from August 12, 2011 through June 17, 2012, from March 5, 2014 through July 1, 2014, and from August 19, 2015 through October 26, 2016. The Arbitrator notes that from that date forward Ms. Patton would be entitled to maintenance unless she was permanently and totally disabled, which will be addressed below.

In support of the Arbitrator's Decision regarding "J" (Medical Treatment), the Arbitrator finds the following:

Petitioner admitted bills into evidence and many of the bills were paid by group insurance. Dr. Coe testified that the bills were reasonable and necessary and causally related to the accident in question. (Pet. Ex. 21, p. 73) Respondent only objected to the bills at trial on the basis of liability.

Accordingly, medical bills are awarded in the total sum of $424,517.09, subject to the Fee Schedule. Respondent shall have a credit for any payments made by group insurance, and shall hold Petitioner harmless with respect to any such payments pursuant to Section 8 of the Act.

In support of the Arbitrator Decision regarding "L" (Nature and Extent of the Injury) the Arbitrator finds the following:

The Arbitrator notes that because the date of accident in this matter is August 12, 2011, an analysis consistent with Section 8.1b of the Act is not appropriate.

Dr. Coe testified that Petitioner was permanently and totally disabled, having seen her six years after her accident. Petitioner has undergone six (6) surgical procedures in her right knee with a very poor outcome in terms of persistent pain, continued stiffness, weakness and atrophy of the right leg, which is not going to improve. Based on the permanent condition of pain, the nature of her multiple surgeries, the limited gait, the stiffness in the right knee, the weakness of the right knee, as well as the left knee overuse type complaints, his medical opinion was that she was permanently and totally disabled in any competitive labor market place. Even in an office environment, her walking tolerance is only about one block, which could make it difficult for her to arrive to a job site. (Pet. Ex. 21, p. 72) Dr. Coe provided that additionally, she would need to be able to change positions and elevate her leg as needed, so she would be in the way and a problem for emergency evacuations from a work place. (Id. at 72-73) Moreover, Petitioner's cognitive abilities to perform work – including alertness, awakeness, cognition, rapid response, and ability to respond rapidly – would be affected by medication prescribed to manage her chronic pain. (Pet. Ex. 21, pp. 70 – 73)

Petitioner testified that when she is in so much pain, she is not in a position to make judgements. She has purchased a scooter from her own funds, has a walker with wheels, and she will also use a cane, depending on the condition of her knees. There will be days where she is homebound, averaging one to two times a week, because the leg will throb and ache and not respond, and it is too painful to walk. She has experienced this with changes of atmospheric pressure. She testified that it is like a cramping sensation, and a like a charley horse which won't release. She learned in physical therapy to use a toggle to roll along the leg to help the spasm

release, and she will use a heating pad and an electric ice wrap, but it still won't respond. These muscle spasms and cramping can last the remainder of the day, two to three days, or a week, as it lets go on its own. Without these spells, the leg is painful, it doesn't bend, the range of motion is restricted, and if she moves forward her toes grab the ground as she has to swing her hip because she feels the length of her legs are now different. Petitioner she was able to wean off Opioids, substituting instead medical marijuana, for which she pays $300.00 to $400.00 a month out of her own pocket.

Respondent has offered no medical evidence to refute Dr. Coe's opinions, nor has it offered any evidence of a stable labor market available to Petitioner. The only evidence in the record is Petitioner's unrebutted testimony that she was sent some leads for sedentary State jobs by State Retirement System, and never received a call back.

Under *Ceco v. Industrial Commission*, 95 Ill. 2d 273 (1983), where a doctor testifies that a Petitioner is permanently and totally disabled, even if a general practitioner (which Dr. Coe is not), and even with conflicting opinions, the burden shifts to Respondent to show that some kind of suitable work is regularly and continuously available to the Claimant. In this case Petitioner testified that she had a high school diploma, two years of general studies at junior college, served in the Coast Guard for two years doing work as a deckhand and grounds keeper, with an honorable discharge, and has no computer skills other than e-mail.

The Arbitrator notes that various disability slips have been filled out by various doctors for Petitioner, most recently her current general practitioner, being Petitioner's Exhibit 5. In the most recent statement, of January 21, 2019, in box 7, asking whether Petitioner is temporary and totally disabled or is disabled from any occupation, the doctor marked "disabled" and that she is suitable for sedentary work only. Petitioner's entire career following the Coast Guard was in corrections as a Corrections Officer at Stateville. She has neither education, training, nor experience which would lead to sedentary work. Based on Petitioner's age, training, education, experience, and the medical evidence outlined herein, her total disability is obvious. With Dr. Coe's opinion of permanent and total disability and the lack of any evidence of a stable labor market for her, pursuant to *Ceco*, Petitioner is permanently and totally disabled, and the Arbitrator so finds, as of the October 27, 2016, MMI date.

release, and she will use a heating pad and an electric ice wrap, but it still won't respond. These muscle spasms and cramping can last the remainder of the day, two to three days, or a week, as it lets go on its own. Without these spells, the leg is painful, it doesn't bend, the range of motion is restricted, and if she moves forward her toes grab the ground as she has to swing her hip because she feels the length of her legs are now different. Petitioner she was able to wean off Opioids, substituting instead medical marijuana, for which she pays $300.00 to $400.00 a month out of her own pocket.

Respondent has offered no medical evidence to refute Dr. Coe's opinions, nor has it offered any evidence of a stable labor market available to Petitioner. The only evidence in the record is Petitioner's unrebutted testimony that she was sent some leads for sedentary State jobs by State Retirement System, and never received a call back.

Under *Ceco v. Industrial Commission*, 95 Ill. 2d 273 (1983), where a doctor testifies that a Petitioner is permanently and totally disabled, even if a general practitioner (which Dr. Coe is not), and even with conflicting opinions, the burden shifts to Respondent to show that some kind of suitable work is regularly and continuously available to the Claimant. In this case Petitioner testified that she had a high school diploma, two years of general studies at junior college, served in the Coast Guard for two years doing work as a deckhand and grounds keeper, with an honorable discharge, and has no computer skills other than e-mail.

The Arbitrator notes that various disability slips have been filled out by various doctors for Petitioner, most recently her current general practitioner, being Petitioner's Exhibit 5. In the most recent statement, of January 21, 2019, in box 7, asking whether Petitioner is temporary and totally disabled or is disabled from any occupation, the doctor marked "disabled" and that she is suitable for sedentary work only. Petitioner's entire career following the Coast Guard was in corrections as a Corrections Officer at Stateville. She has neither education, training, nor experience which would lead to sedentary work. Based on Petitioner's age, training, education, experience, and the medical evidence outlined herein, her total disability is obvious. With Dr. Coe's opinion of permanent and total disability and the lack of any evidence of a stable labor market for her, pursuant to *Ceco*, Petitioner is permanently and totally disabled, and the Arbitrator so finds, as of the October 27, 2016, MMI 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 LASALLE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT TERANDO,

Petitioner,

vs. NO: 18 WC 7318

ILLINOIS CEMENT CO.,

20IWCC0543

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, causal connection, 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 modifies the Arbitrator's award of 17.5% loss of use of the right arm and 15% loss of use of the left arm. The Commission affirms the award of 12% loss of use of the right hand and 10% loss of use of the left hand. The Commission adopts the Arbitrator's analysis of Section 8.1(b) but disagrees with the weight assigned in subsection (v) relative to the arm injuries. The Commission finds that the evidence supports a reduction in the permanency award.

The Commission assigns lesser weight to subsection (v) relative to the bilateral elbow injuries. Petitioner underwent bilateral cubital tunnel releases. During Petitioner's last examination with Dr. Mitchell on September 11, 2018, Petitioner denied any pain, rating it as a 0 out of 10. Examination of both elbows revealed full range of motion, normal alignment, and no tenderness. His strength in both biceps and triceps was 5/5 and his bilateral forearm pronation and supination strength was 5/5 as well. Petitioner was placed at maximum medical improvement and returned to work without restrictions. The Commission finds that an award of 10% loss of use of each arm is proper and more in line with the evidence in the record. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed December 4, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $998.88 per week for a period of 15-2/7 weeks, from May 28, 2018 to September 11, 2018, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $600.62 to Illinois Valley Community Hospital and $847.99 to Orland Park Orthopedics. Respondent shall reimburse Petitioner $556.00, for out of pocket expenses paid.

IT IS FURHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $41,009.80 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 24.6 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 12% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 20.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the left hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

20IWCC0543

DATED: SEP 2 1 2020

DDM/tdm
O: 9/15/20
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TERANDO, ROBERT
Employee/Petitioner

Case# **18WC007318**

ILLINOIS CEMENT CO
Employer/Respondent

20IWCC0543

On 12/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.56% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT GANASSIN KRZAK
LAURA C HALL
2101 MARQUETTE RD
PERU, IL 61354

1872 SPIEGEL & CAHILL PC
MILES CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
) SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Terando
Employee/Petitioner
v.
Illinois Cement Co.
Employer/Respondent

Case # **18 WC 7318**

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 **Seal**, Arbitrator of the Commission, in the city of **Kankakee**, on **September 16, 2019**. After reviewing all the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 1, 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 $**77,912.64**; the average weekly wage was $**1,498.32.**

On the date of accident, Petitioner was **38** 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 $**3995.52** for TTD, $**0** for TPD, $**0** for maintenance, and $**5,000.00** for other benefits (PPD Advance), for a total credit of $**8995.52**.

Respondent is entitled to a credit of $**41,009.80** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $600.62 to Illinois Valley Community Hospital and $847.99 to Orland Park Orthopedics. Respondent shall reimburse the Petitioner $556.00, for out of pocket expenses paid.

Respondent shall be given a credit of $41,009.80 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any provides of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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 17.5% loss of use of the right arm, 12% loss of the use of the right hand, 15% loss of the use of the left arm, and 10% loss of the use of the left hand, representing 124.325 weeks, as provided in Section (8)(e) of the Act.

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

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

Signature of Arbitrator

December 3, 2019
Date

ICArbDec p. 2

DEC 4 - 2019

FINDINGS OF FACT

18WC7318

On May 1, 2017, Robert Terando, the petitioner, was employed by Respondent, Illinois Cement Co. The petitioner remains employed with Respondent.

The petitioner has been employed by Respondent for over a decade. His duties, as explained by Petitioner, include sweeping, shoveling, using pneumatic tools regularly. Mr. Terando testified that he uses his hands and arms constantly throughout the day while employed by Respondent. Photographs of some of the tools used by Petitioner on a daily basis were admitted into evidence. Px. 8. Mr. Terando testified that his typical workday as a process attendant involved two hours of making rounds and checking equipment, correcting problems with equipment, sweeping, shoveling and jackhammers.

Robert Terando indicates that on May 1, 2017, he was performing his required duties when he experienced numbness, tingling and lack of strength in both of his hands and arms. He testified he was unable to straighten his hands, and that his right hand was worse than the left. Petitioner testified that he reported these issues to Pam Jackson. Petitioner testified that for several years prior to May 1, 2017, he had noticed problems with his hands, but that he continued to work, in order to provide for his family. In the months leading up to May 1, 2017, Petitioner testified the symptoms in his hands worsened to the point where he began to drop items.

Prior to reporting his problems to Ms. Jackson, the Petitioner sought the care of his family physician, Dr. Joel Leifheit. Px. 2. Petitioner complained of muscle weakness and that

he couldn't extend his fingers/hands for several years, and his symptoms were getting worse. Px. 2. Dr. Leifheit recommended an EMG/NCV and referred Mr. Terando to Dr. Robert Mitchell, an orthopedic surgeon with Illinois Valley Orthopedics. Px.2.

Mr. Terando followed up with Dr. Szymke on May 11, 2017, for an EMG/NCV. Px. 6. Records from this visit note the Petitioner complained of symptoms which were worsening over the past two months. Id. These records also note the Petitioner's job duties included using a broom, shovel, wrenches and jackhammer. Id. Mr. Terando further explained he could not straighten out his fingers on both hands and experienced pain up his forearms. Id. Dr. Szymke diagnosed the Petitioner with severe right carpal tunnel and severe right cubital tunnel syndrome, moderately severe left carpal tunnel syndrome and moderate to severe left cubital tunnel syndrome. Id.

The Petitioner next sought care with Dr. Robert Mitchell on June 1, 2017. Px. 3. At this initial visit, Mr. Terando's chief complaint was bilateral wrist pain. Id. Dr. Mitchell wrote "the patient uses a jackhammer and tower gun that is 8000 PSI that he has to run from 20 mins to 6 hours straight daily for 7 years. He works 8 hour shifts 7 days a week at Illinois Cement for 8 years". Id. Mr. Terando explained his pain as pins and needles, with difficulty gripping objects. Id.

An examination by Dr. Mitchell of the right wrist and elbow revealed weakened thumb pronation, positive elbow flexion, a positive Tinel's sign and a Phalen's sign. Id. Testing by Dr. Mitchell of the left hand and arm provided the same symptomology, but less severe than the right sided findings. Id.

Following examination and obtaining a history from Mr. Terando, Dr. Mitchell diagnosed the Petitioner with bilateral carpal and cubital tunnel syndromes, reporting "I feel that both carpal tunnel syndrome and cubital tunnel syndrome are work related". Id. Dr. Mitchell recommended a right carpal tunnel release, right cubital tunnel release and medial epicondylectomy. Id.

Mr. Terando continued to work through the duration of 2017. He testified he was unable to proceed with treatment as he continually waited for Respondent to approve treatment. As the Petitioner worked, his symptoms continued to worsen, which the numbness, tingling and lack of strength moving further up his forearms to both elbows. Eventually, Respondent informed Mr. Terando any treatment for his bilateral carpal and cubital tunnel syndromes was denied by their worker's compensation insurance carrier.

Finally, in May 2018, the pain and discomfort became too much for the Petitioner to bear, and he returned to Dr. Mitchell. Px. 3. On May 22, 2018, Dr. Mitchell notes Mr. Terando's bilateral elbow pain worsening, as well as the Petitioner's job entailing a "lot of jackhammering and sledgehammer work as well as a lot of pulling and wrenching. These job activities are performed occasionally to continuous at times." Id. After examining the Petitioner, Dr. Mitchell recommended a bilateral carpal tunnel release and a bilateral cubital tunnel release, with one following the next. Id. He took the Petitioner off work from May 22, 2018 until June 3, 2018. Id. On June 4, 2018, Dr. Mitchell released Mr. Terando to work with restrictions of no lifting, pushing, pulling more than 5 pounds with the upper extremities and no overhead work. Id.

The Petitioner testified he attempted to return to work on June 4, 2018, but Respondent was unable to accommodate his restrictions or any light duty work. As such, Mr. Terando remained off work until he was released for full duty work on September 12, 2018.

Mr. Terando next sought a second opinion with Dr. Blair Rhode on June 6, 2018. Px. 5. Dr. Rhode notes the Petitioner is required to operate heavy machinery including a jackhammer, and also operates a pneumatic pressure gun at work, and had been doing so for over 9 years. Id. Dr. Rhode agreed with Dr. Mitchell's recommendation for surgery. Id.

On June 25, 2018, Dr. Mitchell performed a right carpal tunnel release and a right cubital tunnel release with medial epicondylectomy. Px. 4. Dr. Mitchell next performed a left carpal tunnel release and a left cubital tunnel release with medial epicondylectomy on July 16, 2018. Id. Thereafter, Mr. Terando continued to receive care from Dr. Mitchell, and was prescribed off of work until August 21, 2018, when he was released to work light duty. Id. During this period, Dr. Mitchell ordered the Petitioner to complete physical therapy. Id.

The Petitioner attended physical therapy at City Center Rehabilitation from July 31, 2018 through September 5, 2018. Px.7. On September 11, 2018, Dr. Mitchell saw Mr. Terando and released him to full duty work, placing the Petitioner at MMI. Px. 3.

At the September 16, 2019 hearing in this matter, the Petitioner testified he has resumed working full duty for Respondent. He explained he continues to experience some weakness, noting his strength is now only 90% of what it was prior to sustaining his work-related injury.

Through the date of the hearing, Mr. Terando incurred gross medical bills in the amount of $55,715.77, (Joel Leifheit, MD: $140.00; Illinois Valley Orthopedics: $16,794.00; Illinois Valley Community Hospital: $31,942.78; Central Illinois Radiological Associates: $54.00; Orland Park Orthopedics: $847.99; Unity Point Health/Dr. Szymke: $1,553.00; City Center Physical Therapy: $4,484.00) Px. 1. Discounts on bills of $12,323.36 were taken by the providers. Id. Petitioner's group insurance paid $41,009.80 towards the gross medical bills (Dr.

Joel Leifheit: $90.94; Illinois Valley Orthopedics: $7,643.79; Illinois Valley Community Hospital: $30,673.16; Central Illinois Radiological Associates: $24.30; Unity Point Health/Dr. Szymke: $751.21.00; and City Center Physical Therapy: $1,826.40). The Petitioner also paid $556.00 out of pocket (Dr. Joel Leifheit: $25.00; Illinois Valley Orthopedics: $481.00; and Unity Point Health/Dr. Szymke: $50.00). Id. Of this amount, bills in the amount of $1448.61 remain unpaid (Illinois Valley Community Hospital: $600.62; Orland Park Orthopedics: $847.99). Id.

CONCLUSIONS OF LAW

C. Did an accident occur on May 1, 2017 out of and in the course of Petitioner's employment by Respondent? F. Is Petitioner's current condition of ill-being causally connected to this injury?

On this issue, the Arbitrator adopts the foregoing Findings of Fact and refers to them by reference. A review of these facts determines that by May 1, 2017, Petitioner had worked for over nine years for Respondent, Illinois Cement Co. During the course of his employment, Petitioner engaged in the repetitive motions of sweeping and shoveling, and the use of vibratory tools, such as a jackhammer and 8000 PSI pressure washer. The medical providers who treated Petitioner for his injuries following the occurrence, all noted the repetitive nature of his job duties and use of vibratory equipment. Px 2-7. At. Dr. Leifheit's office, Petitioner complained of pain to his bilateral hands and wrists which had been present for several years. Px. 2. Dr. Mitchell specifically opined that the bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome are related to Mr. Terando's employment. Px. 3.

Dr. Mitchell, Petitioner's treating orthopedic surgeon, explained that Petitioner has been employed by Respondent for over seven years and over the months preceding the date of his work accident, had engaged in the use of vibratory tools as part of his work responsibilities. Px. 3. After an EMG/NCV, performed by Dr. Szymke, bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome was confirmed. Px.6. His bilateral carpal tunnel and bilateral cubital tunnel eventually was treated by two separate surgical events. Px. 3-4.

Following consideration of the testimony and records in evidence, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment.

Following consideration of the testimony and records in evidence, the Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment.

Further, following consideration of the testimony and evidence submitted and there being no contradictory evidence or testimony, the Arbitrator finds that Petitioner's current condition of ill-being, the loss of strength in his bilateral upper extremities, is causally connected to his work-related injury of May 1, 2017.

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

The Arbitrator incorporates by reference the above Findings of Fact and refers to them by reference herein. The medical records presented demonstrate that Mr. Terando sustained serious injuries and ongoing complaints that are a result of his work duties and the injury sustained on May 1, 2017. Petitioner has submitted treatment records supporting the severity of his injuries and the reasonableness and necessity of the medical care and services provided. Px. 2-7. Following consideration of testimony and evidence presented, this Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary.

On the issue of whether Respondent paid all appropriate charges for all reasonable and necessary medical services, it is found that Respondent has not paid all the medical bills for all reasonable and necessary services. Px. 1. Gross bills of $55,715.77 were incurred and $41,387.80 was paid by Respondent on these bills. Discounts per the fee schedule of $12,323.36 were taken. Id. Petitioner has paid $566.00 out-of-pocket. Bills in the amount of $1448.61

remain unpaid (Illinois Valley Community Hospital: $600.62; Orland Park Orthopedics: $847.99).

Respondent shall pay the Petitioner's out of pocket expense, hold him harmless or repay his group insurance for payments made on bills as indicated in Px.1, Petitioner's medical bill exhibit, and pay Petitioner's outstanding, related medical bills pursuant to the fee schedule.

L. What temporary benefits are in dispute? (TTD)

The Arbitrator incorporates by reference the above Findings of Fact and refers to them by reference. It is stipulated that the Petitioner's average weekly was $1498.32. Respondent claims that it paid $3995.52 in TTD. Mr. Terando should have been paid TTD for 15 2/7 weeks TTD while off work for his work injury. Following consideration of the same and considering credits due Respondent, Respondent is to pay Petitioner $15,268.59 in TTD, with a credit of $3995.52 for TTD previously paid and a credit of $5,000 for an advance previously made.

A total credit of $8,995.52 and net TTD due Petitioner is $6,273.07.

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

On this issue, the Arbitrator adopts the foregoing Findings of Fact and refers to them by reference. Prior to May 1, 2017, the Petitioner was functioning at full capacity, but for the increasing pain and numbness in his hands and wrists as a result of the repetitive motions he engaged in as part of his work duties. The injuries sustained by Mr. Terando are a result of the work injury that occurred on May 1, 2017. Px. 2-7.

Section 8.1(b) of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extend of permanent partial disability for accidents

occurring on or after September 1, 2011. 820 ILCS 305-8.1(b). Specifically, Section 8.1(b) states:

"In determining the level of permanent partial disability, the Commission shall base its determination on the following factors"

(i) The reported level of impairment pursuant to subsection (a);

(ii) The occupation of the injured employee;

(iii) The age of the employee at the time of 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."

Pursuant to Section 8.1(b) of the Act, the Arbitrator notes that there has been no AMA evaluation pursuant to 8.1(b)(a) and, therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of Section 8.1(b)(b), the occupation of the employee, the Arbitrator notes that the records reveal the Petitioner was employed as a process attendant at the time of the accident and is able to return to work in this capacity. As such, the Arbitrator gives less weight to this factor.

In regard to subsection (iii), Petitioner was 38 years of age at the time of his injury and testified he has lost approximately 10% of his upper extremity strength as a result of his work-related injury. As such, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv), the Petitioner's future earning capacity, the Arbitrator notes the Petitioner's future earning capacity has not been affected, and, therefore, gives no weight to this factor.

Finally, in regard to subsection (v), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner sustained an injury that is causally connected to his activities at work, and according to his treating physicians, has received reasonable and necessary treatment. Medical records indicate Mr. Terando underwent bilateral carpal tunnel surgery, and bilateral cubital tunnel surgery, with medial epicondylectomy. Px. 3-4. After completing physical therapy, the Petitioner was returned to work full duty, approximately two months after his second surgery. Over two years after the date of the accident, the Petitioner testified he only has approximately 90% of the strength back in his hands and arms. For the above reasons, the Arbitrator gives greater weight to this factor.

Following consideration of the testimony and evidence presented at trial, this Arbitrator finds that Mr. Terando sustained a 17.5% loss of the use of the right arm, 12% loss of the use of the right hand, 15% loss of the use of the left arm and 10% loss of the use of the left hand, pursuant to Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES ROUCHOS,

Petitioner,

vs. NO: 13 WC 21583

20 I W C C 0 5 4 4

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

Permanent Disability

Section 8.1b(b) of the Illinois Workers' Compensation Act provides the following:

(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. *820 ILCS 305/8.1b*

The Commission affirms and adopts the Arbitrator's analysis and consideration of all five factors pursuant to §8.1b(b) in determining the award of permanent partial disability in this case. The Commission modifies the Arbitrator's decision solely with respect to apportioning weight to the Arbitrator's §8.1b(b)(v) analysis. After the Arbitrator's analysis of §8.1b(b)(v), regarding the evidence of disability corroborated by the treating medical records, the Commission inserts one additional sentence following the last line in subsection (v), the third paragraph on page 13, as follows: "As such, this factor is given significant weight in the permanency determination."

Therefore, the end of the §8.1b(b)(v) analysis will read as follows: "...The Arbitrator also notes that evidence in the record reflects evidence of other comorbidities, including cardiac and low back problems, which may impact his work abilities. As such, this factor is given significant weight in the permanency determination."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed on January 23, 2018, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Petitioner sustained accidental injuries arising out of and in the course of his employment on April 5, 2013. The Commission further finds that the Petitioner's left shoulder condition, which resulted in surgery, as well as Petitioner's cervical strain injuries, are causally related to the April 5, 2013, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $910.21 per week for a period of 154 weeks, commencing May 8, 2013, through April 19, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $24,445.64 for temporary total disability benefits that have been paid. Respondent shall also be given a credit of $60,728.83 for non-occupational disability benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injury sustained to the left shoulder caused the loss of use of 10% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injury sustained to the cervical spine caused the loss of use of 2.5% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 1 in the record of evidence, so long as the expenses contained therein are causally related to treatment of the left shoulder and/or cervical spine, as provided in §8(a) and §8.2 of the Act. This would also include any expenses

20IWCC0544

related to pre-operative treatment prior to the December 31, 2015, left shoulder surgery.

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

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

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

Based upon the named Respondent herein, no bond is set by the Commission. *820 ILCS 305/19(f)(2)* (West 2012). The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020
KAD/bsd
O072820
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROUCHOS, JAMES
Employee/Petitioner

Case# **13WC021583**

CITY OF CHICAGO
Employer/Respondent

20IWCC0544

On 6/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

2986 PAUL A COGHLAN & ASSOC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

0010 CITY OF CHICAGO-TORTS DIV
KEVIN REID
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20IWCC0544

STATE OF ILLINOIS	)	☐ Injured Workers' Benefit Fund (§4(d))
	)SS.	☐ Rate Adjustment Fund (§8(g))
COUNTY OF **COOK**	)	☐ Second Injury Fund (§8(e)18)
		☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES ROUCHOS
Employee/Petitioner

Case # **13** WC **21583**

v.

Consolidated cases: ______

CITY OF CHICAGO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **February 23, 2018 and March 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 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 $**70,996.12**; the average weekly wage was $**1,365.31**.

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

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

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

Respondent shall be given a credit of $**24,445.64** for TTD, $**0** for TPD, $**0** for maintenance, and $**60,728.83** for nonoccupational indemnity disability benefits.

Respondent is entitled to a credit for any awarded medical expenses paid by Respondent pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on April 5, 2013. The Arbitrator further finds that the Petitioner's left shoulder condition, which resulted in surgery, as well as Petitioner's cervical strain injuries, are causally related to the April 5, 2013 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$910.21 per week** for **154 weeks**, commencing **May 8, 2013 through April 19, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$24,445.64** for temporary total disability benefits that have been paid. Respondent shall also be given a credit of **$60,728.83** for non-occupational disability benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's Exhibit 1 in the record of evidence, so long as the expenses contained therein are causally related to treatment of the left shoulder and/or cervical spine, as provided in Sections 8(a) and 8.2 of the Act. This would also include any expenses related to pre-operative treatment prior to the 12/31/15 left shoulder surgery.

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

With regard to the left shoulder, the Respondent shall pay Petitioner permanent partial disability benefits of **$712.55 per week**, the maximum allowable statutory rate, for **50 weeks**, because the injuries sustained caused the loss of use of **10% of the person as a whole**, as provided in Section 8(d)2 of the Act.

With regard to the cervical spine, the Respondent shall pay Petitioner permanent partial disability benefits of **$712.55 per week**, the maximum allowable statutory rate, for **12.5 weeks**, because the injuries sustained caused the loss of use of **2.5% of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 19, 2016** through **March 20, 2018**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator JUN 1 - 2018

May 30, 2018
Date

STATEMENT OF FACTS

The Petitioner testified he has worked for the Respondent for 20 years as a food service establishment inspector. This requires him to travel around Chicago inspecting businesses, generally within one zip code area with some exceptions. He testified that he spends his workdays traveling from business to business for inspections other than his lunch period, and "swipes" in and out of work at various locations in the assigned zip code. Petitioner also holds associates degrees in the hospitality and restaurant industries. He is right hand dominant.

Petitioner testified that he was involved in a motor vehicle accident on Friday, 4/5/13 at approximately 4:30 p.m. while driving his personal 2003 Honda Accord. He had been heading east on Chicago Avenue, from near Central Avenue on his way to the fire station he swipes out at near Cicero. His shift generally ended at 4:30. He testified that traffic was moving slow at approximately 10 miles per hour before he came to a stop, and that he was rear-ended while he was stopped at the light. He was wearing his seatbelt. The airbag did not deploy. The Respondent agreed on the record that the Petitioner was in the course of his employment when the accident occurred. Petitioner testified he did not report the accident to the Respondent that day because no one was present to report it to.

The Petitioner testified that the driver who hit him was acting very erratically. There were police in the area who were present for other reasons. While he and the other driver were supposed to go to a nearby police station on Madison, the other driver failed to show up. Petitioner was able to drive his own car. The police report (Rx6) from the accident reflects that it was a hit and run with Petitioner being struck in the rear, though the other driver's contact information was noted. It states that the cars were both traveling eastbound on Chicago Avenue, the Petitioner was coming to a stop, and the other vehicle struck the Petitioner in the rear. There was damage noted to the rear of Petitioner's vehicle. Both drivers had been instructed to go to the 5th police district station, but the other driver never arrived. (Rx6).

The Petitioner indicated he didn't initially know he was injured and was trying to get his composure, but did feel stiff while at the police station. He testified he felt pain in the left shoulder and the left neck areas when he awoke on the morning of 4/6/13, "localized in the shoulder." He rested and took painkillers. After initially indicating he went to the doctor the day after the accident on Saturday, he agreed with the medical records which indicated he initially sought treatment on Sunday, 4/7/13 at the St. Joseph's emergency room.

Petitioner testified he did not report the incident on 4/5/13 because it was late in the day and no one was available. He indicated that because it was right before the weekend, he wanted to see if he would get better. When he didn't, he reported it to the Respondent's chief sanitarian, Ms. Castaneda, on the following Tuesday or Wednesday in person at the office. She provided him with a packet of documentation, including an accident report, which he completed. He testified he also provided Castaneda with the vehicle accident police report at that time, and that she provided and signed off on an accidental injury report completed by Petitioner, who also signed it.

A City of Chicago Report of Occupational Injury report indicates the Petitioner reported the accident to his supervisor, Arleen Lopez, on 4/6/13, stating he was on his way to swipe out when he was rear-ended and felt rear upper back and left shoulder pain. This was signed by the Petitioner as well as Chief Sanitarian Virginia Castaneda on 4/18/13. (Px9).

At the ER on 4/7/13, Petitioner related a consistent history of the car accident two days prior. He indicated he had no initial pain but later developed bilateral "strap muscle" and trapezius pain and spasm. There was no weakness or tingling. Dr. Rothschild noted neck pain and stiffness, as well as muscular tenderness. Cervical x-ray reflected spondylitic changes with a suggestion of bilateral C4/5 foraminal stenosis, possibly at C5/6, with no traumatic changes seen. Petitioner was diagnosed with a cervical sprain status post a motor vehicle accident, prescribed valium and advised to follow-up with his primary care physician. (Px2).

A 4/5/13 note of Dr. Lavell, a podiatrist, noted that Petitioner was a diabetic with thickened and discolored nails. It does appear that this may have been a letter issued, and not a medical visit that occurred, on 4/5/13, the alleged accident date. (Rx5).

Petitioner testified he continued to have left shoulder pain. He saw his primary care physician, Dr. Ahluwalia, on 4/10/13, noting he had only been seeing this provider for a year or so prior to the accident. He could not recall the name of his prior primary provider, but agreed his primary care treatment had involved blood pressure and blood thinners, diabetes and coronary issues. Petitioner testified that Dr. Ahluwalia referred him for therapy, which took place at Presence St. Joseph's, and for a brain MRI, though he testified that his brain "wasn't the problem."

On 4/11/13, Petitioner presented to Dr. Ahluwalia for his Prothrombin Time-INR study, relative to cardiac issues. He also reported having been in a car accident, not going to work and wanting a note to stay home for a few more days. He was noted to have limited range of motion of the arms bilaterally on exam, but no diagnosis was made relative to Petitioner's cervical spine or left shoulder. He was advised to follow up in a week to see how he was doing. He was

held off work for three days. (Rx5). On 4/18/13, Petitioner again appeared for PT-INR levels, and complained of neck pain and headache since the 4/8/13 accident. Petitioner requested an MRI, and Dr. Ahluwalia referred him for a brain MRI. At that time Dr. Ahluwalia wrote a note for Petitioner, stating that he was still in immense pain with restricted motion of the neck joint in all directions, that he had been having headaches since the accident, and that he had been advised to rest at home until further notice. (Rx5).

The 4/29/13 brain MRI reflected no acute cranial abnormality. (Px3).

On 4/30/13, Petitioner presented to Saint Joseph Hospital for physical therapy, with the report indicating it was pursuant to the referral of Dr. Ahluwalia. Petitioner noted he was rear-ended while slowing down to stop, and further reported that neck and shoulder pain that were now constant and worsening in severity. Petitioner reported tingling on the top of both of his shoulders when he lays down at night. Petitioner rated his pain an 8 out of 10, and reported no prior neck or shoulder pain. Upon examination, the therapist noted Petitioner was unable to move his neck enough to assess flexibility, and had increased swelling. He "jumped" with light palpation of any part of his left upper trapezius, cervical manipulation and left-sided scapular manipulation. Therapy was to be performed twice weekly for 3 to 4 weeks. (Px3).

Petitioner testified that his prior attorney then referred him to Dr. Kaplan, whom he saw on 5/8/13. Petitioner reported being rear-ended by an SUV while wearing a seat belt, resulting in injury to the neck and left trapezius with local pain, swelling and stiffness. Exam indicated swelling and tenderness, left greater than right, in the posterior cervical area and left trapezius muscles with reduced range of motion. With respect to the left shoulder, Dr. Kaplan noted mild tenderness with reduced range of motion. He diagnosed sprain/strains of the left shoulder, cervical spine and thoracic paraspinals with left trapezius contusion. Petitioner was prescribed Tramadol and referred to physical therapy, as well as to physical medicine for further evaluation. He also was held off work. (Px3).

Petitioner followed up with Dr. Kaplan on 5/22/13 with continued complaints of pain at the neck and left scapula and trapezius and only minimal improvement. Therapy and off work were continued for the left shoulder and cervical and thoracic spine. On 6/8/13, Dr. Kaplan noted Petitioner had some limited improvement. Petitioner was prescribed Tramadol and Flexeril and was continued off work. (Px3).

On 6/1/13, Petitioner saw Dr. Ahluwalia with complaints of low back pain, indicating there are days when he cannot get up at all, and that he had been unable to control his back pain since an auto accident 18 years ago. He'd undergone therapy at that time for 5 years without much improvement. (Rx5).

On 6/25/13, Petitioner continued to report neck and left trapezius pain, swelling, and stiffness radiating to the left scapular. He also noted a "tremor" in the left arm with shoulder extension. Petitioner indicated only slight improvement. Therapy was again continued by Dr. Kaplan along with off work, and Celebrex was an added medication. On 7/17/13, Petitioner again reported slight improvement to Dr. Kaplan. The doctor noted some improvement with range of motion, as well as less muscle spasms, but that Petitioner continued to have some pain. He was advised to continue with therapy, medication and off work status. On 8/16/13, Petitioner again followed-up with Dr. Kaplan, reporting continued pain and stiffness, along with somewhat improved pain radiating to the left scapular area. Petitioner reported also experiencing such radiating pain to the right scapula area during physical therapy. Petitioner noted unchanged muscle spasms and mild left arm tremor with shoulder extension. Dr. Kaplan noted that cervical kyphosis continued, along with minimal clonic contractions in the left biceps muscle with left shoulder extension. There was mild tenderness in the bilateral thoracic paraspinal areas. Petitioner was given a trigger point injection, and medication, therapy and off work status were continued. (Px3).

On 9/10/13, Petitioner followed-up with Dr. Kaplan with continued local pain and stiffness. Pain radiating to the left scapular area was somewhat, still occasional radiating to the right during therapy, and he had mild tremor in the left arm. Petitioner declined an additional trigger point injection. Dr. Kaplan wanted him to work on reducing kyphosis, in addition to the current therapy, and that they should work on freeing up Petitioner's frozen shoulder. He remained off work, and disability forms were completed for the Petitioner. On 9/24/13, given the Petitioner's prolonged poor response to conservative treatment, Dr. Kaplan noted the Petitioner's therapist recommended MRI testing of the cervical spine and left shoulder to see if something was being missed. (Px3).

Petitioner testified that at this time his arm wasn't moving properly and his shoulder was being addressed. He testified the trigger point injections on 8/3/13 provided only temporary relief.

The Respondent obtained a 9/24/13 utilization review with regard to ongoing physical therapy, and family practitioner Dr. Jones determined, via ODG guidelines for the shoulder, that an additional 24 sessions of therapy were not certified. It was noted that a peer-to-peer review was conducted with Dr. Kaplan on 9/23/13 which did not change Jones' denial of certification. (Px3).

A 10/30/13 MRI of the cervical spine showed degenerative disc disease from C3 to C6, most pronounced at C4/5, with a disc bulge and bilateral osteophytes causing severe neuroforaminal narrowing. The left shoulder MRI performed that same day indicated a possible small partial thickness distal supraspinatus tear at the insertion, mild AC joint osteoarthritis and minimal subacromial/subdeltoid bursitis. (Px4).

On 11/6/13, Petitioner was seen for a Section 12 examination with spine surgeon Dr. Singh at the request of Respondent. Petitioner reported 8 out of 10 neck pain radiating into the left upper arm, bilateral arm spasms that were a direct result of the accident, and that he'd had only moderate relief with therapy. He reported being able to sit, stand or walk for no more than 5 minutes at a time. Dr. Singh reviewed the 10/23/13 cervical MRI, noting it showed mild C4/5 disc space collapse with mild foraminal stenosis, but did not review the left shoulder MRI. He diagnosed the Petitioner with a cervical strain and degenerative disk disease at C4/5. During physical examination, Dr. Singh noted that the Petitioner was intentionally creating a tremor, noting it was not present with distraction and that there was no anatomic basis for it. Dr. Singh also opined that the Petitioner's pain complaints were out of proportion to the examination findings. He opined that the Petitioner's current symptoms were not related to the accident, as the Petitioner had only sustained a soft tissue neck strain. He felt that the MRI findings were incidental in nature. As the Petitioner had undergone over 40 sessions of physical therapy, and his pain complaints were non-anatomic, Dr. Singh opined that Petitioner had reached maximum medical improvement and was able to return to work with no restrictions. (Rx4).

Petitioner testified that Dr. Singh did not examine his shoulder. The Petitioner testified that Dr. Singh examined his neck for 5 to 10 minutes but did not examine his shoulder as his own doctor had.

On 11/9/13, Dr. Kapan issued a note continuing the Petitioner off work. On 11/19/13, Petitioner reported only slight improvement since his last visit, and that his Celebrex was discontinued by "other M.D." due to risks of bleeding, but he was still using Flexeril. Dr. Kaplan reviewed the MRI results and continued physical therapy, but noted surgery for the partial rotator cuff tear could not be ruled out in the future. (Px3).

Petitioner again followed up with Dr. Kaplan on 12/10/13 and 1/11/14, with Petitioner's condition essentially unchanged, and medication, therapy and off work status were continued. He did note that shoulder surgery was becoming less likely given Petitioner's rate of improvement. On 1/24/14, Dr. Kaplan continued the Petitioner off work,

noting he would likely be able to return to work in May 2014. On 2/15/14, Dr. Kaplan noted Petitioner had ongoing complaints, but the neck kyphosis was now near normal. It was noted that since the last visit the Petitioner had undergone coronary stent placement. Medication, therapy and off work were continued. (Px2).

On 3/22/14, Petitioner reported his neck was much better, while the left trapezius/scapular pain was a little better. Dr. Kaplan noted improved cervical range of motion overall, but no significant improvement in cervical extension. Dr. Kaplan advised Petitioner to continue cervical and left shoulder therapy and medication, and continued off work status. On 5/17/14, Dr. Kaplan indicated minimal change. Petitioner advised that he had a heart ablation procedure since his last visit. The last noted visit with Dr. Kaplan was on 7/22/14. Petitioner advised that his therapy was ongoing including ultrasound and electrical stimulation modalities in addition to regular therapy, and that he'd had some improvement. He continued to report left trapezius muscle/shoulder pain and stiffness with pain radiating to the left scapular area. Petitioner's left shoulder range of motion was noted to be slightly improved, although muscle spasms continued. Dr. Kaplan's examination was essentially unchanged since the prior visit, and Dr. Kaplan continued the same treatment plan, continuing the Petitioner's off work status. The record contains an additional 11/6/14 off work note, indicating this status from 5/8/14 to present, but there was no progress note in the record for this date. (Px3).

Petitioner testified that rotator cuff tear surgery was recommended by Dr. Kaplan in November 2013, but he didn't have surgery initially because he had to find a shoulder surgeon who was within his health insurance group. Petitioner testified that he did not originally receive temporary total disability (TTD) benefits in this case for three to four months after the accident. Following his examination with Dr. Singh, the Respondent would not authorize further treatment. Following this exam, Petitioner testified the Respondent benefits. He went onto FMLA leave and had to obtain his own health insurance. He obtained insurance through his employer, which required him to get a new primary provider to obtain a referral to a shoulder specialist. As this process took time, he didn't return for treatment until 8/21/15. During this interim period, Petitioner indicated his shoulder function remained abnormal and he had difficulty with rotation, which he testified is the same problem he'd had with it since the car accident. He testified he had no shoulder problems bilaterally, neck problems or pain down his arm prior to the accident.

The Petitioner testified that he found a new primary provider at this point, Dr. Siddiqui, who referred him to Dr. Fisher, a cervical specialist, at Illinois Bone & Joint Institute, who then referred him to Dr. Garelick for the shoulder.

On 4/6/15, Petitioner underwent bilateral shoulder MRIs at the request of Dr. Siddiqui. On the right, films reflected a suspected full thickness supraspinatus tear. The AC joint was moderately arthritic, and there was a type 3 acromion, both causing impingement. The MRI of the left shoulder was noted to be limited due to excessive motion, so a repeat left MRI was suggested with sedation. (Px5). At the request of Dr. Siddiqui, Petitioner also underwent EMG testing of the left upper extremity which showed no evidence of radiculopathy, peripheral neuropathy, brachial plexopathy or polyneuropathy. (Px6).

On 2/5/15, Dr. Siddiqui held the Petitioner off work through 5/5/15. On 4/9/15, he continued the Petitioner off work again through 6/9/15. On 4/27/15, Dr. Siddiqui issued a work note holding Petitioner off work through 8/5/15. (Px7). The records (Px6) indicate the Petitioner was a no show to his initially scheduled visit with Dr. Fisher on 5/13/15. After rescheduling to 6/22/15, Petitioner again failed to show up for the visit, as well as on 7/16/15. The 8/21/15 initial report of spine surgeon Dr. Fisher noted chief complaint of cervicalgia and left shoulder pain following a car accident two years prior. The symptoms were mild to moderate, worse with activity. He denied radicular symptoms, and noted the shoulder injection he had received provided no relief. Dr. Fisher noted Petitioner had neck tenderness throughout the cervical paraspinals, as well as in the left shoulder, lateral subacromial space, and glenohumeral joint anteriorly. There was limited range of motion. With respect to the bilateral upper extremities, Dr. Fisher noted a positive Neer's and

Hawkins on the left, and that Petitioner had difficulty actively forward flexing or abducting past 70 degrees. Dr. Fisher reviewed the previous MRI and x-ray results. He obtained new x-rays, with the cervical films revealing disc space narrowing at C4/5 and C5/6 with loss of normal cervical lordosis. Left shoulder films showed a slightly high-riding humerus, and no evidence of fracture or tumor. Petitioner was diagnosed with cervical degenerative disc disease and left shoulder internal derangement, most likely supraspinatus rotator cuff tear. Dr. Fisher recommended a repeat cervical MRI and follow-up with a shoulder surgeon. (Px6).

On 9/12/15, cervical MRI was also noted to be poor due to patient movement, but was remarkable for mild multilevel mid-cervical spondylosis, worst at C4/5 with mild central and bilateral neuroforaminal stenosis. C5/6 spondylosis resulted in mild central and right neuroforaminal stenosis. (Px5).

On 11/4/15, Petitioner followed-up with Dr. Fisher with ongoing complaints of left shoulder pain and neck pain. Dr. Fisher noted the cervical MRI, while having slight motion artifact, indicated no significant central canal stenosis, but disk space narrowing at C4 to C6 with disk herniations. Given Petitioner's main complaint was the left shoulder, Dr. Fisher again recommended an updated left shoulder MRI and follow-up with a shoulder specialist. (Px6).

The repeat left shoulder MRI was performed on 11/24/15, indicating a 3 mm partial thickness supraspinatus tear, no full thickness tear, and tendinosis at the subscapularis insertion site. (Px5).

Petitioner initially saw shoulder surgeon Dr. Garelick on 12/1/15. He reported bilateral shoulder pain, with the left much worse than the right. Following examination and review of the left shoulder MRI, Dr. Garelick recommended shoulder arthroscopy and acromioplasty, distal clavicle resection, biceps tenodesis and, if needed, rotator cuff repair. He first requested pre-surgical clearance from Petitioner's primary care physician and possibly a cardiologist. (Px6).

Dr. Garelick performed arthroscopic left shoulder surgery on 12/31/15, involving arthroscopic loose body removal measuring approximately 1 cm in size, subacromial decompression and distal clavicle resection, as well as open biceps tenodesis through a separate incision. The post-operative diagnosis was impingement syndrome, AC arthropathy and biceps tendinitis with loose body. (Px2).

Petitioner followed up with Dr. Garelick on 1/13/16 and he was doing well. X-rays of the left shoulder revealed excellent decompression of the AC joint. Therapy was prescribed, which Petitioner began on 1/21/16. On 2/10/16, Dr. Garelick advised the Petitioner to work harder on his home exercise regimen. He stated that Petitioner had not worked since 2013 and that his prospects for returning to work were "slim", but that he "would not be necessary [sic] participating in keeping him off work forever." Dr. Garelick noted that typically patients go back to work with restrictions by this time, but that Petitioner would be provided with a few extra weeks of therapy before being released with restrictions in five weeks. (Px6).

On 3/16/16, Dr. Garelick noted that Petitioner was passively guarding on exam "a fair amount", with only about 90 degrees of forward elevation and 30 degrees of external rotation. Dr. Garelick released Petitioner to return to work with no lifting over 10 pounds and no overhead work with the left upper extremity. Petitioner was advised to follow-up in 5 weeks. Dr. Garelick noted: "I was met with a fair amount of resistance when I allowed him to return to work. I tried to explain to him that in all of my patients that have injuries and subsequent surgeries like he has, we will usually allow them to return to work at six weeks post-op and we have given him a few extra weeks to heal. Even with this said, I was met with a fair amount of resistance. I further explained to him I think that return to work full duty after this type of operation be somewhere between four to four and a half months post-operative. Ultimately, I think that he may necessitate an FCE (functional capacity evaluation) to assess for his true abilities." (Px6).

The Petitioner's attorney referred him for an independent examination with Dr. Gross in January 2017, with Petitioner indicating Gross examined him for "a couple hours" versus the 10 minutes he testified that Dr. Singh spent with him. On 1/26/17, Petitioner obtained an evaluation with Dr. Michael Gross. The history provided to Dr. Gross was consistent with what Petitioner testified to at trial, namely that he felt stiffness initially after the accident which he thought would go away, but that his neck and shoulder became increasingly painful so he presented to the ER. Petitioner reported neck stiffness and left trapezius pain and stiffness, clicking in his neck when he turns his head since the accident, and left arm pain with use. Petitioner also reported tingling in all of his left fingers when holding a telephone or lifting something heavy, or at night, especially when lying on it. Dr. Gross' diagnoses included residuals of a cervical spine injury and left shoulder supraspinatus tendon tear and left biceps tendon tendonitis. He related the left shoulder surgery and treatment to the cervical spine as being causally related to the accident of 4/5/13. Dr. Gross also opined that Petitioner demonstrated impairment pursuant to the AMA guidelines as it related to the shoulder injury of 4% of the whole person (or 7% of the upper extremity), and 8% of the whole person as it related to the cervical spinal stenosis, resulting in a total of 12% whole person impairment. (Px8).

Petitioner testified he had to sleep sitting up for a while following surgery, and that he underwent physical therapy. He testified that neither his group nor workers' compensation insurers would authorize FCE testing. Petitioner has had no further shoulder treatment since this release, and returned to work on 8/1/16. He testified that the surgery improved his condition, though he still has pain and is not as active as he used to be, including going to the gym and gardening. If he tries to do too much with the shoulder, it pulls and hurts. He now has to carry his work bag with his right hand, and its more difficult if he has to sometimes use a ladder to get.

On cross examination, Petitioner testified that the Respondent utilizes an occupational health clinic, MercyWorks, but that no one sent him there for evaluation after this injury. When the city stopped paying his duty disability/TTD benefits, he agreed he obtained weekly lost time benefits through Prudential, though he couldn't confirm if they began on 11/12/13 or not. After his release from Dr. Garelick he was reinstated back to full duty in approximately August 2016, and he continues to perform his regular job as an inspector. He does not have to move appliances or other items at the inspected facilities in his job. Petitioner agreed that he was provided and instructed in a home exercise program while in physical therapy, and while he tried it, he felt he wasn't sure he was doing it right, but he does do "some stretching."

The Respondent submitted evidence of its payments of lost time benefits (Rx1) and medical benefits (Rx2) related to this case.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner has proven, by the preponderance of the evidence, that he sustained accidental injuries arising out of and in the course of his employment on 4/5/13.

The Petitioner testified that his job involved traveling from place to place by car to perform inspections of food establishments in Chicago, generally within his assigned zip code area. It is clear to the Arbitrator that the evidence in the record supports that the Petitioner was a traveling employee. He testified that when he was involved in an auto accident

on 4/5/13, he was on his way to swipe out. Therefore, he remained in the course of his employment at the time. At hearing, the Respondent stipulated that the Petitioner had been in the course of his employment at the time of the accident. The Petitioner's testimony and the contemporaneous records in evidence support that he was still working and had not yet swiped out when the accident occurred.

With regard to the "in the course of" element of the accident claim, the Arbitrator finds that the Petitioner has proven the accidental injuries occurred in the course of his employment, both based on an auto accident being a clearly foreseeable incident for a traveling employee who has to drive from place to place in his job, but also as an increased risk over and above that to which the general public is exposed to given the amount of driving the Petitioner has to do each day for work. The Petitioner testified that he is essentially in a vehicle or at a place of inspection throughout his daily shift.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

At the second hearing date (3/20/18) in this bifurcated matter, the Respondent withdraw this as a disputed issue. Given the evidence presented in the Respondent's accident report (Px9), the Petitioner clearly provided timely notice of the accident within the proscribed 45-day period of Section 6(c) of the Act.

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 Petitioner testified that he was initially feeling stiff at the police station after the accident, and that when he awoke the next day he had pain in his left shoulder and neck. He was initially diagnosed at the ER on 4/7/13 with a cervical strain, but he also complained of trapezius pain and spasm. The accident report of 4/18/13 reflects complaints of neck and left shoulder pain, and notes that the accident and injury was reported on 4/6/13 to Ms. Lopez. The Respondent did not present any conflicting testimony in this regard. When the Petitioner presented for therapy at St. Joseph's on 4/30/13, it was noted that he had neck and shoulder pain since the accident.

While there are some discrepancies in that the shoulder was not focused on at the ER or the initial visit with Dr. Ahluwalia on 4/11/13, there is enough contemporaneous evidence supporting neck and left shoulder complaints to lead the Arbitrator to conclude that the preponderance of the evidence supports a causal relationship of the Petitioner's initial neck and left shoulder complaints to the 4/5/13 accident.

With regard to the left shoulder, the Arbitrator finds that the Petitioner's treatment, including surgery, through the release of Dr. Garelick remained causally related to the accident. With regard to the cervical spine, the Arbitrator finds that while the condition was causally related to the accident, the causal relationship involves a cervical strain. The Arbitrator finds the 11/6/13 opinion of Dr. Singh to be persuasive in terms of the cervical spine. The Arbitrator finds that the causal relationship of the cervical spine ended as of that date, given the noted findings and opinions of Dr. Singh and the fact that Petitioner had already treated seven months for a cervical strain.

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

Based on the Arbitrator's above findings, the Arbitrator further finds that the Petitioner is entitled to the causally related medical expenses contained in Petitioner's Exhibit 1 pursuant to Sections 8(a) and 8.2 of the Act. This award is limited to treatment that was directed to and causally related to the cervical spine and left shoulder. This award is also limited as noted below. The Respondent is entitled to credit for any and all awarded medical expenses that were paid by Respondent prior to hearing, either directly via workers' compensation or via a group health plan pursuant to Section 8(j). The Petitioner has stipulated that the Respondent is entitled to credit for group payments per Section 8(j), so long as the Respondent holds the Petitioner safe and harmless with regard to any such credited expenses.

Notwithstanding the above, the Arbitrator denies all physical therapy expenses incurred subsequent to the 9/24/13 utilization review obtained by Respondent. This determination of the Arbitrator is applicable to therapy for both the cervical spine and the left shoulder. While the UR opinion was based only on the left shoulder, the fact of the matter is that therapy over five months at that time had resulted in virtually no improvement in the Petitioner's subjective complaints, per the records of Dr. Kaplan. Buttressed by the UR report, as well as the Section 12 report of Dr. Singh on 11/16/13 finding the cervical spine injury was nothing more than a strain, the continuation of therapy despite any real improvement over such a significant period of time is unreasonable on its face. The Arbitrator therefore finds that the Respondent is not liable for physical therapy expenses subsequent to 9/24/13, and is not entitled to expenses related to treatment of the cervical spine after 11/16/13, including but not limited to the treatment performed and diagnostic testing obtained by Dr. Fisher relative to the cervical spine.

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:

Based upon the above findings and other evidence, the Arbitrator finds that Petitioner was temporarily totally disabled from 5/8/13, when Dr. Kaplan initially took him off work, through 4/19/16. While the Petitioner claims TTD benefits through 7/31/16, the day before he returned to work, there is no indication that he was either held off work for this period of time or that the Respondent did not accommodate his restrictions prior to 8/1/15. On 3/16/16, Dr. Garelick indicated that the Petitioner was resistant to returning to work, and that he advised the Petitioner he would hold him off work for an additional 5 weeks, at which time he was to follow up. There is no evidence in the record indicating that the Petitioner did, in fact, follow up at that time. There are no treatment records in evidence which post-date 3/16/16.

While the Respondent's Section 12 examiner, Dr. Singh, on 11/6/13, determined that the Petitioner sustained nothing more than a cervical strain and was capable of going back to work, he did not address the Petitioner's left shoulder condition. Thus, while the Arbitrator agrees with Dr. Singh's determination at that time with regard to the cervical spine, off work status after that date remained reasonable based on the left shoulder condition. While there is a gap in treatment following the last visit with Dr. Kaplan in November 2014, the Petitioner credibly testified that, based on Respondent's denial of further treatment, he had to work to obtain treatment after that time through his group health plan. While this was going on, and while there are no shows indicated with regard to seeing Dr. Fisher initially, the Arbitrator relies on the off work notes of Dr. Siddiqui during that time period.

The Arbitrator finds that the Petitioner is entitled to TTD through the intended follow up visit with Dr. Garelick five weeks after 3/16/16, which was 4/19/16. No valid explanation was provided as to why the Petitioner did not return to work following Dr. Garelick's 3/16/16 release until 8/1/16. Respondent shall receive a credit for compensation paid in the amount of $24,445.64 as well as an 8(j) credit in the amount of $60,728.83 for disability received, however, shall hold the Petitioner safe and harmless in reference thereto pursuant to the applicable provisions of Section 8(j) of the Act.

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 the record contains an impairment rating of 4% of the whole person as to the left shoulder, and 8% of the whole person as to the cervical spine, as determined by Dr. Gross pursuant to the most current edition of the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment. The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. In the present case, the Arbitrator finds that this factor provides some weight in the permanency determination, and notes that the findings of Dr. Gross with regard to the cervical spine appear to involve nerve/cord compression and/or radiculopathy, which does not appear to have been shown via the objective evidence in this case.

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 sanitation food service inspector at the time of the accident and had returned to work in his prior capacity for over two years as of the date of hearing. While he was issued restrictions, and testified that the Respondent would not authorize and FCE, the Arbitrator notes it does not appear that any restrictions he has prevents him from performing his regular job, and that Dr. Garelick's notes are very confusing as to work status, as he initially questioned Petitioner's ability to return to work at all before then issuing fairly significant restrictions, but then goes on to state that the Petitioner was performing significant guarding and normally should have been returned back to full duty work within 5 months or so of the surgery. Overall, on balance, this factor plays a minimal role in the permanency determination given the Petitioner has returned to his regular job for a significant period of time with no indication of an inability to perform same.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Neither party has submitted evidence in support of the impact of the Petitioner's age on his permanent condition as a result of his work accident. 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 no evidence was presented which indicates that the Petitioner's future earnings in his current job with Respondent have been impacted in any way. However, he does have some level of work restrictions that could impact his future earnings if he were to lose his job with Respondent. As such, the Arbitrator gives this factor medium 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 the evidence supports that the Petitioner suffered a cervical strain superimposed on what appears to be a degenerative cervical condition. He also sustained an injury to the left shoulder which ultimately resulted in a need for surgery with Dr. Garelick. As to the cervical spine, there does not appear to have been any significant ongoing sequelae from the accident, and the Petitioner really did not testify to any significant ongoing cervical problems. Petitioner did report ongoing problems with the left shoulder, and Dr. Garelick did issue work restrictions limiting left arm use to 10 pounds of lifting and no overhead use. However, the doctor also noted Petitioner's "resistance" to returning to work, as well as somewhat cryptic language that seems to indicate he would have expected Petitioner to have no work restrictions based on the type of surgery he had. Dr. Gross did make some specific findings of Petitioner lacking a level of range of motion. Petitioner is right hand dominant. The Arbitrator also notes that evidence in the record reflects evidence of other comorbidities, including cardiac and low back problems, which may impact his work abilities.

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 2.5% loss of use of the person as a whole applicable to the cervical injury, and 10% loss of use of the person as a whole applicable to the left shoulder, pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF McHENRY	)		

[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 ALDRIDGE,

Petitioner,

vs. NO: 17 WC 15789

UNISTAFF, INC.,

20 IWCC0545

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 2019 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,430.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020
o--091720
MP/dak
068

Marc Parker

Barbara N. Flores

Deborah L. Simpson

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

ALDRIDGE, JAMES
Employee/Petitioner

Case# **17WC015789**

UNISTAFF
Employer/Respondent

20IWCC0545

On 4/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & EVANS
LEANDRO ALHAMBRA
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2999 LITCHFIELD CAVO
MICHAEL LATZ
303 W MADISON ST SUITE 300
CHICAGO, IL 60606

20 I W C C 0 5 4 5

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

- [ ] 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)

James Aldridge
Employee/Petitioner

Case # **17** WC **15789**

v.

Consolidated cases: ______

Unistaff
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 **03/07/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] 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, **12/29/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**8,572.60**; the average weekly wage was $**428.63**.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $285.75/week for 113-1/7 weeks, commencing 01/05/2017 through 03/07/2019, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical expenses incurred in the care and treatment of his causally related injury as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the medical treatments ordered by Petitioner's treating physician, Dr. Domb, on 7/12/18, pursuant to Sections 8 and 8.2 of the Act.

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

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

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

Carolyn M. Doherty
Signature of Arbitrator

4/8/19
Date

APR 10 2019

FINDINGS OF FACT

At trial, the 46 year old Petitioner testified that he began working for Respondent Unistaff in August 2016. Petitioner testified that at the time he applied for work with Unistaff in August 2016 he was under a 20 pound lifting restriction from a prior workers' compensation claim brought against a different Respondent for an injury to his right ulnar nerve. Petitioner testified that he advised Unistaff of his right arm restrictions. Petitioner further testified that he has had approximately 3 prior workers' compensation claims but none involving his left hip.

Through Respondent Unistaff in August 2016, Petitioner began working at the NuWave warehouse in quality control. Petitioner testified that the job at NuWave was within his work restrictions stemming from the prior right elbow injury. His duties at NuWave included receiving and stocking LED lighting. Petitioner testified that he worked first shift from 7 am to 3:30 pm. Petitioner testified that when he started work on 12/29/16 he "was feeling fine."

Petitioner testified that on 12/29/16 he was at NuWave and operating a standup forklift. Petitioner testified that he was not assigned a specific forklift but just took a lift that was available. He testified that there were 2 standup forklifts to choose from. He testified that the forklift he operated was leaking gas and emitting fumes that effected his operation of the lift. Petitioner testified that while turning the forklift he slipped off the back of the forklift and was pinned between the forklift and a rack. Petitioner testified that the left rear of the forklift was touching his left groin area while he was pinned to the wall. Petitioner testified that he immediately felt burning pain in his left groin and hip area. Within half an hour the pain worsened. Petitioner testified that he reported the accident to Pedro, his supervisor in the LED department. Petitioner testified that he was told to continue working but on a sitting forklift. Petitioner testified that he could not continue working due to pain so Pedro advised Petitioner to go home. Petitioner testified that he left NuWave around 1:00 pm on 12/29/16. On cross-exam, Petitioner denied working on 12/30/16 or any date thereafter.

Petitioner testified that he was in pain so he called Unistaff when he arrived home and advised that he was injured. Petitioner further stated that he later went to the Unistaff offices in person on 12/29/16 to advise of the accident. He testified that he reported the accident to "the ladies" in the office but he was not asked to complete any paperwork at Unistaff. He testified that nothing was done by Unistaff regarding his accident during this visit. Petitioner was not sent for medical care on this date. Petitioner testified that he returned to the Unistaff offices on 1/5/17 after the holidays and again reported the accident and his injury. Petitioner testified that he was then sent for medical care at Concentra by Unistaff.

On cross-exam, Petitioner again testified that he reported the accident to Unistaff on 12/29/16 and denies that he reported it on January 5, 2017 for the first time. The Arbitrator notes that notice is not in dispute. ARB EX 1. RX 2 is a document entitled "Employee Statement." Petitioner testified that he in fact completed and signed the written statement on 1/5/17. Petitioner testified that he could not recall whether he completed and signed the statement at Unistaff offices or at Concentra. However, he testified that he had to complete the statement prior to seeing a doctor so he believes he likely filled out the form while at Concentra. The statement indicates an accident occurred on 12/29/16 at 1:00 pm. The accident occurred in the LED department and was unwitnessed. Petitioner indicated injury to this leg and groin. The form asks what work conditions contributed to the injury and Petitioner wrote, "Fork lift was leaking battery acid the smell." The form also asks for a detailed description of how the accident happened and Petitioner indicated "Driving forklift started gaging [sic] on fumes made me loose [sic] control and ran into a rack got pinned between rack and forklift." RX 2.

Petitioner was sent to Concentra on 1/5/17 by Respondent. He did not return to work for Respondent, has not received benefits at any time and has not returned to work for any other employer since 1/5/17.

Pedro Enriquez testified for Respondent. He continues to work for NuWave as the assistant warehouse manager. In 2016, he was Petitioner's supervisor in the LED department. He testified that the does recall Petitioner working in his area at the end of December 2016. Further, he testified that on the last day Petitioner did work in the LED area in December 2016 Petitioner asked if he could leave early due to a family matter. Mr. Enriquez testified that he told Petitioner to ask permission to leave from the warehouse manager. He testified that he did not see Petitioner at work after that date.

Mr. Enriquez testified that standup forklifts are also known as reach forklifts. He does not recall that Petitioner ever reported an accident while working on a forklift at NuWave and that no one ever reported to him that a standup lift was leaking battery acid. Mr. Enriquez testified that if someone was to fall off a forklift the lift would completely stop due to the safety break which kicks in if the foot on the lift pedal is taken off the pedal. He testified that Petitioner never advised him of an accident so he never filled out an accident report for Petitioner as was required per the accident policy.

On cross-exam, Mr. Enriquez agreed that on the same day that Petitioner asked to leave early, he recalls sending Petitioner to work in a different department to help and that Petitioner was assigned to work on a "sit down" forklift.

Mr. Eddie Dettling testified on behalf of Respondent Unistaff. He testified that he has worked in Respondent's Mundelein office for 3.5 years. Mr. Dettling testified that NuWave is his customer and that he became aware of Petitioner's claim around January 4 or 5 2017. He testified that Petitioner came into the Mundelein office and filled out an accident report on either January 4 or 5. He testified that he looked at the employee time cards and Petitioner's time cards for NuWave indicate that his last day worked was on 12/20/16 when he worked 6 hours and then left early.

Mr. Dettling testified that Unistaff policy requires work injuries to be reported immediately and directly by the client NuWave directly to Unistaff. In less severe cases injured parties are asked to come to the Unistaff office and fill out an accident report. The employee is then asked if they want to go to a doctor for medical care. He testified that Petitioner reported his injury directly to Unistaff "officially" on 1/5/16. Mr. Dettling was not aware of any earlier visit made by Petitioner to the Unistaff offices to report an injury.

On cross-exam, Mr. Dettling testified that he was not personally in the office on 12/29/16 but that two female office managers were present in the office that day- namely Yolanda and Grace. He again testified that he was not aware that Petitioner stopped by the office on 12/29/16 or spoke with these women. He further testified that he does know that Grace or Yolanda did help Petitioner fill out the report on the date it was completed. Mr. Dettling never met with Petitioner directly or personally about this accident and he believes the reporting was handled directly and solely between Petitioner and Grace.

Mr. Dettling testified that he went to the NuWave warehouse to investigate the incident, warehouse and forklift. He testified that Pedro Enriquez took him around and that Pedro was not aware of any accident involving Petitioner until Mr. Dettling advised him of the claim made. Mr. Dettling testified that he did not personally speak with or interview Petitioner on 1/5/17 in the Unistaff office even though he was present that day in the office. He further testified that he did not review Petitioner's statement prior to visiting NuWave warehouse.

He stated that he knew where to look around after receiving information from Grace about the accident in the LED area. Lastly, Mr. Dettling reviewed the statement at RX 2 and could not definitely identify the report as a Unistaff report.

The Concentra records of 1/5/17 indicate a date if injury as 12/29/16. Petitioner complained of a left hip injury with symptoms in the left groin and left thigh. The pain radiated to the inner left thigh, lower left leg and foot with numbness on the inner left thigh. Petitioner reported the symptoms as constant and sharp at 8/10 level. Petitioner reported that he was driving a forklift and while trying to prevent himself from falling possibly twisted the left hip and the forklift back/hit into his left groin. On a separate Concentra form titled "Employer Services – Injury Care Patient Information" Petitioner wrote that the accident occurred on 12/29/16 at 1:00 pm in the LED department. He wrote, "while driving forklift I became nausious [sic] from a leaking battery which made me gag and loose [sic] control of forklift at which time I was tossed form forklift and it backed into my leg/groin." PX 1. Petitioner signed that form on 1/5/17 at Concentra.

X-ray of left hip was normal. Petitioner was diagnosed with a left groin contusion and left hip sprain. He was prescribed Naproxen and recommended a course of PT. Work restrictions included no climbing, squatting, kneeling, occasional lifting, pushing and pulling up to 20 pounds and frequent change positions with 90% seated work. Respondent did not accommodate the restrictions. PX 1. Petitioner followed up on 1/10/17. His symptoms were not resolving. A CT scan of pelvis was ordered. PX 1.

After attending PT without symptom relief, Petitioner was referred to Dr. Alden at Hinsdale Orthopaedics. Petitioner was previously seen by Dr. Nacke at Hinsdale for his prior right elbow injury. Of note in the records is a visit date to Dr. Nacke on 1/5/17, the same date as Petitioner's visit to Unistaff office and to Concentra for his hip complaints. Dr. Nacke's record of 1/5/17 addresses only Petitioner's right elbow and no mention is made of pain or injury to Petitioner's left hip.

Petitioner was first seen by Dr. Alden at Hinsdale on 2/9/17. Dr. Alden noted left hip pain for approximately 6 weeks following a work accident of 12/29/16. Petitioner reported being hit directly in the groin with the end of a forklift that pinned him against a wall. An MR arthrogram with CT guidance was ordered and performed on 3/10/17. Findings included fluid and contrast material within the left femoral acetabular joint space suggesting an underlying labral tear. On 3/30/17, Dr. Alden recommended surgery to repair the tear and referred Petitioner to his colleague Dr. Domb.

Petitioner then treated for the remainder of 2017 for his prior unrelated right elbow injury per the records of Hinsdale Ortho and Dr. Nacke. PX 2.

On 10/3/17 Petitioner attended a Section 12 exam with Dr. Sterba at Northwestern per Respondent's request. RX 4. Petitioner testified that he attended the exam which he estimated lasted 10 minutes. Dr. Domb reviewed the MRI and noted a subtle labral tear and no degenerative changes. He noted that Petitioner had "an exaggerated stiff leg gait going from the chair to the exam table but was able to walk out of the exam with an improvement in that, though still with a stiff legged gait." Dr. Sterba noted that he believed Petitioner had left hip pain of exaggerated degree and that the pain behavior prevented an adequate evaluation and determination of appropriate medical treatment. He agreed that the MRI showed a small labral tear but "does not provide an explanation for the degree of symptoms that he is currently experiencing and I think that is out of proportion to what would be expected for a labral tear of this type." He did agree that the hip injury is causally related to the reported work injury and mechanism of injury based on the medical records. However, in his opinion, given Petitioner's demonstrated exaggeration, he does not agree with the surgical recommendation to repair the tear.

He suggested a more thorough work up from a neurologic standpoint "as his MRI does not suggest injury which would give the degree of pain which would prevent me from having any type of adequate physical exam." He does not believe Petitioner's reported pain is consistent with the pathology detected on the MRI and indicated that his subjective complaints do not correlate with the objective findings. He concluded, "In my experience, the small labral tear noted on MRI, should not be causing the degree of pain that he is currently experience on constant basis. Labral pathology in the population over the age of 45 is more common, and not necessary always surgically repaired. If neurologic injury was sustained in the hip region, I would expect there to be distal findings of that which he does not currently have."

On 2/21/18 Petitioner followed up with Dr. Alden. He complained that his groin pain was significant and worse with activity. ROM was diminished and he had pain with internal and external rotation of the left hip. Dr. Alden still recommended surgery. Petitioner was referred back to Dr. Domb and saw him for the first time on 3/15/18. Dr. Domb prescribed hip surgery to repair the labral tear and again recommended the surgery at the last visit of 7/12/18. Dr. Domb noted symptoms of locking and catching with worsening hip pain. He believed the hip injury was related to the accident in December 2016 given the temporal onset of symptoms and mechanism of injury. PX 2. Petitioner was continued off work pending his surgery.

Petitioner testified that he still wants the surgery recommended by Dr. Domb. He testified that he continues to have hip pain with difficulty walking and sitting. He testified that he can only stay in one position for about 5 to 10 minutes before the hip pain flairs.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

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

The Arbitrator notes that notice is not in dispute. The Arbitrator notes that the existence of a left hip labral tear is not in dispute. Rather, Respondent disputes that the alleged accident at NuWave ever happened. Based on the Petitioner's testimony as corroborated by the accident reports and the medical records of all treating physicians, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of employment on 12/29/16. In so finding, the Arbitrator notes that although the testimony of Respondent's witnesses referenced above gave initial pause, the Arbitrator places greater weight on Petitioner's testimony as it is better corroborated by the medical evidence and the accident reports referenced above. In addition, noted minor discrepancies between Petitioner's trial testimony regarding the accident mechanism and the accident descriptions in the record are not lost on the Arbitrator. However, the Arbitrator notes that these discrepancies are not so persuasive to prevent a finding of accident based on the record in its entirety.

The Arbitrator finds that Petitioner sustained accidental injury to his left hip while driving a standup forklift at work on 12/29/16. Petitioner testified to smelling gas fumes while operating the forklift and that he lost control of the lift falling and getting pinned against a rack by the rear left side of the lift. Petitioner's accident testimony is consistent with the accident history documented on the accident report he completed on 1/5/17. The accident report states the following: "Driving forklift started gaging [sic] on fumes which made loose [sic] control and ran into a rack got pinned between rack and forklift." RX 2. The first medical note from Concentra documents the following, "This is the result of preventing himself from falling from forklift possibly twisted left hip and forklift back/hit into his left groin." PX 1. On a separate Concentra form titled "Employer

Services – Injury Care Patient Information" Petitioner wrote that the accident occurred on 12/29/16 at 1:00 pm in the LED department. He wrote, "while driving forklift I became nausious [sic] from a leaking battery which made me gag and loose [sic] control of forklift at which time I was tossed form forklift and it backed into my leg/groin." PX 1. The accident history documented when Petitioner was first examined by Dr. Alden on 2/9/17 indicates, "It began with a work-related accident on 12/29/16. The patient was hit in the groin with the end of the forklift that pinned him against the wall." The Arbitrator finds these accident descriptions to comport with Petitioner's trial testimony regarding the mechanism of his injury.

Although Mr. Enriquez denied that Petitioner operated a standing forklift, the Arbitrator notes that Mr. Enriquez agreed Petitioner was assigned to operate a sitting forklift in a different department on the last day he worked at NuWave. Further, Mr. Dettling did not review the accident statement or speak with Petitioner prior to his post accident inspection at NuWave which was conducted by Mr. Enriquez who testified that he did not know an accident even occurred. These facts cast doubt on the credibility of Mr. Dettling's testimony. Accordingly, based on the Petitioner's testimony, the accident reports, medical records, the mechanism of injury provided by Petitioner and reflected in the medical records, the temporal nature of the complaints, lack of prior left hip problems and consistent treatment after the accident, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of employment with Respondent on 12/29/16.

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

Incorporating the findings on the issue of accident, the Arbitrator further finds that the condition of ill-being in Petitioner left hip is causally related to the injury. Dr. Alden, Dr. Domb and Respondent's section 12 examiner, Dr. Sterba diagnosed Petitioner with a left labral tear. Although Dr. Domb and Dr. Sterba disagree on whether Petitioner is a surgical candidate, both doctors opine that Petitioner's hip condition is causally related to the forklift accident. Dr. Domb states on the 7/17/18 medical note,

> ***Given the temporal onset of symptoms and mechanism of injury, it is with reasonable medical certainty that the patient's current condition is causally related to the injury described in his March 2018 note.***

(Pet. Ex. 2). Similarly, Dr. Sterba opined:

> *The patient reported after being specifically asked about his history to the hip but there was no prior hip issues and that his hip was normal". This would suggest a causal relationship to his current complaints, as I have nothing further to go off f other than the medical records which indicates a claim made to the left hip and leg shortly after the injury.*

(Resp. Ex. 4).

Based on the chain of events and the opinions of Drs. Domb and Sterba, the Arbitrator finds that Petitioner's left hip condition is causally related to the 12/29/16 work injury.

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?

Dr. Alden, Dr. Domb and Dr. Sterba all have diagnosed Petitioner with a left labral tear. Petitioner treatment consisted of office visits to Concentra and Hinsdale Orthopedics Petitioner also underwent a short course of physical therapy, which provided only minimal relief. The Arbitrator finds that Petitioner's treatment has been reasonable and necessary. Accordingly, the Arbitrator finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related left hip injury pursuant to Sections 8 and 8.2 of the Act.

K. Is Petitioner entitled to prospective medical care?

Both Dr. Domb and Dr. Alden agree that Petitioner is a candidate for surgical repair of the torn left labrum. According to Dr. Domb's medical note of 7/12/18, Petitioner's hip condition continues to get progressively worse with more catching and locking. Respondent's Section 12 examiner, Dr. Sterba, examined Petitioner on 10/3/17. According, Dr. Sterba the MRI arthrogram of the left hip suggested a labral tear. However, Dr. Sterba did not recommend surgical intervention based on his observation of symptom exaggeration.

Based on the findings of accident and causal connection as well as on the opinions of Drs. Domb and Alden, the Arbitrator find that Petitioner is entitled to the surgery recommended by Dr. Domb on 7/12/18. Respondent shall authorize and pay for the medical and surgical treatment recommended by Dr. Domb and its attendant care pursuant to Sections 8 and 8.2 of the Act.

L. What temporary benefits are in dispute?

Having found accident and causal connection, the Arbitrator awards TTD from 1/5/17 through 3/7/19 for a total of 113-1/7 weeks. When Petitioner was first examined at Concentra, he was given restriction no lifting, pushing or pulling more than 20 pounds occasionally, change positions periodically, weight bearing as tolerated, sitting 90% of the time, no squatting, no kneeling, no walking on uneven terrain, no climbing stairs or ladders. Respondent was unable to accommodate these restrictions. These restrictions remained in effect until Petitioner saw Dr. Alden on 2/9/17. At that time Dr. Alden took Petitioner off work completely. Petitioner has yet to be released to work in any capacity. When Petitioner was last seen by Dr. Domb 7/12/18, Dr. Domb continued to keep Petitioner off work.

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 WINNEBAGO	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MONICA MARTINEZ,

Petitioner,

vs.

NO: 09 WC 09385

GENERAL MILLS,

20IWCC0546

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, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2019 is hereby affirmed and adopted.

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

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

20IWCC0546

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

DATED: SEP 21 2020
o--091720
MP/dak
068

Marc Parker

Barbara N. Flores

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, MONICA
Employee/Petitioner

Case# **09WC009385**

GENERAL MILLS INC
Employer/Respondent

20 I :: CC0546

On 3/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2986 PAUL A COGHLAN & ASSOC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

ATE OF ILLINOIS)
)SS.
COUNTY OF **Winnebago**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MONICA MARTINEZ
Employee/Petitioner

v.

GENERAL MILLS, INC.
Employer/Respondent

Case # **09** WC **9385**

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 **Rockford**, on **December 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ 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 **6/4/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**31,365.88**; the average weekly wage was $**603.19**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**.00** for TTD, $**.00** for TPD, $**.00** for maintenance, and $**.00** for other benefits, for a total credit of $**.00**.

Respondent is entitled to a credit of $**54,540.40** under Section 8(j) of the Act.(for disability benefits paid plus credits listed in PX1 for group medical payments).

ORDER

- Compensation denied. See attached findings of fact and conclusions of law.

<u>See attached findings of fact and conclusions of law.</u>

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

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

Arbitrator Michael Glaub

March 6, 2019
Date

MAR 6 - 2019

The Arbitrator hereby makes the following findings of facts:

On June 4, 2008, the Petitioner was 32 years of age and employed by General Mills as a full time QRO tech. (R. 10-12). Petitioner testified she was merely walking while at work on this date in question when she felt a pop in her left calf muscle. Petitioner testified that she went up a flight of stairs shortly before the occurrence (and when she got up she felt her calf muscle "get tight"); and also lifted her foot up to cross a door threshold but did not touch it or trip on it. (R. 14-17).

Petitioner presented to Physician's Immediate Care ("PIC") that same date, June 4, 2008. Petitioner testified that things were fresh in her mind at the time of the subject occurrence and also that she told her doctors and others the truth about what happened. (R. 51-53). The history on the PIC records indicate that Petitioner was walking at work and felt a pop in her calf. There is no mention of going up stairs or over a threshold. (PX1).

Petitioner initially presented to Dr. Carlson on July 30, 2008. Petitioner again related a history of being at work when she felt a pop in her left calf muscle. Petitioner was enrolled in a course of physical therapy at Carlson Orthopedic and became treated frequently at the Carlson Orthopedic Facility receiving therapy approximately every two to three days beginning in September and continuing on a steady basis through December at which point Petitioner's visits began to trail off to approximately one visit per month. (PX2).

Petitioner was seen by Dr. Carlson on 8/20/2008 and his records state "Pt. was walking at work and felt a pop in the back of her right leg above the ankle." (PX2). The reference to the right ankle appears to be a clerical error as the diagnosis was "left calf strain with questionable soleus/gastric tendon tear." (PX2).

Petitioner also provided a detailed history of the subject event to her physical therapist two (2) days later on 8/22/2008 stating "Pt suffered injury just walking at work, no trauma or fall." (PX2).

Petitioner had a left calf MRI performed on August 22, 2008 which was negative with the exception of some swelling. Petitioner was seen in follow-up by Dr. Carlson and to review the MRI results on 9/4/2008. Dr. Carlson's diagnosis after review of the MRI was ***"left gastrocnemius strain."*** (PX2)(emphasis added).

Petitioner's recovery from the left calf injury was slow. She continued to follow up with Dr. Carlson into 2009 and a number of treatment modalities were attempted including physical therapy, injections to the left calf, orthopedic boots and long leg cast.

Petitioner followed up with Dr. Carlson on March 26, 2009 at which time she was noted to have been improved but still walking with a limp. The Petitioner was referred for aquatic therapy. (PX2).

Petitioner followed up with Dr. Carlson on July 13, 2009. She related a history of "recheck left Achilles tendon strain. Pt still cannot do tip toe exercises during PT; and also she having grinding & popping sensations in her right knee for about 3 weeks." (PX2). When seen in follow up by Dr. Carlson on 8/24/2009, Petitioner's complaints had expanded to also include swelling of the right ankle. (PX2). An MRI of the right knee was ordered.

Petitioner followed up with Dr. Carlson on 10/26/2009 to review the MRI results, which he stated revealed Grade 3 chondromalacia of the patella. Surgery was discussed and a knee injection was provided. (PX2).

On March 5, 2010 Dr. Carlson performed surgery to the Petitioner's right knee consisting of an arthroscopic patellofemoral chondroplasty and lateral release of the right knee with autologous cartilage transplantation, lateral and central mid patellar facet, right knee. (PX2). Petitioner continued to follow up with Dr. Carlson following her right knee surgery and he ultimately released her to return to modified work activities on August 10, 2011 noting that she should "changing positions as needed and avoiding climbing or crawling" and to return to sports activities based upon strength and agility. (PX2).

Petitioner's "PT" notes confirmed that her right knee recovery was slow, and her complaints waxed and waned on various dates following surgery. The records also reveal that the Petitioner appears to have injured her right knee on during the August 28, 2010 weekend as was contemporaneously recorded in the PT notes of 8/30/2010: **"Pt. reported twisting knee badly this past weekend resulting in increased pain levels/buckling."** (RX6)(Emphasis added).

Petitioner testified that she did not return to work following Dr. Carlson's release but was taking computer programming classes at Kishwaukee Community Hospital. Petitioner testified that when she finishes the program, she will be capable of earning $40,000 a year to start and that her income with experience could potentially exceed $100,000 a year. (R. 83-85).

Petitioner was examined at the request of the employer by Dr. Lawrence Lieber. Dr. Lieber opined that the Petitioner had a resolved left gastrocsoleus muscle strain with zero permanent impairment or disability. (RX1).

Ms. Ronda Turner, Respondent's HR Manager, testified on behalf of Respondent. Ms. Turner testified that in 2008 she was the Safety Manager and spoke with the claimant within a day or two of the subject incident who stated "she wasn't doing anything she was just walking." (R. 93-95). The Arbitrator notes that Ms. Turner's testimony is consistent with the histories contained in Petitioner's contemporaneous medical records.

The Arbitrator renders the following findings on the issues of (C – Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?):

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that [s]he has suffered a disabling injury which arose out of and in the course of h[er] employment." *Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 671 (2003).* " 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Id.* For an accident to be compensable, the injury "generally must occur within the time and space boundaries of the employment." *Id.* Here, the claimant's Achilles tendon ruptured "in the course of" her employment. To be compensable under the Act, an injury must also "arise out of" the employment. *Id.* "To satisfy [the 'arising out of'] 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.* An injury is said to arises out of one's employment if:

> "at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. *[Citations.]* A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties.' " *Id. at 203-04, 797 N.E.2d at 671 (quoting Caterpillar Tractor Co. V. Industrial Comm'n, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989)).*

The determination of whether an injury arose out of and in the course of one's employment is generally a question of fact." *Hosteny v. Illinois Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 674, 928 N.E.2d 474, 482 (2009).* "In resolving questions of fact, it is within the province of the Commission to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *Id.*

Prior to addressing whether claimant's left calf tendon rupture arose out of her employment, the Arbitrator must first examine the claimed mechanism of her injury. There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment; (2) risks that are personal to the employee; and (3) neutral risks that have no particular employment or personal characteristics, such as those that the general public is commonly exposed. Springfield Urban League v. Illinois Workers' Compensation Comm'n, 2013 IL App (4th) 120219WC, ¶ 27, 990 N.E.2d 284. Injuries resulting from a neutral or personal risk generally do not arise out of employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. Id.; Illinois Institute of Technology Research Institute v. Industrial Comm'n, 314 IL App. 3d 149, 163, n. 1, 731 N.E.2d 795, 807 (2000).

In this case, claimant argues her injury is compensable under the Act as it occurred as a result of a risk directly associated with her employment, or in the alternative, as a result of being exposed to a neutral risk greater than that to which the

general public is exposed. Importantly, claimant's arguments are based on the premise that her injury occurred while she was walking faster than normal, and also raising her foot to cover a threshold stop on a door. The claimant's medical records, as well as the testimony of Ms. Turner, failed to contain a history of anything other than simply walking. The Arbitrator further notes that there is no medical opinion suggesting that the claimant's condition of ill-being was due to walking faster than normal or raising her foot to clear a threshold.

"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 Financial Services v. Industrial Comm'n, 367 Ill. App. 3d 102, 105,853 N.E.2d 799, 804 (2006).* Here, the Arbitrator similarly finds claimant's act of walking did not pose a risk directly associated with her employment. Moreover, the Arbitrator does not find claimant established she would have been exposed to a neutral risk which was increased from either a qualitative or quantitative aspect even if the additional facts she added to the equation at trial were credible since going up one flight of stairs and/or lifting her foot to step over a door threshold are also neutral risks and her testimony of doing these things only once is insufficient to raise them to the level of an increased risk of injury, even assuming arguendo the Arbitrator found her testimony credible which he does not. *See Springfield Urban League, 2013 IL App (4th) 120219WC, ¶ 27, 990 N.E.2d 284 ("Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. [Citation.] Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. [Citation omitted]").*

The Arbitrator finds that the Petitioner sustained a calf muscle strain injury merely by walking, and further finds that the occurrence did not arise as a result of some risk attributable to her employment. The Arbitrator finds that the testimony of Ms. Turner and the contemporaneous medical records establish that the Petitioner was merely walking at the time of the injury; and in any event, the additional facts that the Petitioner claimed at the hearing (which the Arbitrator does not find credible since they contradicted the more contemporaneous medical records) would not change the result since going up one flight of stairs or lifting one's foot over a door threshold is similarly a neutral risk. Moreover, there was no expert testimony that the subject injury related to those alleged events. Such an injury could have happened anywhere, and was associated with either a personal risk, or a neutral risk not associated with her employment to a degree greater than the general public. Therefore, no accident occurred as defined under the Act and all compensation is denied.

The Arbitrator renders the following findings on the issues of (F – Is Petitioner's Condition of Ill-being causally related to the accident):

Based on the Arbitrator's findings regarding the issue of Accident, the Arbitrator finds that none of the petitioner's medical conditions are causally related to her employment.

The Arbitrator renders the following findings on the issues of (J – Notice):

The Arbitrator finds that the Petitioner met her burden in establishing Notice as required under the Act.

The Arbitrator renders the following findings on the issues of (J – Medical Expenses) and (K – TTD/Maintenance):

In light of the Arbitrator's finding to the issue of "C" above, the Arbitrator further finds that all medical treatment and lost time is denied. The Arbitrator also denies all claimed maintenance based upon the same reasoning; as well as the fact that the Petitioner failed to demonstrate proof of entitlement to any maintenance.

The Arbitrator renders the following findings on the issues of (L – Nature and Extent of Injury):

In light of the Arbitrator's finding to the issue of "C" above, the Arbitrator further finds that all PPD is denied. The Arbitrator further notes that Petitioner failed to introduce any evidence as to any alleged permanent disability as it relates to the left calf injury or otherwise rebut the opinions of Dr. Lieber that there was no impairment as it related to the left calf muscle condition.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVE TAVOLACCI,

Petitioner,

vs. NO: 12 WC 039237

VILLAGE OF GLEN ELLYN,

Respondent.

20IWCC0547

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 expenses, and permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, while correcting a clerical error and clarifying the PPD/credit section of the Order, said decision being attached hereto and made a part hereof.

The Commission corrects a scrivener's error on the Notice of Arbitrator's Decision to reflect the proper spelling of Respondent's name to "Village of Glen Ellyn".

The Commission clarifies page 2, paragraph 2, of the Order section, regarding the PPD/credit award. The Commission clarifies that the Arbitrator found Petitioner to have sustained a 30% loss of use of Petitioner's right leg under §8(e) of the Act. Respondent is to receive a credit of 17.5% loss of use of the right leg from the prior settlement in case 06 WC 34038, for a net award in this case of 12.5% loss of use of the right leg (26.875 weeks at $712.55 per week).

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2018 is hereby affirmed and adopted with changes as stated herein.

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

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

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

DATED: SEP 2 1 2020
o-7/28/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Decision of the Arbitrator in part. After carefully considering the totality of the evidence, I believe Petitioner met his burden of proving by a preponderance of the evidence his current condition of ill-being regarding his right knee is causally related to the July 30, 2012, work accident. Additionally, I believe Petitioner met his burden of proving the medical treatment he received through January 17, 2014, relating to his right knee was reasonable, necessary, and related to the July 30, 2012, work injury.

It is undisputed that on the date of accident, Petitioner sustained an injury to his right knee while performing his work duties. Petitioner has a history of pre-accident complaints and treatment relating to his right knee. However, a close review of the credible evidence reveals that Petitioner's right knee symptoms noticeably worsened following this work accident. While an early arthroscopy initially provided some relief, Petitioner continued to experience worsening symptoms in the right knee. Ongoing conservative treatment did not provide significant long-term relief. Petitioner eventually underwent a right total knee replacement surgery on October 21, 2013. Petitioner was discharged from physical therapy on January 17, 2014, and has not sought any additional treatment relating to his right knee. He returned to work with restrictions and eventually retired in November 2014 after undergoing an unrelated left total knee replacement in May 2014.

After weighing the evidence, I believe Dr. Kim, the treating physician, testified more credibly than Dr. Sporer, Respondent's Section 12 examiner. Dr. Kim credibly testified that the work accident was a contributing factor in accelerating Petitioner's need for a right total knee replacement. Dr. Kim believed Petitioner's eventual need for the right total knee replacement was most likely inevitable given the deteriorated condition of Petitioner's knee and his morbid obesity. However, the doctor also explained in detail why he believed the work accident accelerated the

deterioration of Petitioner's right knee condition. I believe the credible evidence supports a finding that the work accident at the very least exacerbated Petitioner's pre-existing condition to the degree that Petitioner had to proceed with a significant surgery that he otherwise could have delayed for several years. As such, I would reverse the Arbitrator's conclusion that the causal connection between Petitioner's condition of ill-being and the work incident ceased as of March 11, 2013. Instead, Petitioner's condition of ill-being regarding his right knee continues to be causally related to the July 30, 2012, work incident. Thus, medical treatment relating to the right knee, including the right total knee replacement, through January 17, 2014, was reasonable, necessary, and related to the work injury.

After weighing the five factors pursuant to Section 8.1b(b) of the Act, I do not believe an award of 30% loss of use of the right leg adequately compensates Petitioner for the full scope of his work-related injury. After all, Petitioner underwent a right total knee replacement surgery that his doctor had otherwise hoped to delay for several years given Petitioner's relatively young age. Following this surgery, Petitioner briefly returned to work but, worked pursuant to restrictions prescribed by his treating physician. Given the totality of the evidence, I believe Petitioner met his burden of proving he sustained a 55% loss of use of the right leg as a result of this work incident.

For the forgoing reasons, I would reverse the Decision of the Arbitrator in part. Petitioner clearly met his burden of proving his current condition of ill-being regarding his right leg is causally related to the July 30, 2012, work accident. Furthermore, Petitioner proved his medical treatment regarding the right leg, including the right total knee replacement surgery, was reasonable, necessary, and related to his work injury. Finally, I would modify the Arbitrator's award and find Petitioner suffered a 55% loss of use of the right leg due to the July 30, 2012, work incident.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAVOLACCI, STEVE
Employee/Petitioner

Case# **12WC039237**

VILLAGE OF GLEN ELLEN
Employer/Respondent

20IWCC0547

On 7/27/2018, 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 2.14% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0863 ANCEL GLINK
DOUGLAS J SULLIVAN
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

20 IWCC0547

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

Steve Tavolacci
Employee/Petitioner
v.
Village of Glen Ellyn
Employer/Respondent

Case # **12** WC **39237**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **June 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 IWCC0547

FINDINGS

On **July 30, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**66,625.17**; the average weekly wage was $**1281.25**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**10,128.16** for TTD, $**0.00** or TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,128.16**.

Respondent has paid $**156,826.56** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $854.17/week for 11 6/7 weeks, commencing July 31, 2012 through October 29, 2012, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,128.16 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 26.875 weeks, because the injuries sustained caused the 30% loss of the Right Leg, after reduction for the credit of 17.5% loss of use of the Right Leg for the prior settlement received, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

July 23, 2018
Date

JUL 27 2018

Statement of Facts

Arb. Ex. 1 notes that there are fee petitions filed by former attorneys in this matter. No former attorney appeared at trial and the Arbitrator makes no findings with respect to fees in this matter.

Petitioner Steve Tavolacci testified that he was employed by Respondent Village of Glen Ellyn since 1995. On July 30, 2012, he was employed as a Maintenance Worker II. He testified that his job duties included taking care of the water and sewer system and hydrants. He was on his feet 98% of his workday. He was required to lift up to 150 pounds. The job description was admitted as PX 7. Petitioner testified his weight at that time was 260 pounds. He now weighs 100 pounds more. On July 30, 2012, Petitioner was sent to the DuPage River to look for manholes. He stepped on something and twisted his right knee.

Petitioner testified that he had prior injuries to his knees. Petitioner testified that he had an arthroscopic surgery to his right knee and was released in 2006. He also had two surgeries on his left knee. Dr. Sporer took a history of this prior right knee surgery in 2005 by Dr. Watt who noted that the patient showed mild chondromalacia of the patella with a central fissure and chondromalacia of the femoral trochlea with about a 1 cm area of loose articular cartilage in the mid-femoral trochlea. Petitioner said he recovered quite well, however, stated he always walked differently after his right knee surgery. Petitioner also reported a 2006 left knee injury with surgery by Dr. Watt and a second surgery in 2008 by Dr. Matlock (RX 1, Dep. Ex. 2). Petitioner testified that he received a settlement of 17.5% loss of the right leg and 25% of the left leg. The Arbitrator takes judicial notice of the Workers' Compensation Commission records in case 06 WC 34038, *Steven Tavolacci v. Village of Glen Ellyn*, which document that Petitioner settled an injury of 4/8/05 on 12/5/08 for 17.5% loss of the right leg and 06 WC 34039, *Steven Tavolacci v. Village of Glen Ellyn*, for an accident on 6/6/06 with a settlement of 25% loss of the left leg on 12/5/08.

After the July 30, 2012 injury, Petitioner sought treatment the same day at Northwestern Occupational Medicine (PX 1). Petitioner provided a history of tripping over something and twisting his knee. He complained of pain, swelling and difficulty bending and with weight bearing in the right knee. He advised of the prior injury and surgery. X-rays noted mild tri-compartmental osteoarthritic changes. Petitioner was diagnosed with a knee sprain. Petitioner was disabled for one day and then released to return to work at sit down work only. On August 7, 2012 Petitioner reported no improvement and a feeling of giving way. The examination noted effusion and crepitus with pain and reduced range of motion. The diagnosis was right knee sprain with internal derangement. An MRI was ordered of the right knee (PX 1).

An MRI performed August 21, 2012 showed a small bone contusion or stress injury along the medial tibial metaphysis, a very large Baker's cyst, findings along the suprapatellar recess which may be due to a lipoma. a likely sprain of the ACL, and an extensive degenerative tear of the medial meniscal tear. Orthopedic consult was recommended. On August 24, 2012, Petitioner reviewed the MRI results and advised he has scheduled the orthopedic consult with Dr. Matlock for August 27, 2012 (PX 1).

Petitioner saw Dr. Matlock on August 27, 2012 (PX 2). He reported his weight was 350 pounds. Dr. Matlock recorded a BMI of 44.93. Petitioner reported a history of walking in the woods when he stepped on something and twisted his knee. He stated that previously he had not had any significant problems in the right knee. The physical examination noted a slight antalgic gait and a little bit of medial joint line tenderness. There was no lateral joint line tenderness. there was no effusion. Petitioner had full extension with some loss of flexion due to tightness. Dr. Matlock's review of the MRI notes a medial meniscus tear with extrusion. Dr. Matlock's

impression was right knee medial compartment osteoarthritis with medial meniscus tear and likely lipoma. He recommended a cortisone injection. He stated he was not certain he could take care of the medial meniscus tear and that Petitioner would likely still have some pain from arthritis. Petitioner said he does not want a temporary fix and would rather proceed with arthroscopy. Dr. Matlock notes the option of a replacement, but Petitioner is a bit young for that. He states that Petitioner really wants to proceed with arthroscopy. Surgery was scheduled (PX 2).

Petitioner underwent surgery to the right knee on October 4, 2012 consisting of a right knee arthroscopy with partial medial and lateral meniscectomies, chondroplasty of the medial and patellofemoral compartments, synovial biopsy, and partial synovectomy of the suprapatellar pouch. The operative report notes a post-operative diagnosis of right knee medial meniscus tear, lateral meniscus tear, osteoarthritis in the medial compartment and the patellofemoral compartment, and likely lipoma arborescens in the suprapatellar pouch (PX 2).

Petitioner had follow up with Dr. Matlock on October 8, 2012. Dr. Matlock noted arthritic changes of diffuse Grade 3 over the medial compartment, Grade 4 on the medial aspect of the plateau, Grade 2 throughout the lateral compartment and some Grade 3 changes over the trochlea (PX 2). Petitioner began physical therapy at Athletic on October 18, 2012 and noted initial improvement (PX 3). On October 28, 2012, Petitioner told Dr. Matlock that the knee is feeling a lot better. He had full extension. There is crepitus, no effusion. Dr. Matlock notes he is doing pretty well with not much pain, just a little stiffness. Petitioner was released to return to work with restrictions (PX 2). Petitioner testified he returned to work on October 30, 2012. He noticed pain in both knees. On November 26, 2012, Dr. Matlock noted no effusion with full extension and limited flexion symmetric with the left side. He advised Petitioner that the meniscal aspect is diminished and he is having some more arthritic symptoms. He recommended a Synvisc injection which was administered on December 17, 2012 (PX 2). Petitioner completed therapy on December 17, 2012. The notes reflect his complaints were greater on his left knee that the right (PX 3).

On January 28, 2013, Petitioner reported some pain in his right knee but also in the left. He said he put in a kitchen floor a week ago and was sore for a day or two. The physical examination noted no effusion in either knee. He had full extension and some tightness of the quad with flexion. There was no real joint line tenderness and no pain with McMurray. He had a relatively normal gait. Petitioner was released to full duty work. Dr. Matlock advised he could repeat the Synvisc in 6 months if things flare up. He also discussed using a topical cream for pain (PX 2). Petitioner testified he returned to his regular job. He testified he handled it with care. On March 11, 2013, Petitioner reported he was not really having any pain anymore. The knee feels much better. Physical examination noted good range of motion, no joint line tenderness, negative McMurray and a pretty normal gait. Dr. Matlock stated Petitioner will continue with full duty work and was released to be seen on an as needed basis (PX 2).

Petitioner returned to Dr. Matlock on April 22, 2013. He had complaints primarily in the left knee. He stated it had really been going on for about 6 weeks with limping. X-rays noted arthrosis of both knees, probably a little more severe on the right, but approaching bone on bone on both sides. He also has patellofemoral arthritis in the left knee with some patellar spurs as well as some trochlear spurs. He has some posterior osteophytes developing as well on both the femur and the posterior tibia. Dr. Matlock discussed options including cortisone and Synvisc and ultimately knee replacement. Petitioner was interested in "getting this taken care of." Dr. Matlock provided a left knee cortisone injection and referred Petitioner to Dr. Kim to discuss knee replacement surgery (PX 2).

Petitioner was seen by Dr. Andrew Kim on May 1, 2013. He notes the diagnosis of severe arthritis in both knees. Petitioner noted the recent cortisone injection to the left knee made him feel very good. He noted he was considering knee replacement. Dr. Kim noted Petitioner was young, in a laboring job and obese. He suggested Petitioner lose weight, and if the cortisone injections continue to work, delay surgery by several years. He administered a cortisone injection to the right knee. On May 31, 2013, Petitioner reported only two weeks relief form the injection and requested total knee replacement. Dr. Kim diagnosed degenerative joint disease. He discussed issues with Petitioner including his age, his line of work and his weight. Petitioner still wished to proceed with total knee replacement. Dr. Kim tried to convince him to use a knee brace, but Petitioner wanted to proceed with surgery and Dr. Kim agreed to seek authorization.

Petitioner was examined by Dr. Scott Sporer at Respondent's request on August 14, 2013. Dr. Sporer diagnosed bilateral degenerative arthritis. He opined that the current right knee complaints were related to degenerative joint disease and not related to the accident on July 30, 2012. He notes that Petitioner's right knee pain was resolved as of Dr. Mattock's March 11, 2013 visit. He found Petitioner at MMI for the July 30, 2013 accident (RX 1, Dep. Ex. 2).

On August 30, 2013., Dr. Kim administered cortisone injections to both knees. He placed Petitioner on work restrictions. On September 6, 2013, Petitioner advised Dr. Kim that he was ready to proceed with a right total knee replacement. Petitioner underwent a right total knee replacement on October 21, 2013. He was seen by Dr. Kim for post-operative care through January 15, 2014 (PX 2). Petitioner was discharged from physical therapy at Athletico on January 17, 2014 (PX 3). On January 15, 2014, Dr. Kim notes Petitioner is doing very well for his right knee, but the left knee is bothering him. The right knee examination found no effusion, good range of motion, good stability and strength. Petitioner declined a left knee cortisone injection. He told Dr. Kim that the time for the left knee replacement is coming up pretty soon (PX 2).

Petitioner had a left knee replacement on May 5, 2014. Petitioner has post-operative care with Dr. Kim. On July 30, 2014, Petitioner noted that he is doing well with his right knee, but has a sensation of things slipping. Dr. Kim's physical examination records the right knee has good motion, strength and stability. Petitioner was to follow up in one year for his right knee (PX 2).

Petitioner testified he returned to work after the right knee replacement on light duty, 4 hours per day. He noticed pain and discomfort in his knees. He would avoid stairs and lifting over 20 to 30 pounds. He then went off work for the left knee replacement. The bills were paid by Blue Cross/Blue Shield. He received SSDI effective September 4, 2013. He testified he last saw Dr. Kim in October 2014. He took early retirement in November 2014. He has not looked for other work. He has moved to Tennessee. Petitioner testified that he is not currently under any treatment for his knees. He takes it easy. He used Tylenol and Aleve.

Dr. Kim testified by evidence deposition taken June 1, 2018 (PX 6). He testified to his treatment of Petitioner beginning May 1, 2013. His impression was right knee medial compartment degenerative joint disease. He testified to the discussions concerning knee replacement and the obstacles to Petitioner including his obesity. his younger age and his physical work. He performed the right knee replacement on October 21, 2013. His last visit with Petitioner for the right knee was January 15, 2014. He testified that, with respect to the right knee, Petitioner would have limitations on squatting, kneeling and high impact activities (PX 6).

Dr. Kim testified that the work accident was a contributing factor in accelerating the need for the right knee replacement. This was based upon the fact that Petitioner was relatively asymptomatic prior to the injury and then after the injury, he had symptoms. he had a meniscus surgery. He continued to have symptoms. So, from a symptomatic standpoint, there was an acceleration of his arthritis. Dr. Kim has no opinion if the left knee arthroplasty was related to the work accident. Dr. Kim testified his last visit with Petitioner was October 2014. Petitioner then moved to Tennessee (PX 6).

Dr. Kim testified that he was not privy to Petitioner's entire prior medical history. He did not have the operative report for the prior 2005 right knee surgery. He did not have the prior operative reports or diagnostic films from 2005 or 2012. He did not have a history of the accident. Petitioner had longstanding osteoarthritis. Radiographically he had advanced osteoarthritis that was pre-existing to the work accident. He testified that the condition of Petitioner's knee could be a ticking time bomb waiting to trigger pain. Petitioner was going to need a knee replacement at some time. the question is when. Maybe the work injury was the last straw (PX 6).

Dr. Sporer testified by evidence deposition taken May 9, 2018 (RX 1). He testified to his examination of Petitioner on August 14, 2013. He noted records he reviewed including surgical notes of Dr. Watt on 6/10/2005 and Dr. Matlock on 10/4/2012, Cadence Health, Dr. Matlock, Dr. Kim, x-rays and MRI studies, and IME reports by Dr. Levin from 03/08/2007. He testified Petitioner told him that after the earlier surgeries he improved significantly, but walked differently. He told him he had mild pain in his knee prior to the injury on July 30, 2012. Dr. Sporer testified he reviewed the operative findings including the arthritic findings. Dr. Sporer testified his diagnosis was bilateral knee degenerative arthritis. He opined that Petitioner's right knee complaints were related to the degenerative joint disease and not at all related to the accident of July 30, 2012. He testified that Petitioner's body mass index of 44% and his prior arthroscopy in 2005 were contributing factors. He opined that the left knee complaints were not related to the accident. Dr. Sporer opined that, with Petitioner's pre-existing factors, normal activities of life could trigger his symptoms.

Conclusions of Law

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

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. 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. The Commission may find a causal relationship based on a medical expert's opinion that the injury "could have" or "might have" been caused by an accident. *Mason & Dixon Lines, Inc. v. Industrial Comm'n*, 99 Ill. 2d 174, 182, 457 N.E.2d 1222, 1226, 75 Ill. Dec. 663 (1983). However, expert medical evidence is not essential to support the Commission's conclusion that a causal relationship exists between a claimant's work duties and his condition of ill-being. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982). A chain of events suggesting a causal connection may suffice to prove causation. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892, 203 Ill. Dec. 327 (1994). It is well established that prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000).

Petitioner has a prior history of knee complaints and treatment. He had prior work accidents to both knees. He had a prior right knee surgery in 2005 and two prior left knee surgeries. The initial x-rays taken immediately after the July 30, 2012 accident showed degenerative arthritic changes. Petitioner had been working his physically demanding job for many years prior to the undisputed accident on July 30, 2012 with no recent medical care for his knees. He advanced immediate complaints in the right knee thereafter and sought medical care. Initial medical examinations noted effusion and crepitus with pain and reduced range of motion. The Arbitrator notes that Petitioner's mechanism of accident did not involve the left knee and he advanced no contemporaneous complaint in the left knee.

Petitioner's August 21, 2012 MRI found an extensive degenerative tear of the medial meniscal tear in additional to the other degenerative findings. On August 27, 2012, Dr. Matlock's impression was right knee medial compartment osteoarthritis with medial meniscus tear and likely lipoma. His review of the MRI notes a medial meniscus tear with extrusion. Petitioner underwent surgery to the right knee on October 4, 2012 consisting of a right knee arthroscopy with partial medial and lateral meniscectomies, chondroplasty of the medial and patellofemoral compartments, synovial biopsy, and partial synovectomy of the suprapatellar pouch. There is no evidence of an ongoing meniscus injury before July 30, 2012. On November 26, 2012, Dr. Matlock advised Petitioner that the meniscal aspect is diminished and he is having some more arthritic symptoms. Petitioner had right knee post-operative care through March 11, 2013. On March 11, 2013, Petitioner reported he was not really having any pain anymore. The knee feels much better. Physical examination noted good range of motion, no joint line tenderness, negative McMurray and a pretty normal gait. Dr. Matlock stated Petitioner will continue with full duty work and was released to be seen on an as needed basis. Based upon the chain of events, the Arbitrator finds that Petitioner's work accident caused or aggravated the meniscus tear and the need for his October 2012 arthroscopic surgery. This condition reached MMI on March 11, 2013 based upon the opinion of Dr. Matlock releasing Petitioner to return to full duty work and releasing him from care. This is supported by the opinion of Dr. Sporer who stated that the current condition is not causally related in part because the Petitioner's right knee pain was effectively resolved on March 11, 2013.

Petitioner thereafter has had further treatment including bilateral total knee replacements performed by Dr. Kim. Petitioner had a significant prior history of injury and surgeries on the left knee. He did not injury the left knee in the accident on July 30, 2012. The mechanism of injury did not involve the left knee. He advanced no complaints in the left knee at the time of his initial treatment. The left knee diagnosis is degenerative joint disease. Dr. Matlock does not present any causation opinions in his records with respect to the left knee. Dr. Kim testified he has no opinion of causation of the left knee condition. Dr. Sporer testified that left knee condition is not causally related to the accident. The Arbitrator finds this unrebutted opinion persuasive as to the lack of causal connection of the left knee condition to the accident.

With respect to the right knee, Petitioner has presented the testimony of Dr. Kim that the work accident was a contributing factor in accelerating the need for the right knee replacement. Respondent presented the testimony of Dr. Sporer that the right knee complaints were related to degenerative joint disease and not related to the accident on July 30, 2012.

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

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

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). Based on the Arbitrator's finding with respect to Causal Connection, only reasonable and necessary treatment for the right knee through March 11, 2013 would be causally related to the accident. Petitioner has admitted PX 4 which is an unpaid balance to Athletico for therapy from November 7, 2013 through January 14, 2014. This therapy was following the right knee replacement surgery and would not be causally connected to the accident.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he is entitled to any additional medical expenses.

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

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter. Based upon the Arbitrator's finding with respect to Causal Connection, the Arbitrator will only consider the causally related condition of ill being in the Petitioner's right knee.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Maintenance worker at the time of the accident and that he was able to return to work in his prior capacity as a result of said injury. This was a physically demanding job. Thereafter, Petitioner underwent bilateral total knee replacements and took retirement. Because of these facts, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 53 years old at the time of the accident. Petitioner returned to his full duty job, but took early retirement following his unrelated bilateral knee replacements. He has not sought work thereafter and has withdrawn from the labor market. Because of these facts, 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 returned to his full duty job, but took early retirement following his unrelated bilateral knee replacements. He has not sought work thereafter and has withdrawn from the labor market. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered a twisting injury to the right knee. He had immediate complaints of

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.

Having reviewed the medical opinions in light of the medical records and evidence presented, the Arbitrator finds the opinion of Dr. Sporer more persuasive that Dr. Kim. Dr. Kim acknowledges that Petitioner had a significant pre-existing osteoarthritic condition in the right knee. His sole diagnosis and treatment is for the arthritic condition. He also concedes that Petitioner would have needed a total knee replacement at some time regardless of the accident. This is supported by Dr. Matlock who raises this likelihood at his initial August 27, 2012 office visit. Dr. Kim states that the basis for his opinion that the need for this surgery was accelerated was based upon the increase in Petitioner's complaints not any advancement pathology as demonstrated on the studies. He notes he did not review the MRI studies at all. He testified that from a symptomatic standpoint, there was an acceleration of his arthritis.

This opinion is unpersuasive for several reasons. The Petitioner testified and Dr. Sporer's history documents some complaints prior to the accident including walking different and occasional pain. The Petitioner's pre-existing condition would be aggravated by Petitioner's obesity. His testimony that he weighed 250 pounds at the time of the accident is contradicted by the medical records. Dr. Kim's opinion does not adequately address Petitioner's improvement after the arthroscopy with no pain complaints, a negative physical examination, return to full duty. and discharge from follow up care by Dr. Matlock on March 11, 2013. Dr. Kim's opinion also failed to address the fact that Petitioner had similar symptoms and complaints in the uninjured left knee and, in fact had a total knee replacement in the left knee within months of his right knee surgery. This timing contradicts any implication that the accident accelerated the need for surgery. Dr. Kim's opinion is also flawed because the decision to proceed with surgery was driven in large part by Petitioner's own demand to proceed with the knee replacement. Both Dr. Matlock and Dr. Kim actually wanted to delay the surgery for several years. It was Petitioner's insistence that determined the timing of the surgery as much as the physical finding.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that, as a result of the accidental injury sustained on July 30, 2012, he suffered a meniscus injury to the right knee resulting in arthroscopic surgery. Said condition of ill-being reached maximum medical improvement as of March 11, 2013. Petitioner's condition of ill-being thereafter, including the osteoarthritis in his right knee and the total knee replacement are not causally related to the accident. The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that any condition of ill-being in the left knee is causally related to the accident.

pain, swelling and stiffness. His MRI noted a tear of the medial meniscus. Dr. Matlock performed surgery which included repair to the medial and lateral meniscus. Petitioner was treated post-operatively through March 11, 2013. At that time, Petitioner reported he was not really having any pain anymore. The knee feels much better. Physical examination noted good range of motion, no joint line tenderness, negative McMurray and a pretty normal gait. Dr. Matlock stated Petitioner will continue with full duty work and was released to be seen on an as needed basis. Thereafter Petitioner was treated for his arthritic condition of both knees and underwent bilateral total knee replacements. He has not sought further treatment after being released by Dr. Kim in October 2014. He currently is not under active medical care. He takes only over the counter pain medication. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

The record notes that Petitioner has received a prior settlement of 17.5% loss of use of the right leg. Respondent is entitled to credit for this prior amount pursuant to Section 8(e)17 of the Act.

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 30% loss of use of Right Leg pursuant to §8(e) of the Act. Respondent is entitled to credit of 17.5% against this amount for the prior settlement.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TANYA ZAKS,

Petitioner,

vs. NO: 18 WC 28784

STATE OF ILLINOIS,
DEPARTMENT OF JUVENILE JUSTICE
IYC CHICAGO,

20IWCC0548

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission, herein, modifies the decision of the Arbitrator, specifically on page 14, paragraph 1, only as to striking the third and fourth sentences beginning, "The Arbitrator emphasizes Petitioner is highly educated…" through "…lay witness."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2019, but for the above noted modification, 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.

20IWCC0548

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

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

DATED: SEP 2 1 2020
o-8/18/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

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

ZAKS, TANYA
Employee/Petitioner

Case# **18WC028784**

ST OF IL DEPT OF JUVENILE JUSTICE IYC CHICAGO
Employer/Respondent

20IWCC0548

On 3/13/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

6143 ASSISTANT ATTORNEY GENERAL
KRISTIN LEASIA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

MAR 13 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20 IWCC0548

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)

Tanya Zaks,
Employee/Petitioner

Case # **16** WC **14666**

v.

State of Illinois, Department of Juvenile Justice, IYC Chicago,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **January 7, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 07, 2018**, Respondent-Employer ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent-Employer.
On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
Timely notice of this accident ***was*** given to Respondent-Employer.
Petitioner's current condition of ill-being ***is not*** causally related to the accident.
In the year preceding the injury, Petitioner earned **$78,897.00**; the average weekly wage was **$1,517.25**.
On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.
Petitioner ***has*** received all reasonable and necessary medical services.
Respondent-Employer ***has*** paid all appropriate charges for all reasonable and necessary medical services.
Respondents 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**.
Respondents are entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Petitioner has failed to prove her current conditions of ill-being (both physical and mental) are causally related to any injuries sustained relating to a workplace incident on September 7, 2018. Petitioner is therefore not entitled to any temporary total disability benefits under Section 8(b) or medical expenses under Section 8(a). Claim for compensation under the Act is therefore denied.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris — March 12, 2019 Date

 MAR 13 2019

20 I W C C 0 5 4 8

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

Tanya Zaks,	)	**Case No. 16 WC 14666**
	)	
Petitioner,	)	**Chicago, IL**
	)	
v.	)	
	)	
State of Illinois Department of Juvenile Justice IYC Chicago,	)	
	)	
Respondents.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

An Application for Adjustment of Claim was filed by Petitioner, Tanya Zaks, seeking relief under the Illinois Workers' Compensation Act from Respondent State of Illinois Department of Juvenile Justice Illinois Youth Center Chicago (hereinafter "DJJ IYC"). A hearing pursuant to Section 19(b) of the Act was held before Arbitrator Robert M. Harris on January 7, 2019 in Chicago, Illinois. The Illinois Attorney General's Office appeared on behalf of the State of Illinois/

I. FINDINGS OF FACT

Petitioner's Testimony

Petitioner Tanya Zaks ("Petitioner") testified she was born on August 28, 1977. Petitioner obtained her M.D. degree from Bangladesh Medical College and completed a six-month rotation in general surgery. During medical school, she was briefly exposed to instruction on Post Traumatic Stress Disorder (PTSD) but did not pursue coursework in the subject. Petitioner obtained a Masters of Public Health and an MBA in Public Health Administration from St. Xavier University in Chicago, Illinois in 2006. Petitioner worked in healthcare administration for 10 years.

On August 1, 2018, Petitioner began working for DJJ IYC Chicago as an educator. The facility houses incarcerated youths, some of whom have convictions for murder and armed

robbery. Petitioner was hired to teach computer programming and resumé writing. Once hired, Petitioner was also asked to build an educational healthcare program. She was not, however, given the funding or materials needed to build such a program.

During her first month at the facility, Petitioner assisted other educators in a variety of classrooms. Every day, she found the youth to be constantly unruly. In early September 2018, Petitioner was assigned her own classroom with her own students. She indicated that the size of the classroom was approximately one-and-a-half times the size of the arbitration room.[1] Ten youth were assigned to the classroom. Two adults were also present, an educator and a diagnostician who administered tests to the youth. The classroom included an area where several computer workstations were set up against the wall. There was little space to move between the computer area and the rest of the classroom. The classroom did not have air conditioning; as it was summer, temperatures in the room approached 90 degrees. Petitioner stated that these conditions created an unsuccessful classroom environment, and that she had previously informed her superiors that she needed a bigger room with air conditioning and more security personnel posted.

Issues with a particular student in her classroom, Youth "P"[2], began on September 4, 2018. Petitioner stated that while the other students in her classroom were unruly at times, they were otherwise controllable; she could tell them when they were committing an offense, and they would calm down. This management did not work with Youth P, and behavior issues with him continued to the date of the accident on September 7, 2018. Beginning on September 4, Youth P threatened Petitioner with physical harm. He also told Petitioner that he had assaulted other staff members in the past, had gotten staff members fired, and that nothing had ever happened to him. He stated that he would do the same to her. Youth P specifically threatened to get Petitioner fired by filing a false rape accusation against her, and requested that Petitioner give him a pencil and paper so that he could write out a complaint. During these outbursts, Youth P would pace around the classroom, throw furniture, and tell Petitioner to "fuck off." Over the course of the four days, Youth P's behavior became progressively worse. After each incident, Petitioner filed reports with the facility.

On September 7, 2018, Youth P had another outburst directed at Petitioner lasting 20 minutes. Youth P and the other students were in the classroom's computer area. Petitioner was

[1] The Arbitrator noted on the record that the arbitration room is approximately 20 feet by 30 feet in size.
[2] Due to privacy concerns over identifying a minor, during the hearing the youth involved in the incident was identified only by his initial.

standing by the door to the classroom, off to the side from the computer stations. Youth P threw classroom furniture and a computer keyboard down on a table, causing some of its keys to fly off. He verbally threatened to punch Petitioner in the face. Youth P, who was physically larger than Petitioner, began to "zero in" on Petitioner and come towards where she was standing by the door.

Petitioner backed up against a wall, jerked her neck back and heard a "thud" as she hit her head. Her entire back hit the wall. She opened the 200-pound door to the classroom several times, using her body weight and a very tight grip to keep it open. Per facility policy, security guards – the facility's correctional officers – were not present in the classroom. They were instead stationed right outside the door to the classroom. At the outset of Youth P's outburst, Petitioner requested that security come into the classroom to assist with and remove Youth P. They told Petitioner that they were unable to enter the room until they had adequate backup, which took 20 minutes to arrive. Four security guards eventually entered the room to remove Youth P. As they were escorting Youth P from the classroom, a "scuffle" between Youth P and the guards occurred above Petitioner's head. Petitioner believes that during this scuffle, both Youth P and the security personnel grazed the top of her head. Youth P was never able to physically get closer than one foot of Petitioner, although he did spit at her and the spit landed on her face.

On cross-examination, Petitioner testified that by the end of the altercation, she had moved herself to the other side of the classroom in order to "call code" from the classroom phone. The call occurred in a different part of the room from where Youth P was being removed.

Petitioner testified that during the incident, she was in fear of bodily harm. She was unable to do anything to defend herself from Youth P. Petitioner testified she had previously been told she was never permitted to touch a youth, and if she did so, she would be immediately fired. Petitioner testified she was told that in the event of an assault or incident with a youth, she could try to run from the situation. On cross-examination, Petitioner testified that security regulations in the facility require that educators stay with their charges and cannot leave the room. Petitioner also testified that while she was told she could try to run, if she had run, security would have tried to stop her. Petitioner testified that after the first incident with Youth P on September 4, she asked if

security could remove him from the classroom if he acted up. She testified security told her they could give her no assurances due to understaffing at the facility.[3]

In the immediate aftermath of the incident, Petitioner did not experience any serious pain. Petitioner remained at work for another three to four hours filling out paperwork about the incident. In her initial report, Petitioner checked the "no" box for the question asking whether she had sustained any injuries or required hospitalization. Petitioner explained that she marked the form in this manner due to her still being in shock and having vibrations in her head, but experiencing no other symptoms until later that evening.

Petitioner testified earlier, however, that while she was filling out the paperwork, she began to experience acute head pain as well as discomfort on her right side. Petitioner had testified that by the time she left work, she was experiencing full pain in her shoulders and hips, and her head was throbbing. Petitioner then testified that it was when she was filling out the workers' compensation paperwork that she began to experience a migraine as well as pain in her shoulder, neck, and hip.

A number of reports were completed in the aftermath of the September 7 incident. The Supervisor's Report of Injury, filled out by Valerie Jackson (Petitioner's Exhibit "Pet. Ex." 16), indicates that Youth P spit in Petitioner's face, that Petitioner hit her head against the wall, and that Youth P grazed her head. Jackson was not present to witness the incident, however, and was told of its specifics by Petitioner. After viewing a copy of the Supervisor's Report in court, Petitioner testified that it accurately recorded what she had told Jackson. Petitioner filled out a Disciplinary Report and an Incident Report. Adult witnesses to the event also filled out reports.

Once Petitioner left the facility on September 7, she took public transportation to the Emergency Room at Evanston Northshore Hospital for treatment. After her initial emergency room visit, Petitioner treated primarily with Dr. Thomas Pontinen at Midwest Anesthesia and Pain Specialists/Centers for Pain Control (MAPS) for her injuries. Petitioner also visited doctors Joseph O'Donnell and Andrew Pundy, a psychologist and psychiatrist, respectively.

Prior to the September 2018 incident, Petitioner had never seen a psychiatrist or a psychologist, nor had she experienced any psychological or psychiatric issues. Petitioner has been

---

[3] According to Petitioner, the facility holds 75 to 100 youths and that due to a recent consolidation of Illinois youth centers, IYC Chicago – which was designed as a low-security prison – is housing maximum-security-designated youth

married to a psychiatrist since 2013. Petitioner experienced previous lower back issues approximately 10 years ago, when it was revealed that she had a small disc bulge at L4-L5. Petitioner received an epidural injection for this condition, and it resolved within weeks. Petitioner was seen by doctors at Northshore University Health System on July 9, 2018, after her back issues began to act up again. The treaters recommended she wait to see if the symptoms would resolve on their own, which they did. Petitioner has not experienced prior neck problems. She has a history of migraines.

Following the incident, Petitioner testified she began experiencing psychological symptoms. These include crying spells where she begins crying for no reason and feeling claustrophobic in environments without windows. Due to these claustrophobia feelings, Petitioner has not driven a vehicle since the incident, and finds going to the grocery store difficult. Petitioner feels panic when people stand close to her, and experiences sudden and intrusive memories of the incident which come to her "jumbled up." Petitioner has panic attacks and serious migraines. Petitioner only gets about three hours of sleep at night and when she does sleep, she grinds her teeth and talks out loud.

Physically, since the accident, Petitioner testified her hip functionality has decreased. Petitioner testified this has caused significant interference in her intimate relations with her husband, and that her husband often complains to her about this problem. Otherwise, her physical symptoms have markedly improved over the course of her treatment. Petitioner has experienced approximately 50 percent improvement in her ability to walk on the treadmill, although her right hip still buckles under her. Petitioner still experiences sporadic migraines, but they no longer last two days. Her shoulder and neck pain are improving. Petitioner continues to have difficulty with sitting, standing, and lifting. Currently, Petitioner is taking prescribed medications following the accident, including Lunesta for sleep, as well as high-dose ibuprofen and local, topical ointments and solutions for body pain. These medications have been prescribed to her by Dr. Pontinen.

Petitioner testified she is the sole provider for her family, and the family relies on her for income and benefits. At 56 years old, her husband is much older than she, and is not as healthy. Petitioner testified she has not been paid since October 2018.

Petitioner's Medical History

Petitioner's Pre-Accident Medical History

On May 11, 2018, Petitioner saw Dr. Pamela Goodwin for gynecological issues. (Pet. Ex. 1). Petitioner presented with TVUS with small cysts and vulvar pain. Petitioner was diagnosed with a UV prolapse, vulvodynia, and pelvic pain. (Pet. Ex. 1). Physical therapy was ordered. Petitioner was also noted to have ovarian cysts. (Pet. Ex. 1).

On July 9, 2018, Petitioner saw Dr. Patrick Michael Birmingham at Northshore University Health. (Pet. Ex. 1) for pain in her low back and hips, with the pain on her right side more pronounced. Petitioner relayed that she has a history of a L4-5 herniation that resolved with an epidural injection. (Pet. Ex. 1). Other past history listed included back pain, sciatica, endometriosis, PCOS, and pelvic pain. (Pet. Ex. 1). Petitioner stated that she had been experiencing five to six weeks of constant, deep posterior hip pain. Petitioner reported that this pain was interfering with her normal work quite a bit. (Pet. Ex. 1). Petitioner also reported that she felt calm and peaceful only "some of the time," and that her physical or emotional problems were interfering with her social activities most of the time. (Pet. Ex. 1).

Petitioner saw Dr. Roger Goldberg on July 9, 2018 (two months before the incident) for a midline cystocele, uterine prolapse, rectocele, acute pelvic pain, vaginal prolapse, and vulvodymia. (Pet. Ex. 1). Petitioner reported sexual symptoms of decreased sexual satisfaction and painful intercourse. Petitioner had been experiencing the vaginal prolapse for the past one to two years. (Pet. Ex. 1). Petitioner reported that she seldom felt sexual desire, that she seldom climaxed, that she seldom felt sexually excited when engaging in sexual activity, and that she was not very satisfied with the variety of sexual activities in which she engaged. She reported always feeling pain during intercourse, and that she avoided intercourse due to pain caused by the bulging. (Pet. Ex. 1).

Petitioner's Post-Accident Medical History

On September 7, 2018, Petitioner presented to the Emergency Room at Evanston Hospital. Petitioner arrived with complaints of a head injury, back pain, hip pain, and general musculoskeletal pain. (Pet. Ex. 1). Petitioner first reported she hit the back of her head, her hips, and her lower back against a wall in the course of an assault at work. Petitioner reported she may have pulled a muscle in her neck. Petitioner reported that the involved student may have grazed the top of her head, but that he did not make fully physical contact. (Pet. Ex. 1 at pg. 40). Later Petitioner reported to different treating personnel that, "she reflexively 'jerked backwards' to avoid

him and c.o. head, neck pain;" but that she "did not fall or strike wall – she was up against wall at the time." She told another Emergency Room nurse that she "fell against wall, c.o. neck pain, back pain," but experienced "no head pain." (Pet. Ex. 1 at pg. 42). In another instance while still in the Emergency Room, Petitioner relayed that "she was back up to wall by student and does not recall exact events but thinks she either 'snapped' her head back or hit her head on wall." (Pet. Ex. 1 at pg. 43). Petitioner denied any vision changes, dizziness or any other complaints. (Pet. Ex. 1). Petitioner requested that Chicago Police be called to the hospital so that she could file a police report. Petitioner requested physical therapy, as well as a psychiatrist to help her cope with her symptoms. (Pet. Ex. 1). The Emergency Room notes indicate Petitioner likely suffered a sprain/strain/spasm. Petitioner was discharged with instructions to take Tylenol and apply ice for the pain. (Pet. Ex. 1). Petitioner would not consent to any labs or imaging. (Pet. Ex. 1).

On September 13, 2018, Petitioner saw Dr. Thomas Pontinen at MAPS for acute headaches, bilateral shoulder and neck pain and pain in her legs and back following an assault by an inmate. (Pet. Ex. 2) Petitioner reported the pain was sharp and stabbing, a constant 8/10 in severity, and worse than her past back and hip pain. (Pet. Ex. 2). Petitioner testified that she gave Dr. Pontinen a history of her injuries as well as a past medical history. Dr. Pontinen diagnosed Petitioner with headaches, low back pain, pain in her right hip, cervicalgia, spondylopathy and spondylosis, radiculopathy in the lumbar region, and pain in her left and right shoulders. (Pet. Ex. 2). Dr. Pontinen recommended physical therapy for four-to-six weeks at two-to-three sessions per week. Dr. Pontinen ordered MRIs of the lumbar region and Petitioner's right hip, and prescribed Tramadol, Flexeril, and lidocaine patches. Dr. Pontinen stated that Petitioner's injuries were related to the workplace injury. Dr. Pontinen placed Petitioner off work and gave Petitioner a referral to a psychiatrist for PTSD symptoms. (Pet. Ex. 2).

On September 15, 2018, Petitioner saw Dr. Sangeeta Senapati at Northshore University health on a referral from Dr. Goldberg for painful intercourse, vaginal prolapse, and pelvic pain. (Pet. Ex. 1). These records indicate Petitioner had been experiencing these symptoms for one-to-two years. Petitioner described deep pain with intercourse that rated 8/10. (Pet. Ex. 1) Petitioner's exam with Dr. Senapati revealed a normal musculoskeletal condition in her lower extremities. Dr. Senapati diagnosed Petitioner with pelvic floor pain, and prescribed physical therapy, muscle relaxants, and topical lidocaine. (Pet. Ex. 1).

Records from ATI Physical Therapy indicate Petitioner had an initial physical therapy evaluation on September 24, 2018 and she followed a course of treatment through November 16, 2018, approximately seven weeks. (Pet. Exs. 3, 3A, 3B).

On September 27, 2018, Petitioner underwent MRIs of her right hip and lumbar spine at Northwestern Memorial Hospital. (Pet. Ex. 4). The MRI of the right hip revealed mild right gluteus minimus and medius insertional tendinosis with peritendinitis associated with gluteus minimus low-grade myolendinous strain. (Pet. Ex. 4). The lumbar MRI revealed multilevel degenerative changes; specifically, minimal facet degenerative changes at T12-L1, L1-2, L2-3, L3-4, and L4-5. Mild disc bulges at L4-5 and L5-S1 were also evident. (Pet. Ex. 4). Petitioner was diagnosed with low back pain potentially associated with radiculopathy and hip pain. (Pet. Ex. 4).

On October 1, 2018, Petitioner followed up with Dr. Pontinen. Petitioner had begun physical therapy and remained compliant with the program. The diagnosis remained the same, and Dr. Pontinen recommended that Petitioner continue with the physical therapy and the prescribed medications. (Pet. Ex. 2). Another follow-up visit on October 24, 2018 noted the same, with the same recommendations. Dr. Pontinen did note that Petitioner was not interested in pursuing any injections for her pain. (Pet. Ex. 2).

On October 5, 2018, Petitioner saw Dr. Joseph O'Donnell at the Center for Biofeedback Therapy. (Pet. Ex. 5). Dr. O'Donnell memorialized the results of this initial evaluation in a statement dated October 12, 2018. (Pet. Ex. 5). Petitioner had been referred to him for PTSD. (Pet. Ex. 5). Petitioner relayed a history of her injury, and reported symptoms of emotional outbursts, uncontrolled crying, panic and anxiety attacks, feelings of foreboding sadness, insomnia with nightmares, and a continued refusal to get into a car. (Pet. Ex. 5). Dr. O'Donnell noted that during the appointment, Petitioner was tense and agitated, often rushing her responses. Petitioner frequently burst into tears, and was obviously emotionally upset. Petitioner's body language indicated tenseness and stress. (Pet. Ex. 5). Dr. O'Donnell opined that these observed symptoms corroborated her story, and that these along with her self-described symptoms and history were consistent with PTSD. (Pet. Ex. 5). Dr. O'Donnell prescribed Petitioner a course of neuro biomechanical feedback. (Pet. Ex. 5). Petitioner testified this treatment involves the use of a machine with probes that attach to each ear and a sensor placed on the scalp. The machine emits rays into the brain that improve its relaxation mechanisms in an attempt to train the brain to calm

itself out of an agitated state. Petitioner continues to see Dr. O'Donnell about twice per week for this treatment. Her last appointment occurred on January 4, 2019.

On November 16, 2018, Dr. Pontinen gave Petitioner a referral to a dentist due to her beginning to grind her teeth in her sleep. (Pet. Ex. 2). Dr. Pontinen indicated Petitioner might need a mouth guard. Petitioner testified that between her initial appointment with Dr. Pontinen and November 16, 2018, she began to experience headaches and migraines that would last up to two days, neck pain, and pain in both shoulders and hips. Petitioner testified the pain on her right side was more pronounced than that on the left.

On November 21, 2018, Petitioner followed up with Dr. Pontinen. He noted Petitioner had seen a psychologist for PTSD and she reported trouble sleeping due to pain and anxiety. (Pet. Ex. 2). Petitioner reported to Dr. Pontinen she did "not feel that psychologically she can return to a place of employment where her safety is threatened as it was, but she is hopeful to return to some type of meaningful work." (Pet. Ex. 2 at pg. 50)[4]. Dr. Pontinen called Petitioner off of undergoing any additional physical therapy after she complained that the therapy was giving her migraines and extra soreness. Dr. Pontinen instructed Petitioner to continue her medications. (Pet. Ex. 2).

Petitioner saw Dr. Pontinen on December 19, 2018. Petitioner reported that since she stopped physical therapy, her migraines had improved. (Pet. Ex. 2). Petitioner reported overall pain improvement from an 8/10 intensity to a 6/10 intensity with the use of her Home Exercise Program. (Pet. Ex. 2). Petitioner reported continued trouble sleeping and night terrors due to her pain and PTSD. Petitioner indicated trouble with being in public places and felt jumpy around people. (Pet. Ex. 2). Dr. Pontinen continued to hold Petitioner off physical therapy. (Pet. Ex. 2). On December 21, 2018, Dr. Pontinen referred Petitioner to a sleep study. (Pet. Ex. 2).

On December 26, 2018, Petitioner saw Dr. Andrew Pundy, an M.D. psychiatrist. (Pet. Ex. 19, 19A). Petitioner testified that Dr. Pundy, unlike Dr. O'Donnell, holds an M.D. degree and can therefore prescribe medications. Petitioner saw Dr. Pundy on her husband's recommendation; Dr. Pundy was one of Petitioner's husband's teachers during his medical training.[5] Petitioner stated that her husband was not happy with her physical and emotional progress under Dr. O'Donnell, and thought that she might experience greater results with a doctor who could write prescriptions.

---

[4] During her in-court testimony, Petitioner stated that her goal is to return to work at IYC Chicago, as she cannot afford to lose her job and needs the benefits.

[5] Petitioner noted that her husband has been retired from medical practice for fifteen years, and that she is not being treated by her husband in any manner.

Dr. Pundy took a history of Petitioner's injury and listed a diagnosis of PTSD. (Pet. Ex. 19, 19A). Dr. Pundy noted Petitioner was afraid of taking any psychiatric medications. (Pet. Ex. 19, 19A). Petitioner confirmed this during her testimony, stating that she rejected the use of medications due to concerns over dependency (Arbitrator's note: Petitioner's testimony here contradicts the reason why Petitioner's husband referred her to Dr. Pundy in the first place, that is, for prescriptions). Petitioner testified Dr. Pundy prescribed her cognitive therapy and exposure therapy. Petitioner testified she intends to continue treatment with Dr. Pundy but will not do so if her workers' compensation claim remains denied.

II. CONCLUSIONS OF LAW

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

A. Regarding disputed issue F., Is Petitioner's current condition of ill-being causally related to the injury? The Arbitrator finds and concludes as follows:

The Arbitrator initially highlights there is no dispute that an "incident" occurred on September 7, 2018. There is also no dispute that Petitioner was involved in an "incident", more or less as she testified, and more or less as many records corroborate, on September 7, 2018, while in the course of her employment with Respondent. The threshold issue in dispute is whether this agreed "incident" rises to a level sufficient to be classified and considered as an "accident" within the meaning of the Act. Questions arise whether Petitioner's alleged physical condition is related to this incident, and even more substantial questions arise whether Petitioner's alleged emotion/mental condition of ill-being is related to this incident; that is the heart of the "causation" dispute. Whatever happened on that date, the Arbitrator finds and concludes Petitioner has not proven by a preponderance of the credible evidence that her alleged physical condition of ill-being or her alleged emotional/mental condition of ill-being are causally related to whatever happened on September 7, 2018. In summary, the Arbitrator reaches this conclusion based on problems with Petitioner's credibility and a lack of expert medical testimony offering solid causation opinions. But in regards to Petitioner's emotional/ mental claim, the Arbitrator specifically finds and concludes that not only is there a lack of credible expert medical causation opinions, but the

facts of the events lead to the conclusion that Petitioner has failed to meet the high burden of proving her alleged emotional/mental condition of ill-being satisfies the legal requirements to prove a mental claim; **Petitioner did not prove she was exposed to "a severe, sudden emotional shock" as case law requires.** The Arbitrator finds the evidence indicates Petitioner likely does suffer PTSD and other emotional/mental conditions as a consequence of the events of September 7, 2018; however, the evidence does not prove the vents rose to the level necessary to show Petitioner was exposed to a "severe, sudden emotional shock" as case law requires. **Therefore, even if expert medical opinions were provided to offer causation, that would nonetheless not be enough to make the claim compensable, as the facts must still meet the threshold of proof of a "severe, sudden emotional shock" which is a legal – not a medical – conclusion.** That legal conclusion Petitioner has been unable to prove in this claim. Petitioner does not present a persuasive argument that the exposure to whatever stress actually occurred (and the nature of that exposure is in dispute) on September 7, 2018 met the required legal standard.

Petitioner bears the burden of proving all of the elements of her case by a preponderance of the evidence. *Chicago Rotoprint v. Industrial Comm'n.*, 157 Ill.App.3d 996. To be entitled to compensation under the Act, an employee must establish that his or her condition of ill-being is causally connected to a work-related injury. *Bolingbrook Police Dep't v. Illinois Workers' Comp. Comm'n*, 2015 IL App (3d) 130869WC, ¶ 50 (2015). The claimant has the burden of proving some causal relation between her employment and her injury: that some act or phase of the employment was a causative factor in the ensuing injury. *Republic Steel Corp. v. Indus. Comm'n*, 26 Ill. 2d 32, 45 (1962); *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, ¶ 38. Whether such a causal relationship exists is a question of fact to be resolved by the Commission. *Certi–Serve, Inc. v. Industrial Comm'n,* 101 Ill.2d 236, 244 (1984).

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).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her physical symptoms are causally related to the September 7, 2018 incident. Likewise,

Petitioner's claims regarding her mental/psychological condition are legally insufficient in establishing a compensable claim under the Act.

Petitioner's Physical Condition

Many inconsistencies and contradictions exist in Petitioner's testimony, and between her testimony and the information she provided her treaters, regarding the circumstances of the accident, the mechanism of injury and what body parts were injured, and when her symptoms appeared. These inconsistencies and contradictions call into question Petitioner's credibility and the manner and extent to which Petitioner experienced any physical contact or injury during the September 7 incident. The Arbitrator emphasizes Petitioner is highly educated and therefore her credibility will be assessed based on her elevated status. Further, as a trained medical physician, the Arbitrator assumes Petitioner fully understands medical terminology, anatomy and related matters (she knows what she is talking about) such that when she offers testimony regarding same, she should therefore be held to a higher standard of accuracy than the average lay witness; this also means Petitioner will be held more accountable regarding her credibility for inconsistencies and contradictions and vagueness than the average lay witness.

Petitioner testified during her direct examination that Youth P came at her, and in response she backed up against a wall, jerked her neck back and heard a "thud" as she hit her head. She also testified she hit her back against the wall. Petitioner's medical records, however, show that her version of how she obtained her injuries continuously changes.

Emergency room records from September 7 indicate Petitioner informed treating personnel that during the incident she "jerked back" reflexively but "did not fall or strike wall," as she was already "up against wall at time." (Pet. Ex. 1 at pg. 42). Yet Petitioner indicated to other Emergency Room personnel that she did not "recall exact events," but thought she either "'snapped' her head back or hit her head on a wall." (Pet. Ex. 1 at pg. 43). Petitioner finally settled on telling her treaters she did hit her body against the wall. (Pet. Ex. 1 pg. 42). Such inconsistencies in her recollection of the event on the very same day it occurred seriously call into question the veracity of the history she relayed in court, only four months later.

Petitioner's in-court testimony was likewise inconsistent and lacked credibility. Petitioner testified Youth P never made physical contract with her, only getting within about a foot of her person at his closest. Petitioner also testified he was able to "spit at her", and the spit landed on

her face. If Youth P was not able to actually fully get to her, that means he must have somehow been blocked from approaching or reaching her. Per Petitioner's testimony, security people arrived on scene and restrained Youth P. Petitioner testified, however, that it took the security personnel twenty minutes to appear, meaning their arrival would have been towards the end of the altercation. This fails to make sense as well.

On cross-examination, Petitioner admitted that by the end of the incident, when Youth P was being lead out, she had been able to move away from the area of the altercation to the other side of the room to place a phone call. Petitioner therefore could not have been within a foot of Youth P at the end and would not have been within spitting distance. This also does not make sense. Petitioner testified that as security personnel were leading Youth P from the room, a "scuffle" ensued between in which her head was "grazed" by Youth P and/or the security officers. Yet if by the end of the incident Petitioner was on the other side of the room, she could not have been subject to the alleged "scuffle" that ensued. The story she offers the Court is simply not credible.

While the narrative in the Supervisor's Report (Pet. Ex. 16) seems to corroborate Petitioner's version of the altercation, Petitioner admitted her supervisor was not present to witness the event. Rather, her supervisor obtained details of the incident for the report directly from Petitioner. Neither of the witness reports completed by individuals actually present during the altercation make any indication that Youth P spit on Petitioner, nor do they state that a "scuffle" occurred above Petitioner's head. **But the witness reports are consistent with each other in describing what happened -** Youth P threatened to get Petitioner fired by filing a false report against her and asked for pencil and paper to do so, stating he had gotten other staff fired in this manner; he threw a keyboard to the ground, breaking it; and as he was being led away by security, he punched his own hand against the classroom door. (*See* Pet. Ex. 17 and 18). **These witness reports, however, do not corroborate Petitioner's version of the events.**

The Arbitrator finds other aspects of Petitioner's account of the incident not credible. Petitioner testified she opened the door to the classroom multiple times during the altercation. Yet she also testified it took security personnel stationed right outside the door twenty minutes to arrive in the room to restrain Youth P. The Arbitrator does not find it likely that during the course of a security incident, the facility would have allowed the classroom door to remain open without the appropriate personnel actually on scene to contain the situation. Nine other students were present

in the classroom. A propped-open door would present an unacceptable security risk. The Arbitrator also finds it unlikely that in a prison setting, where securing the premises is of utmost concern, if a scenario like that described by Petitioner was actually unfolding, security posted right outside the room would wait 20 minutes to respond.

Petitioner also testified official facility policy prevented her from touching or physically defending herself in any manner from Youth P. Petitioner alleged she was told she could try to run from any situation. But due to her responsibility to the other youths, however, Petitioner alleged she was actually not permitted to run away and would be prevented from doing so. Petitioner testified she was expected to let Youth P attack and possibly kill her. The Arbitrator finds this alleged policy, essentially requiring Petitioner to sacrifice her own personal safety – and possibly her life – to be so extreme and absurd as to be lacking any credibility. As to Petitioner's contention that she was not permitted to run from the situation, Petitioner testified that in addition to herself, there was at least one other adult (a diagnostician) stationed in the classroom. If the need for supervision of the juveniles by adults constituted the concern underlying such an alleged policy, those concerns seem to be allayed by having multiple adults in the room. It therefore seems highly unlikely Petitioner would be punished for trying to remove herself from a dangerous situation involving one of her charges. The Arbitrator also notes this other adult in the room (the diagnostician) was not present to testify at the trial.

The Arbitrator also finds Petitioner's testimony regarding her symptoms immediately following the incident suspect. Petitioner first testified that after the altercation, she did not experience any serious pain. Later in her testimony, however, Petitioner testified she did in fact feel "vibrations" in her head as she was filling out paperwork that day, but she did not experience any other symptoms. Yet at another point in her testimony, Petitioner testified that while she was filling out the incident forms, she began to experience acute head pain as well as discomfort on her right side. Over the course of about 30 minutes of testimony, Petitioner went from not experiencing any pain after the incident, to having head "vibrations," to experiencing full-body pain. Further to the point, the emergency room notes indicate that at various points during treatment, Petitioner indicated both that she did **and** did not have head pain (*see* Pet. Ex. 1 at pgs. 40, 42), and that she denied vision changes or dizziness. Such responses are at odds with Petitioner's contention that while she was still at work, she began to experience head "vibrations."

Petitioner's own medical records indicate that the physical symptoms Petitioner attributes to the incident are actually pre-existing – and were not aggravated by the incident. Following the incident, Petitioner complained of migraines "lasting two days." Petitioner testified – and her medical records corroborate – that Petitioner has had an ongoing continuous medical history of migraines.

Regarding the pain in her back, neck, and shoulder, Dr. Pontinen diagnosed Petitioner with acute headaches, bilateral shoulder and neck pain and pain in her right hip, cervicalgia, spondylopathy and spondylosis, and radiculopathy in her lumbar region. (Pet. Ex. 2). Petitioner has a history of a disc bulge at L4-5, (Pet. Ex. 1), also admitted to in her testimony. Petitioner testified it had finally resolved with an epidural injection.

On July 9, 2018 (just two months prior to the incident on September) Petitioner saw Dr. Birmingham for back pain stemming from her history of L4-5 herniation. The appointment notes indicate she had been experiencing pain for the previous five-to-six weeks. Significantly, Petitioner indicated to Dr. Birmingham that the right-side pain was more pronounced than the left-side pain (Pet. Ex. 1). Petitioner now says the same about the pain that is allegedly the result of the September 7 incident. Also at this appointment, Petitioner was already stating that her pain was interfering with work, (Pet. Ex. 1), the very same contention Petitioner now makes regarding her alleged workplace injuries. Petitioner testified the doctor advised her to see if the back pain resolved on its own and that it did. Yet her medical records show no such indication of any spontaneous resolution prior to September 7. Finally, the September 2018 MRI of Petitioner's lumbar spine showed the presence of several multilevel facet degenerative changes. (Pet. Ex. 4). Thus to the extent that Petitioner suffers any back problems, her medical records and history demonstrate that they are pre-existing and degenerative in nature, rather than the result of an acute injury or permanent aggravation following the events of September 7, 2018.

Finally, Petitioner testified that the physical injuries allegedly resulting from the September 7 accident have caused her hip to dysfunction and that this dysfunction interferes with her ability to engage in sexual relations with her husband. Petitioner stated that she cannot physically move her hip as before, and that this deficiency has caused her intimate life to become "horrible" as she is unable to functionally engage sexually. Petitioner testified this has caused strife in her marriage.

Petitioner's medical records, however, clearly do not support her testimony. In May 2018, Petitioner was already treating for gynecological and pelvic issues that were clearly interfering

with her intimate life. Dr. Goodwin diagnosed Petitioner with a UV prolapse, vulvodynia, and pelvic pain, as well as ovarian cysts. (Pet. Ex. 1). On July 9, 2018, Petitioner followed up with Dr. Goldberg for these conditions, and was already reporting serious sexual dysfunction and dissatisfaction. (Pet. Ex. 1). In a sexual health survey Petitioner completed, she specifically attributed her sexual dysfunction and tendency to avoid intimate relations to the bulging from her prolapse and the resulting pain during intercourse. Petitioner further indicated that these symptoms had been ongoing for the preceding one-to-two years. (Pet. Ex. 1). Thus to the extent that Petitioner is physically unable to pursue intimate relations, this is a pre-existing problem attributable to conditions – including already-extant pelvic/hip pain – predating the workplace incident and not permanently aggravated by the workplace incident.

The Arbitrator further finds serious inconsistencies with Petitioner's testimony regarding whether and to what extent she actually suffered physical contact and injury during the events of September 7, 2018. This, along with unbelievable aspects of Petitioner's testimony regarding the facility's security policies, irreparably damages Petitioner's credibility regarding the circumstances of the incident. The Arbitrator further finds Petitioner's medical records reveal her physical ailments are pre-existing in nature and were not permanently aggravated by the workplace incident. Petitioner has therefore failed to prove by a preponderance of the credible evidence that her current physical condition is causally related to the workplace incident of September 7, 2018.

Petitioner's Mental Condition

Petitioner claims she suffers from PTSD as a result of the September 7, 2018 incident.[6] Psychological injuries are compensable under the Act through one of two theories. Compensable "physical-mental" psychological injuries are those which are related to or caused by physical trauma. *Chicago Transit Authority v. Ill. Workers' Comp. Comm'n.*, 2013 IL App (1st) 120253 WC at ¶17. Compensable "mental-mental" injuries occur when a claimant suffers a sudden, severe emotional shock traceable to a definite time, place and cause, which causes psychological trauma or injury even where no physical trauma or injury was sustained. *Id.* Though Petitioner has failed

[6] Petitioner also provided testimony and documented evidence regarding other incidents involving Youth P in the three days preceding the September 7, 2018 that forms the basis of Petitioner's claim. While Petitioner only lists September 7, 2018 as the claimed day of accident, her testimony and submitted evidence suggest that Petitioner wishes to claim, in part, that the cumulative effect of all of these interactions with Youth P has negatively affected Petitioner's mental state.

to prove any compensable physical injury as a result of the workplace incident, in theory she could still have sustained a compensable "mental-mental" injury of PTSD. As a matter of law, however, Petitioner's PTSD claim fails to rise to the level of compensability under the Act. Petitioner therefore failed to establish that her psychological/mental condition is causally connected to the September 2018 workplace incident(s).

Under *Pathfinder v. Industrial Commission*, an employee who suffers a sudden, severe emotional shock traceable to a definite time, place and cause, and which causes psychological injury or harm, has suffered an accident within the meaning of the Act, even in the absence of physical injury. 62 Ill. 2d 556, 562 (1976). *Pathfinder*, however, does not "permit recovery for every non-traumatic psychic injury from which an employee suffers merely because the employee can identify some stressful work-related episode"; rather, the claimant must show that the psychic injury arose from "an uncommon event of significantly greater proportion or dimension than that to which an employee would otherwise be subjected in the normal course of employment." *General Motors Parts Division v. Indus. Comm'n*, 168 Ill. App. 3d 678, 687-88 (1988). Whether a worker has suffered the type of emotional shock sufficient to warrant recovery is determined by an objective, reasonable-person standard that takes into account the claimant's occupation and training. *Diaz v. Ill. Workers' Comp. Comm'n*, 2013 IL App. (2d) 120294 WC at ¶4-5. Being placed in personal danger is a factor that can support an award for a psychological injury, *Matlock v. Indus. Comm'n.*, 321 Ill. App. 3d 167, 171-21 (2001); a claimant must present, however, objective evidence supporting inferences of psychological injury, causation, and disability of an "exceptionally distressing" and "uncommon" work-related experience. *Chicago Transit Authority*, 2013 IL App (1st) at ¶21, 27.

While there is no delineated threshold or measurement of "gruesomeness" or "shock" that a claimant must pass in order to establish a claim, "mental-mental" cases deemed compensable reveal that **the triggering event must be sufficiently uncommon as to be extreme**. Compensable "mental-mental" injuries have included situations where an employee firefighter personally witnessed the death of one co-worker and the severe burning of another, *see Moran v. Ill. Workers' Comp. Comm'n.*, 2016 IL App (1st) 151366 WC; a police officer responding to a standoff with an armed perpetrator had a gun pulled on him, *see Diaz*, 2013 IL App. (2d) 120294 WC; and a CTA bus driver struck a pedestrian with the bus and watched the pedestrian die on the side of the road, *see Chicago Transit Authority*, 2013 IL App (1st) 120253 WC. In *Pathfinder*, the claimant worked

in a factory and witnessed her coworker get her hand stuck in one of the machines. When the claimant went to assist the coworker, the claimant pulled the coworker's severed hand from the machine. *Pathfinder*, 62 Ill. 2d 556. Even in *Matlock*, the claimant experienced an extreme workplace event: a passenger on a flight which the claimant was working as a flight attendant attempted to blow up the plane and sprayed the claimant with an unknown chemical agent. 321 Ill. App. 3d (2001). The court, in upholding the claimant's award, noted that **the experience was outside the bounds of typical unruly passenger behavior and not a normal incident encountered** in flying. *Id.*

Petitioner similarly failed to establish that the events of September 7, 2018 rise to the level of a "sudden, severe emotional shock" that was suitably uncommon as to be extreme. Compensable "mental-mental" cases all share characteristics of either involving a claimant personally witnessing the death or severe bodily harm to self or another, or the claimant being placed in a situation of imminent and life-threatening harm. **Petitioner has experienced none of the above.** While Petitioner felt in fear of bodily harm during the incident, being threatened verbally is quite different than having an actual deadly weapon directed at their person, as in *Diaz*, or being subjected to an attempt to blow up an airplane while being sprayed with a potentially toxic chemical agent, as in *Matlock*. Petitioner herself noted that while Youth P made movements towards her, he only got, at most, within a foot of her, and was only able to spit on her. And how close Youth P was actually able to get to Petitioner, and whether he actually spit on her, is called into question by Petitioner's admission that she was able to remove herself to a different area of the classroom by the end of the altercation. **Youth P was arguably a typical unruly incarcerated youth. While the circumstances of the incident would certainly have been unpleasant, gross, and distressing, nothing about Petitioner's testimony suggest that she was indeed in imminent or life-threatening harm or that her factually unclear situation was uncommon and extreme.**

Particularly instructive is a look at what has been deemed legally insufficient to establish a compensable "mental-mental" claim. In *Macris v. United Airlines*, 06 IL WC 29237 (Ill. Indus. Com'n), 08 I.W.C.C. 1464 (2008), the Commission declined to find compensability where the claimant, a flight attendant, witnessed the natural death of a passenger. The Commission found that the death of the passenger did not "arise from a situation of greater dimension than the day-to-day emotional strain and tension to which all employees must experience." *Id.* The claimant's

bearing witness to a natural, non-traumatic death was "part and parcel of the training he was provided [...] as one of many anticipated events he may encounter while performing his job duties." *Id.* **As such, the claimant did not prove he suffered a sudden, severe emotional shock traceable to a readily-perceivable cause that actually exists in reality from an objective standpoint. Nor did he show that his condition was caused by an uncommon non-traumatic work-related experience out of proportion to incidents of normal employment activity.** *Id.*

If witnessing the death of a fellow human being does not create a compensable claim, then Petitioner's claim from witnessing an excessive temper tantrum (or even feeling threatened) by any account a much less extreme and uncommon situation – must also fail. A significant factor in the *Macris* decision was the fact that the potential for a passenger to die in-flight was something that could be expected by the employee as part of the potentialities of his job. **In the instant case, Petitioner noted several times during her testimony that DJJ IYC housed juvenile felons– youth with severe behavioral issues. Therefore the possibility - more likely the probability - of an emotional outburst or threat such as that occasioned by Youth P would be reasonably expected as a scenario in which Petitioner might find herself during her employment at a youth facility.**

Finally, Petitioner has failed to bring sufficient required evidence tying the September 7, 2018 incident to her PTSD symptoms. As articulated in *Chicago Transit Authority*, a claimant must present some objective evidence that their mental condition is related to the triggering episode. *See Chicago Transit Authority*, 2013 IL App (1st) 120253 WC. In *Matlock*, the claimant tendered to the court a medical opinion from a qualified doctor explicitly tying the claimant's mental condition to the situation on the plane. Here, Petitioner presents the statement from Dr. O'Donnell. (Pet. Ex. 5). While Dr. O'Donnell states that Petitioner's history, self-described and observed symptoms are consistent with PTSD, and gives a PTSD diagnosis, **nowhere does he explicitly state - let alone offer a specific and complete opinion - that the PTSD is caused by the September 7 incident.** The court is left to make the inference that her PTSD is caused by the workplace accident. That is not sufficient. Liability, however, cannot rest upon imagination, speculation or conjecture. *See United Airlines v. Comm'n*, 991 N.E.2d 458, 463 (2013). Further,

Petitioner bears the burden of proving each element of his case by a preponderance of credible evidence. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470 (4th Dist. 1987). In order to meet this burden, a Petitioner must "produce competent evidence of objective conditions and

symptoms to support [a] claim." *Nunn* at 477. Where a claimant has a pre-existing condition, whether it is aggravated or accelerated is a question of fact for the Commission. *Caterpillar Tractor Co. v. Indus. Comm'n,* 92 Ill. 2d 30, 36-37 (1982). Furthermore, in questions involving causation, the parties need not necessarily submit a medical opinion in order to prove causation. **However, "where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that the claimant's work activities caused the condition complained of."** *Nunn* at 507, citing to *Interlake Steel Co. v. Indus. Comm'n*, 136 Ill. App. 3d 740 (1985). In this case, the Arbitrator finds and concludes that the question of causation is "the question is one within the knowledge of experts only and not within the common knowledge of laypersons." The Arbitrator finds and concludes the evidence submitted by Petitioner is insufficient to prove by a preponderance of the evidence that her current conditions of ill-being are related to the September 7, 2018 incident. Petitioner offered no medical evidence and no expert medical opinion to support a theory of causation. Again, when difficult medical causation issues are presented, that falls outside the realm of a layman to decide, and therefore expert medial opinions are required. While Petitioner's other treaters (Dr. Pontinen, Dr. Pundy) seem to concur with a PTSD diagnosis, the medical records do not indicate that Petitioner has ever been formally tested or screened for PTSD beyond Dr. O'Donnell's in-office observations. The treaters' opinions come from Petitioner's self-described history and symptoms. The Arbitrator notes that Petitioner is a trained medical personnel who has had exposure to coursework in PTSD and psychological illness. Petitioner is also married to a retired psychiatrist. In light of credibility issues stemming from Petitioner's testimony, the Arbitrator questions the extent to which Petitioner's statements regarding her PTSD symptoms, both in court and to her treaters, stem from her own experience versus a general knowledge of what collection of symptoms could coalesce into a PTSD diagnosis.

Based on the foregoing, the Arbitrator finds that Petitioner has failed, as a matter of law, to prove by a preponderance of the credible evidence that her PTSD/mental/psychological condition of ill-being is causally connected to the events of September 7, 2018.

B. Is Respondent-Employer Liable for Unpaid Medical Bills?

As Petitioner has failed to prove that her conditions of ill-being are causally related to the workplace incident of September 7, 2018, the Arbitrator finds and concludes Respondent is not liable for any unpaid medical bills.

C. Temporary Total Disability

As Petitioner failed to prove that her conditions of ill-being are causally related to the events of September 7, 2018, the Arbitrator finds and concludes Petitioner is not entitled to any Temporary Total Disability as provided in the Act.

Robert M. Harris

____
Arbitrator Robert M. Harris

March 12, 2019
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES KAO,

Petitioner,

vs. NO: 06 WC 06270

20 I W C C 0 5 4 9

INSIGHT ENTERPRISES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, permanent partial disability, penalties and attorney fees, and Other-job description/sham, and being advised of the facts and law, herein, corrects an apparent scrivener's error in the Memorandum of Arbitrator's Decision, specifically on page 1, paragraph 3, and page 6, last paragraph, to reflect the proper date of the Functional Capacity Evaluation date to October 28, 2010, and otherwise, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 25, 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 $58,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020
o-7/ 28/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAO, JAMES Case# **06WC006270**
Employee/Petitioner

INSIGHT ENTERPRISES
Employer/Respondent

20 I WCC0549

On 5/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER HART ETAL
DANIEL L GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

20 IWCC0549

STATE OF ILLINOIS	)	☐ Injured Workers' Benefit Fund (§4(d))
	)SS.	☐ Rate Adjustment Fund (§8(g))
COUNTY OF **Cook**	)	☐ Second Injury Fund (§8(e)18)
		☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Kao
Employee/Petitioner

v.

Insight Enterprises
Employer/Respondent

Case # **06** WC **006270**

Case # on review: **14 IWCC 0040**

An *Application for Adjustment 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 **11-27-12 & 03-07-18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **01-26-06**, 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 $**21,657.75**; the average weekly wage was $**434.77**.

On the date of accident, Petitioner was **61** 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.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $ 260.86 / per week for 225 weeks, because the injuries sustained caused 45% loss of use of a person as a whole, as provided in Section 8(d)(2) of the Act.

Petitioner's claim for additional TTD benefits are denied.

Petitioner's claim for penalties and attorney 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

05-23-18
Date

MAY 25 2018

20 I W C C 0 5 4 9

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES KAO, Petitioner,

vs. No. 06 WC 6270

INSIGHT, Respondent.

MEMORANDUM OF DECISION

This Memorandum of Decision and Order is attached to the IWCC Arbitration Decision form and is made a part thereof as though fully set forth therein. This cause came to be heard on a remand order from the Circuit Court of Cook County for the taking of additional evidence in relation to this case. Pursuant to an order of the Illinois Workers' Compensation Commission dated April 4, 2017 (Arbitrator's Exhibit #2), additional evidence was to be taken with the limited purpose of reconciling evidence of the petitioner's then-job activities. Therefore, proofs were re-opened and were limited to the admission into evidence of the job description of the petitioner's then-job activities, the testimony of the therapist who conducted the petitioner's Functional Capacity Evaluation (FCE), and the live testimony of the petitioner limited to the description of the then-job activities.

FINDINGS OF FACT

The Arbitrator incorporates by reference all of the evidence previously admitted into the hearing record on November 27, 2012. What follows is a summary of the additional evidence submitted at hearing on March 7, 2018.

The petitioner called Joseph Rappa to testify. Mr. Rappa is an occupational therapist employed by Athletico Physical Therapy and was the therapist that performed the FCE on the petitioner on October 28, 2018. The FCE test that was administered on the petitioner took three hours. The job description Mr. Rappa had available at the time of performing the FCE was from December of 1999 stating that the petitioner's lifting requirements were between five pounds and forty pounds. The petitioner's FCE performance indicated he could return to work as a picker packer within the description of the job duties from December of 1999.

When Mr. Rappa was asked a hypothetical question about whether the petitioner could return to work if his lifting requirement was up to sixty pounds, he stated it would be speculation to answer the question, though it would appear from the FCE results that the petitioner would be

unable perform lifting up to sixty pounds. Mr. Rappa also stated that if the petitioner were to return to work he would recommend a modified schedule with rest breaks being included in order to transition the petitioner into working at the time, but frequent rest breaks would not be necessary. Mr. Rappa testified regarding neck extension, and stated that based upon the FCE findings the petitioner would have a limited extension, making it difficult for him to look up.

Mr. Rappa could not comment or answer why another physician would have restricted the petitioner to a three-hour workday, as FCEs attempted to be non-biased in their assessment of work capabilities. Mr. Rappa testified that, though the FCE test lasted for only three hours, the Matheson FCE system was designed to extrapolate a patient's performance over an eight-hour workday. Mr. Rappa stated that the FCE timed the petitioner's standing and walking and he was doing both for a combination of one hour and forty-three minutes during the test.

Though Mr. Rappa noted that the petitioner continued to complain of pain during the FCE at either five or six out of ten, it was his opinion that the petitioner's perception of his pain was higher than expected based on how he actually performed in his FCE. Mr. Rappa further testified that the petitioner would be unable to perform lifting up to sixty pounds at any height based upon the FCE results.

On cross-examination Mr. Rappa stated that he stood by all of the opinions contained in his report and nothing would change. He confirmed that there was no deficits noted in the petitioner's abilities for sitting, standing or walking. Furthermore, nothing from the three hour FCE test stood out that these things would be difficult for the petitioner and that he is able to perform these activities without limitation.

Mr. Rappa testified that the Matheson System was designed to determine how a patient could safely return to work in a full workday in the regular course of their employment. In evaluating the job requirements and performing an FCE, the therapist looks at a job description and also takes a history or information from the patient to understand the physical requirements of the job. Mr. Rappa did testified, however, that he is able to perform a full FCE on a patient without having a complete job description and that he is able to determine a patient's safe work capabilities without having a full job description. He also testified that not having a complete job description at the time performing an FCE does not affect the patient's performance during the test. Also, having a complete or full job description does not affect the ultimate recommendations about a patient's ability to return to work. Mr. Rappa confirmed that the FCE test result stated that the petitioner could perform some lifting categories at the medium physical demand level, or occasionally anything between twenty-five and fifty pounds, and some lifting capabilities at the heavy physical demand level, or frequently lifting between twenty-five and fifty pounds.

Mr. Rappa commented upon the validity testing measures used during the FCE. He noted that when a patient fails validity testing measures, it could mean that the patient was not providing a full physical effort and that they were capable of greater physical abilities than they demonstrated during the test. Mr. Rappa confirmed that the petitioner had failed three out of seven Waddell's in appropriate responses, which were part of the validity testing. A Waddell's

test sign is indicative for inappropriate elicited behavior, which in his opinion would be expressing greater pain than was actually being experienced. Furthermore, Mr. Rappa stated that a patient could be exaggerating their pain during the test if they failed a Waddell's test or other validity testing measures. Mr. Rappa also confirmed that the petitioner performed greater than his subjective complaints indicated, and that his perception and disability was greater than what he objectively performed at the time of his FCE. Mr. Rappa's conclusion was that the petitioner was capable of performing at a greater physical level than the petitioner had himself indicated during the FCE test.

Mr. Rappa also testified that if a doctor had given the petitioner a restriction of not being able to work more than three hours, that would be inconsistent with the findings in his FCE. He also testified that, assuming the petitioner was required to lift up to sixty pounds in his job, and if team lifting were available where the petitioner and a coworker could lift a sixty pound box and each share the weight of approximately thirty pounds, the petitioner could return to work in his position as a picker packer for the respondent. On re-direct examination, however, that if one of the lifts was performed with poor body mechanics and the load was uneven, then the petitioner might be unable to perform the lift. Mr. Rappa did note that the petitioner did perform lifting during the FCE with fair to good body mechanics.

Further questioning revealed that Mr. Rappa would not change anything about the contents of his report, knowing what he knows at the time of trial. During further redirect and re-cross examination, Mr. Rappa testified that he would like to have had an accurate job description at the time of performing the FCE, but he again confirmed that the outcome of the physical abilities in the FCE are not affected by not having an accurate job description.

The petitioner was called to testify on his own behalf. The petitioner testified that he used a wire cart to pick up and transfer merchandise in the course of his job duties as a picker packer. The cart had four shelves, with the bottom shelf being approximately half a foot off the ground, the first shelf being about one and a half feet off the ground, the middle shelf about two feet high and the top shelf about four feet high. Occasionally he would put packages on the top shelf of the cart.

The petitioner reviewed the job description that had been previously provided as Exhibit #8, which was dated from December of 1999. The petitioner confirmed that the description of lifting packages ranging from five pounds to forty pounds was an accurate description of his job duties as a picker packer, but then added he would occasionally have to lift boxes weighing ten to fifteen pounds more than that, or up to fifty-five pounds. He further stated that fifty-five pounds was not every time they lifted something. The petitioner also testified that team lifting was something that he performed in he course of his job duties as a picker packer, but he was not sure where that information was located in the job description.

On cross examination the petitioner stated that he worked in the small parts department as a picker packer. The petitioner testified that the plastic cart pictured in Respondent's Exhibit #12 was no longer in use as of 2005. He further testified that both the size and weight of the various packages he would pick up would be different and would vary. He also stated that, in the small

parts department, they had about twenty-five or thirty people working in the same position in the same department at the same time.

Ms. Bozica Tanasica was called as a witness on behalf of the respondent. Ms. Tanasica was employed by the respondent as a manager of operations and had worked with the respondent for seventeen years. Her past positions included supervisor team lead and as a picker/packer. Ms. Tanasica worked for the respondent at the same time as to the petitioner, and she was one of his supervisors although did not supervise him directly. Ms. Tanasica testified that she was familiar with the position of a picker packer, which is now called a shipping associate by the respondent.

Mr. Tanasica reviewed the respondent's job description, submitted as Respondent's Exhibit #12, which was a job description prepared on November 27, 2012, which was the date of the last trial in this case. Ms. Tanasica testified that this was a true and accurate depiction of the petitioner's job duties, or his "then-job duties", at the time of the prior hearing. She testified that she helped prepare this document with someone from human resources.

Ms. Tanasica related that shipping associates (formerly called picker packers) are most often lifting merchandise between one pound or twenty-five pounds, with occasional lifting up to fifty pounds. She broke this down as lifting between one pound and twenty-five pounds approximately ninety percent of the time, and lifting in excess of twenty-five pounds up to fifty pounds for approximately ten percent of the time. She also testified that picker packers utilize shipping carts, both metal and plastic, in the course of retrieving and moving merchandise. She testified that both the metal carts and the plastic carts have always been available to picker packers, and there has never been a time when the plastic carts were not available, contrary to the petitioner's testimony.

Ms. Tanasica testified that a prior hearing witness, Carlos Alvarez, had retired from working at the respondent. She stated that she disagreed with Mr. Alvarez' prior testimony that boxes could weigh as much as sixty pounds, and reiterated that the boxes weighed no more than fifty pounds. Ms. Tanasica also testified that team lifting was an available option for picker packers, in that teammates or coworkers were readily available to help with lifting any boxes.

On cross examination Ms. Tanasica stated that there was a discrepancy between the job description from December of 1999 (Resp.Ex.#8) and the more recent job descriptions requiring lifting up to fifty pounds. She stated that she did not agree with any prior testimony from Mr. Alvarez that stated that the average weight of boxes was sixty pounds. Ms. Tanasica also noted that the job description does not include a description of team lifting, but that team lifting would be accounted for in the metrics in a picker packer's jobs. On re-direct examination Ms. Tanasica testified that team members are trained in lifting mechanics and states that she could not recall if any team member ever refused to help out with a team lift for a coworker.

In terms of documentary evidence, Petitioner's Exhibit #51 was the Insight University brochure from April 18, 2005. This brochure documents instructions for what appears to be the packing system utilized by the respondent. While the brochure lists various instructions under specific packing requirements, it makes no mention of physical job requirements of a picker packer

positoin. Petitioner's Exhibit #55 was a job description from December of 1999, which was also part of Respondent's Exhibit #8 and was admitted into evidence in the prior hearing. This was previously considered and discussed in the prior decision of the Arbitrator dated January 14, 2013, but in brief and as described above it states the petitioner's job duties require lifting between five and forty pounds. Petitioner's Exhibits #57, #58 and #59 were Volumes I, II, and III of the prior trial exhibits, respectively. The Arbitrator notes that the admitted evidence in Volumes I through III of the prior trial exhibit were summarized in the Arbitrator's prior decision, and the Arbitrator incorporates those factual findings by reference herein.

Respondent submitted Exhibit #11, which is a job description of the effective date of November 27, 2012. The Arbitrator notes that this job description was the respondent's attempt to describe the petitioner's "then-job activities" per the remand order. Similar to prior testimony, the job description states that it requires lifting up to fifty pounds as well as being able to sit, stand, walk, talk, hear, use hand and fingers to operate a computer, as well as perform material and equipment handling. Respondent's Exhibit #12 was pictures of the two types of carts testified to by the parties at hearing.

CONCLUSIONS OF LAW

The issues in dispute at the prior November 27, 2012 hearing were as follows:

F. IS THE PETITIONER'S CURRENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE INJURY?

K. IS THE RESPONDENT LIABLE FOR TEMPORARY TOTAL DISABILITY BENEFITS TO THE PETITIONER?

L. NATURE AND EXTENT OF THE PETITIONER'S INJURIES.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON THE RESPONDENT?

Pursuant to the remand order, consideration was given to each of these disputed issues in light of the additional evidence taken into the record. Evaluating each issue, both the evidence from the prior hearing will be taken into account as well as the additional evidence taken into the record on the remand order. Having carefully considered all of the evidence in the record, the following findings of fact and conclusions of law are rendered.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE ALLEGED WORK INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

The Arbitrator adopts the previous findings of fact and conclusions of law outlined in the January 14, 2013 decision. Nothing about the evidence submitted changes the prior finding that the condition of the petitioner's neck and his low back is causally related to the accident injury previously described.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO THE NATURE AND EXTENT OF THE PETITIONER'S INJURIES, THE ARBITRATOR FINDS THE FOLLOWING:

The Arbitrator has carefully reviewed considered the additional evidence taken into the hearing record on remand. After considering the additional evidence, the Arbitrator finds that this does not change the prior award for nature and extent of the petitioner's disability for 45% loss of a person under Section 8(d)(2) of the Act.

The petitioner's prior claim that he was permanently and totally disabled as premised upon a January 3, 2011 disability slip of Dr. Lu. The Arbitrator previously found the disability slip from Dr. Lu to be unreliable and it carried little weight in terms of evidence, and nothing about the additional evidence submitted into the record changes that finding.

The question of whether the petitioner was able to return to work in his former position as a picker packer or shipping associate for the respondent was addressed in the prior hearing decision, and is again reviewed in light of the additional evidence. There is credible evidence in the record that the petitioner can still perform the job duties as a picker packer or shipping associate for the respondent. First, the Arbitrator notes that the therapist, Mr. Rappa, testified that his opinions as they pertain to the FCE of October 28, 2010 did not change and remain the same as of trial. Under the FCE, the petitioner could lift upwards of thirty to forty-eight pounds on an occasional basis depending upon the lifting height.

The Arbitrator notes that there is a discrepancy between the evidence regarding the petitioner's lifting requirements as part of his job duties as a picker packer or shipping associate. At one point in time the petitioner had indicated he had to lift up to seventy-five pounds in his job duties. During hearing on remand, the petitioner changed his testimony to state he had to lift between five and forty pounds, though occasionally he could have to lift up to fifty-five pounds. This is a significant difference in the petitioner's prior description of his job duties and suggests the petitioner is either not fully aware of his job requirements or he was attempting to be misleading about his job duties. The witness for the respondent, Ms. Tanasica, had worked for the respondent for seventeen years and indicated that, at most, a shipping associate in the small parts department would have to lift up to fifty pounds on an occasional basis. The majority of a picker packer's lifting (90%) would be between one and twenty-five pounds. She specifically disagreed with the prior testimony of Mr. Alvarez that stated that lifting might be up to sixty pounds. Under the circumstances of this case, it appears that a shipping associate or picker packer might occasionally be faced with lifting a package weighing up to fifty or fifty-five pounds, but most often they were lifting up to twenty-five pounds or less.

If the petitioner were required to lift fifty to fifty-five pounds by himself, this would exceed his capabilities as delineated by the Functional Capacity Evaluation of October 28, 2018. In this case, however, both the petitioner and Ms. Tanasica testified that team lifting was allowed to occur for heavier packages. In this instance, if a team lifting event occurred for a package weighing fifty-five pounds, that would mean the petitioner would be required to lift 27.5 pounds

on an occasional basis. Ms. Tanasica testified that team lifting was readily available for team mates and that she was not aware of instances of team mates refusing to conduct team lift with their coworkers. Since only 10% of packages weighed greater than twenty-five pounds, only a small portion of the petitioner's job duties would require team lifting. Assuming the petitioner was faced with lifting a fifty-five pound box, he could request a coworker to help assist with him lifting that box, which would then presumably require him to lift only 27.5 pounds on an occasional basis. This does not exceed the petitioner's lifting abilities at any lifting height as delineated by the October 28, 2010 FCE. Furthermore, Mr. Rappa testified that, under the circumstance of appropriate team lifting, the petitioner could return to work in his job duties for the respondent as a picker packer or shipping associate. Though the Arbitrator notes that Mr. Rappa also testified that, hypothetically, if a coworker did not practice good lifting mechanics then it could conceivably shift more than half of the load onto the petitioner and therefore, he would not be able to perform the duties of the job, this conclusion is speculation as it presumes another employee is incapable of performing their full job duties. Moreover, Ms. Tanasica testified that the picker packers or shipping associates are trained in good lifting mechanics as part of their job and do not refuse to do team lifts.

The petitioner's treating physician, Dr. Citow, opined the petitioner could return to work within the constraints of the Functional Capacity Evaluation of October 28, 2010. The respondent's Section 12 examining physician, Dr. Bauer, opined that the petitioner could return to work full duty for the respondent after examining the petitioner, reviewing the FCE and also reviewing a written job description and job video. The therapist who performed the FCE, Mr. Rappa, testified that the petitioner could return to work full duty for the respondent with team lifting being available for packages up to fifty pounds (and even sixty pounds). All of this evidence supports and reaffirms the prior conclusion that the petitioner was able to return to work in his prior job duties as a picker packer or shipping associate for the respondent as of the prior hearing date.

Even assuming, for the sake of argument, that the petitioner could not return to work full duty for the respondent, he is still not entitled to permanent and total disability benefits on the evidence in this case. For example, it was previously found that the prescription slip of Dr. Lu was not persuasive and carried little weight. That leaves the question of whether the petitioner is proved he is entitled permanent and total disability benefits under the "odd lot" catergory. The petitioner's vocational expert, Joseph Belmonte, stated that if the petitioner was able to return to work within the restrictions of the October 28, 2010 Functional Capacity Evaluation, then it was his opinion that there was a stable labor market for the petitioner and he would be capable of earning $11.00 per hour in the open labor market. It was previously noted that no evidence rebutted Mr. Belmonte's opinions and testimony on this issue, and the Arbitrator found that the petitioner had a stable labor market to which he could return. The additional evidence on remand does nothing to change that prior factual finding and conclusion of law on that point. Mr. Belmonte offered no opinions that the petitioner was unemployable or that he conducted a failed job search within the restrictions outlined by the FCE. Under the circumstances, at best the petitioner could prove that he is unable to return to his usual and customary line of employment, but he did not lose access to other lines of employment and it would not result in a

loss of earning capacity. Under Section 8(d)(2) of the Act, the prior award of 45% loss of use of a person is still appropriate under the circumstances of this case.

IN SUPPORT OF THE ARBITRATOR'S DECISION AS TO WHETHER THE RESPONDENT IS LIABLE FOR TEMPORARY TOTAL DISABILITY BENEFITS CLAIMED BY THE PETITIONER, THE ARBITRATOR FINDS THE FOLLOWING:

In the prior trial, there were three periods in dispute: July 23, 2006 through February 21, 2010; April 10, 2010 through July 27, 2010; and, November 24, 2010 through November 27, 2012 (the last date of trial).

With respect to the period from July 23, 2006 through February 21, 2010, the Arbitrator notes that the additional evidence on review has no effect on the previous finding of TTD benefits for this period of time. Any additional evidence taken on remand was relevant to the petitioner's job duties after this period of time. Nothing about this initial evidence affected the medical opinions upon which the denial of TTD benefits was based.

With respect to the period of TTD benefits in dispute from April 10, 2017 through July 27, 2010, the Arbitrator reaffirms the prior denial of TTD benefits. Nothing about the additional evidence on review addressed this period of time or the medical evidence supporting the denial of TTD benefits.

With respect to the denial of TTD benefits from November 24, 2010 through November 27, 2012, the Arbitrator reaffirms the prior denial of TTD benefits for that period of time. The Arbitrator noticed that the petitioner's claim for TTD benefits for this period of time was premised upon the January 3, 2011 disability slip of Dr. Lu. As previously indicated in the prior decision and in this decision, Dr. Lu's disability slip was questionable at best and was found to be unpersuasive and carried little weight. Furthermore, the Arbitrator notes that the petitioner was released to return to work by Dr. Citow on November 19, 2010 consistent with restrictions outlined in the October 28, 2010 FCE. The petitioner testified at the prior hearing he made no attempt to return to work for the respondent with these restrictions. Again, nothing about the additional evidence received on remand affects or changes the medical opinions outlined in the prior decision denying TTD benefits for this period of time.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO PENALTIES AND ATTORNEYS' FEES, THE ARBITRATOR FINDS THE FOLLOWING:

The Arbitrator reaffirms the prior finding that the petitioner was not entitled to penalties and attorneys' under Sections 16, 19(k) and 19(l) of the Act, and that the respondent's denial of benefits was reasonable and not vexatious.

CONCLUSION

In conclusion, after consideration of both the evidence taken into hearing during the original trial and the additional evidence taken into the record on remand, the Arbitrator finds the following: The petitioner's condition of ill being is causally related to the January 26, 2006 accident; the petitioner's claim for additional TTD benefits is denied; the petitioner's claim for penalties and attorneys' fees is denied; the petitioner sustained 45% loss of use of a person as delineated by Section 8(d)(2) of the Act.

Rules Regarding Appeals: Unless a party files a Petition for Review within thirty days after receipt of its 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.

Honorable Kurt Carlson

05.23.18
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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JERRALE PALMER,

Petitioner,

vs. NO: 15 WC 41949

PROVISO TOWNSHIP H.S. DIST. 209,

20 IWCC0550

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, notice, average weekly wage, benefit rates, temporary total disability, medical expenses, and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2018 is hereby affirmed and adopted.

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

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

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

DATED: SEP 2 1 2020
o-9/15/20
KAD/jsf

Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PALMER, JERRALE
Employee/Petitioner

Case# **15WC041949**

PROVISO TOWNSHIP HIGH SCHOOL
Employer/Respondent

20IWCC0550

On 8/21/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

1067 ANKIN LAW OFFICES
JILL WAGNER
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
CHARLES M MARING II
10 S LASALLE ST 9TH 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

JERRALE PALMER,
Employee/Petitioner

v.

PROVISO TOWNSHIP HIGH SCHOOL,
Employer/Respondent

Case # **15** WC **41949**

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 Seal**, Arbitrator of the Commission, in the city of **Chicago**, on **6/27/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0550

FINDINGS

On **10/5/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned $**$45,719.91**; the average weekly wage was $**879.22**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $**680.00** for other benefits, for a total credit of $**680.00**.

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

ORDER

Credits

Respondent shall be given a credit of $680.00 for sick leave benefits.

Denial of benefits

The petitioner failed to bear his burden of proving by the preponderance or greater weight of the evidence that he sustained an accident arising out of and in the course of his employment with the respondent for which compensation is payable. Therefore, compensation is denied. All other issues are rendered moot.

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

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

Signature of Arbitrator

August 21, 2018
Date

AUG 21 2018

STATEMENT OF FACTS

On October 5, 2015, the petitioner was employed by the respondent as a security guard. (TA 10) Among his duties was breaking up any fights that might occur. (TA 10-11) He worked eight hours per day, five days per week earning $17.50 per hour. (TA 11) The petitioner testified that if a fight broke out between the students, the protocol was to alert the other security guards who then were expected to rush to the scene and break it up. (TA 12-13)

The petitioner testified that in addition to working as a security guard he also was employed with Aabcor as a home health assistant through the state of Illinois. (TA 13) He testified that in this position he assisted an elderly person with household chores and did his cooking, cleaning, and laundry; and, he took him to and from doctors' appointments. (TA 13) He worked in this position five hours per day, seven days per week. (TA 14) Petitioner's Exhibit 8 is his W-2 indicating that he earned $21,901.25 from Aabcor in 2014. The petitioner testified that his wages remained the same in 2015. (TA 16) He testified that the respondent knew he had a second job with Aabcor. (TA 14)

On October 5, 2015, two fights broke out between students. (TA 16) The petitioner received the first call of a fight and ran to respond. When he arrived, the students were already separated by another security guard. (TA 16-17) He then received a second call for another fight on the upper floor. (TA 16-17) He responded and ran up the stairs to help break up the fight and while doing so, he felt a pop and pain in his back. (TA 16) When he arrived at the scene of the second fight, he learned that it was a false alarm. (TA 17) The petitioner was able to continue and complete his shift. He testified that, after the end of the day, he felt pain in his back down his right leg. By the next morning, he was in severe pain. (TA 17) He sent a text message to his supervisor, Donald Mobley, reporting what happened the day before. (TA 19) The petitioner

testified that Mr. Mobley sent him a text message indicating that the petitioner's message was received, and if it was over an extended period of time he had to send a doctor's note.

The petitioner initially presented with pain to various emergency rooms before establishing consistent care with Dr. Michael Taylor. On October 6, 2015, he presented to his primary care physician, Dr. Subhash Goyal at Union Health Services with complaints of right low back pain radiating down to his calf. He said that it "felt tight" for two weeks. (RX6, pg.20) No trauma was noted. (RX6, pg. 21) He was given pain medications and discharged.

On cross examination the petitioner agreed that he did not mention any work accident at this appointment, and that he would have no reason to dispute the notation that he denied trauma to his back. (TA 39-40) He further admitted to describing leg pain for the prior two weeks at the time of this appointment. (TA 40)

The petitioner testified that he went to Chiro One October 10, 2015, and saw Markisha Hamilton. They took x-rays. (TA 20) On October 21, 2015, the petitioner was evaluated at Rush Oak Park Hospital. (RX5; PX5) He denied injury at this appointment. (RX5, pg. 106) He complained of right low back pain radiating to his buttock and leg for the past two and a half weeks and said that he had to go up and down stairs several times daily, sometimes two stairs at a time, while working as a security guard. He was diagnosed with sciatica, given pain medications, and told to follow up with his primary care physician in 2-3 days. (TA 20-21; PX2)

On October 24, 2015, the petitioner was evaluated at Adventist La Grange Hospital, where he denied specific injury. (TA 41; RX9, pg. 8) He provided a history of experiencing pain in his right hip radiating down the right side of his leg for the prior month. He said that he was active and played basketball, and he exhibited a normal gait.

The petitioner returned to Chiro One on November 3, 2015, with continued back pain. (RX3) He indicated that his symptoms of back and right leg pain began when he woke up with pain on October 10, 2015. (TA 43; RX3, pg. 6) In the portion of the medical history form entitled "Physical & Trauma History," the petitioner denied any "home" or "other" injuries, and under "work activities" provided "standing for 8-10 hours a day, walking about 2 miles." (RX3, pg. 8) He stated that "when I run it feels like my hip is moving in and out."

On November 8, 2015, the petitioner returned to Rush Oak Park Hospital. (RX5, pg. 126) He provided a history of working as a security guard and being on his feet for long periods of time. These records contain no other history. (TA 46)

He had several follow up visits and then returned to Union Health Services and saw Dr. Tatjana Guzina on November 13, 2015. He was diagnosed with right hip trochanteric bursitis and lumbar strain, and he received pain medications and a referral for physical therapy. (RX6)

On November 20, 2015, the petitioner was seen at ATI Physical Therapy. (RX4; PX 4) He stated that his pain began one month prior when he "purchased a new vehicle that cause[d] him to be in a more flexed posture." (TA 46-47; RX4, pg. 4) The petitioner also stated that he was working as a security guard at a school and was running towards a fight when he felt a right leg pain and pop in his buttocks. The petitioner completed a course of physical therapy at ATI Physical Therapy November 20th through 25th, 2015. (PX4)

He was still in pain and went to the emergency room again on November 28, 2015, where he stated that "standing and walking made his right hip throb for 6 weeks." (RX5, pg. 143) He was diagnosed with atraumatic low back pain with right side sciatica, and was given pain medications, and an orthopedic referral. (PX2; RX5, pg. 145) The petitioner was discharged from therapy for non-compliance December 7, 2015. (RX4, pg. 22)

The petitioner's pain persisted and he then established consistent care with Dr. Michael Taylor at Taylor Rehabilitation and Wellness Center. (PX3) On December 11, 2015, he presented to Dr. Taylor with low back pain radiating down his right leg. He completed a medical history form at Taylor Rehabilitation attributing his symptoms to "various incidents two months ago." (RX8, pg. 6) He elsewhere indicated that he incurred a work-related injury "breaking up a fight" while working on October 5, 2015. (PX3; RX8, pg. 7) Dr. Taylor ordered a lumbar MRI, therapy, and took the petitioner off of work for four weeks. (PX3)

The petitioner underwent the MRI on December 12, 2015, and it revealed a 2mm posterior central herniation at L3-4, a broad based annular bulge with superimposed paracentral protrusion and lateral recess stenosis at L5-S1, impingement on the right traversing S1 nerve foot, and lumbar spondylosis with multilevel disc bulging. (PX3) Dr. Taylor reviewed the MRI and referred the client to Advanced Physical Medicine for pain management. (PX3)

The petitioner presented to Dr. Aleksandr Goldvekht at Advanced Physical Medicine on January 4, 2016. (PX5) He informed Dr. Goldvekht that on October 5, 2015, he was "breaking up a fight" when his "lower back was pulled." (RX7, pg. 8; PX5) Dr. Goldvekht diagnosed him with work-related lumbar disc right radiculitis, and he prescribed pain medications and referred him to an interventional pain management doctor for injections. (PX5) The petitioner followed up with Dr. Scott Glaser, a pain management doctor, who diagnosed work-related lumbar radiculopathy and performed two epidural steroid injections on January 5, 2016, and May 23, 2016. (PX6) The petitioner testified that the injections helped his pain temporarily. (TA 24-26) He was referred back to Dr. Taylor for more therapy. (PX5)

The petitioner presented to Dr. Taylor again on January 15, 2016, where he diagnosed him with work-related lumbar disc displacement at L3-4 and L5-S1, lumbar radiculopathy, and lumbar spasm, and he ordered more therapy and continued his off-work restrictions. (PX3) The petitioner underwent a course of therapy at Taylor Rehabilitation and Wellness from December 15, 2015, through March 18, 2016. (PX3) On March 18, 2016, he had decreased pain complaints and was released from care and returned to full duty work as of March 21, 2016. (PX3)

The petitioner testified that while he was on restrictions and off work with the respondent, he was able to do his work at Aabcor. (TA 27) He testified that he was able to do so because he had the help of an assistant who completed the heavy tasks while he supervised. (TA 55)

The respondent had the petitioner examined under section 12 of the Act by Dr. Bobak Lami on March 2, 2016. RX10) In his history, Dr. Lami noted that the petitioner had two jobs, one as a security guard and a second as a home health provider. He noted a history of breaking up a fight on October 5, 2015, and while running to a second fight, he felt a pop in his lower back. In his records review, Dr. Lami reviewed medical records and an Employer's First Report of Injury dated January 6, 2016, with a work injury of breaking up students fighting on October 5, 2015. Dr. Lami diagnosed the petitioner with subjective low back pain and lumbar spondylosis, which he did not causally relate to the work injury on October 5, 2015. He opined that he did not need any further care and could return to work without restrictions. Dr. Lami completed an addendum report on March 2, 2016, after viewing surveillance footage. The footage showed the petitioner at the doctor's office and getting in a car. Dr. Lami's opinions did not change after viewing the footage.

The respondent called its security manager, Donald Mobley, as a witness. (TA 61) He is the petitioner's supervisor and helped hire and train him as a security guard with the respondent. (TA 62) He testified that all employees, including the petitioner, were given a copy of the Employee Handbook when they began work with the respondent. (TA 68) One of the rules in the handbook requires that physical assaults be reported to the principal. On direct examination, Mr. Mobley denied ever being told about the petitioner's accident or receiving a report about any student fight on October 5, 2015. (TA 69)

On cross-examination, he admitted that he did not remember the date in question. (TA 75-76) He testified that usually he was with the petitioner for only a few minutes per day; but, he could not remember any specifics regarding October 5, 2015. He admitted that he did not witness any fight or witness the petitioner respond to the fight. He further testified that if there was a "false fight," no report would be made and it would not have been brought to his or the principal's attention. (RA 74) Finally, he testified that the petitioner was able to work full duty before October 5, 2015, and he was unable to work following that date for a period of time. (TA 77)

The respondent introduced records from Union Health Services showing that the petitioner received treatment to his back before the injury on October 5, 2015. (RX6) The petitioner admitted that he had prior treatment to his back. (TA 29) He testified that previously he treated conservatively for back spasms, but he never had any MRIs or any recommendations for injections before October 5, 2015. (TA 29-30) He admitted that he initially told his boss that it might have been from a prior injury; but, shortly thereafter he knew that his pain was related to his work injury on October 5, 2015. (TA 28-29)

The petitioner testified that because of his injury he wakes up with stiffness and pain in his back and right leg. (TA 31) He also still experiences right leg spasms if he sits too long without movement.

CONCLUSIONS OF LAW

C. WITH REGARD TO ITEM (C), WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator places great weight on the credibility of the petitioner – the credibility of his testimony, especially in conjunction with the histories that he gave his medical providers. Despite his testimony at trial, those contemporaneous histories three years ago in 2015 are rife with inconsistencies and do not establish that an accident occurred that arose out of and in the course of his employment with the respondent.

The petitioner testified that on October 5, 2015, he went to break up a fight. But, when he arrived, that situation was already handled. He then received another call for a second fight, which turned out to be a false alarm. However, before he could know that, while running up the stairs to this second reported fight, he felt a pop in his back.

Despite his testimony, his first treatment the following day reported no accident history and that his back felt tight for two weeks. (RX6, pg. 20-21) The petitioner admitted at trial that he gave this history. (TA 39-40)

At his next treatment October 21, 2015, at Rush Oak Park Hospital, (RX5; PX5) he denied injury. (RX5, pg. 106) He complained of right low back pain radiating to his buttock and leg for the past two and a half weeks; but, he did say that he had to go up and down stairs several times daily, sometimes two stairs at a time, while working as a security guard. These records contain no mention of a specific October 5, 2105 fight incident toward which the petitioner was running upstairs.

Three days later at Adventist LaGrange Hospital, the petitioner denied specific injury and said that his symptoms had been for the prior month and that he was active and played basketball. He exhibited a normal gait. (TA 41; RX9, pg. 8)

On November 3, 2015, the petitioner told Chiro One that his pain began when he woke up in bed at night October 10, 2015. He denied any accident or work activity. (TA 43; RX3) November 8, 2015, the petitioner gives a history of standing on his feet long periods of time. (TA 46; RX5)

On November 20, 2015, the petitioner told physical therapy (RX4; PX 4) that his pain began one month prior when he "purchased a new vehicle that cause[d] him to be in a more flexed posture." (TA 46-47; RX4, pg. 4) The petitioner also stated that he was working as a security guard at a school and was running towards a fight when he felt a right leg pain and pop in his buttocks.

By December 2015 and January 2016, the petitioner gave the history of breaking up a fight. This is 2-3 months after his alleged accident, and he has multiple denials of accident as well as competing histories and descriptions of both his symptoms and their onset to numerous other providers during this span of several months.

Taking any one of these discrepancies in the petitioner's medical histories by itself might be considered minor. However, taken as a whole together with his testimony at trial, they lead to the conclusion that the petitioner failed to meet his burden of proving by the preponderance or greater weight of the evidence that he sustained an accident arising out of and in the course of his employment with the respondent for which compensation is payable. The Arbitrator finds that the testimony of the petitioner at arbitration is not credible, nor is it consistent with his multiple and diverging histories to his medical providers.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LARRY JACKSON,

Petitioner,

vs. NO: 16 WC 35798

CANTON SCHOOL DISTRICT #66,

20 I W C C 0 5 5 1

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical, temporary total disability (TTD), and vocational rehabilitation, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 modifies the Arbitrator's Decision with respect to the finding of maximum medical improvement (MMI) and the award of vocational rehabilitation. All else is affirmed and adopted.

TTD was placed at issue during the Arbitration hearing. The Petitioner alleged an entitlement to TTD benefits from November 10, 2016 through August 16, 2019, the date of arbitration. The Respondent disputed the issue and claimed Petitioner was entitled to TTD benefits through August 22, 2018 only. After reviewing the record, the Commission finds that Petitioner

has reached MMI for his injuries and, therefore, he is entitled to TTD benefits through August 22, 2018 only.

A claimant is temporarily totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit. *Gallianetti v. Industrial Comm'n,* 315 Ill. App. 3d 721, 732-33, 734 N.E.2d 482, 248 Ill. Dec. 554 (2000). The dispositive inquiry is whether the claimant's condition has stabilized, that is, whether the claimant has reached MMI. *Nascote Industries v. Industrial Comm'n,* 353 Ill. App. 3d 1067, 1072, 820 N.E.2d 570, 289 Ill. Dec. 794 (2004). In determining whether a claimant has reached MMI, a court may consider factors such as a release to return to work, medical testimony or evidence concerning the claimant's injury, the extent of the injury, and, most importantly, whether the injury has stabilized. *Mechanical Devices v. Industrial Comm'n,* 344 Ill. App. 3d 752, 760, 800 N.E.2d 819, 279 Ill. Dec. 531 (2003). Once an injured claimant has reached MMI, the disabling condition has become permanent and he is no longer eligible for TTD benefits. *Nascote Industries,* 353 Ill. App. 3d at 1072.

The Commission find that the Petitioner injuries to the neck, back, left shoulder, left wrist, elbow, left knee, and his traumatic brain injury have since stabilized. As Petitioner is at MMI for those injuries, he is no longer entitled TTD benefits effective August 22, 2018.

The parties deposed Drs. Brent Johnson, Glen Feather, James Williams, Blair Rhode, and Lawrence Li regarding the orthopedic issues and Drs. Maria Karbowska-Jankowska and Robert Fucetola regarding the traumatic brain injury.

Dr. Li performed a Section 12 examination on February 8, 2018 and commented on Petitioner's various orthopedic issues. Regarding the cervical and lumbar spine, Dr. Li noted that Petitioner's subjective complaints did not comport with the objective findings on the cervical and lumbar MRI. He noted that the previous lumbar MRI was the same as the November 2016 MRI and the cervical MRI did not show any acute changes. Based upon his examination, he opined that Petitioner sustained contusion strains of the lumbar and cervical spine that did not cause any acute structural injury or disk herniations. RX.2. pg.18-19. He did not see evidence of any permanent aggravation or acceleration of the underlying cervical and lumbar degenerative conditions. *Id.* He opined that Petitioner was at MMI for his cervical and lumbar spine. RX.2. pg.21-22. He saw no reason to impose any restrictions and noted Petitioner could work full-duty. RX.2. pg.22. Dr. Feather noted that Petitioner was not able to return to work but it was due to his knee pain. PX.17. pg.14. However, on cross-examination, Dr. Feather noted that he was not treating Petitioner's knee and Petitioner was referred to him for the neck and low back. PX.17. pg.17-18.

Dr. Johnson testified regarding Petitioner's left knee injury. Dr. Johnson noted that Petitioner had peripheral neuropathy during his last examination on February 2, 2018. Dr. Johnson did not believe the neuropathy was coming from the knee. PX.19. pg.29-30. He stated there was nothing more he could do for the Petitioner and released him from care. PX.19. pg.30. Dr. Li also testified regarding the left knee and stated that Petitioner was at MMI. RX.2. pg.21-22.

Dr. Williams testified regarding Petitioner's left arm injuries. Dr. Williams released Petitioner from his care on February 16, 2017 and Petitioner was to follow-up as needed. PX.21. pg.18. Petitioner followed-up on July 2, 2018 for increasing pain. Despite this follow-up examination, Dr. Johnson did not restrict Petitioner's work activities. Dr. Li opined that Petitioner was at MMI for his left arm injuries, despite finding the elbow and cubital tunnel not related. RX.2. p.21-22.

Petitioner treated with Dr. Karbowska-Jankowska for his traumatic brain injury and the Respondent obtained a Section 12 examination for the traumatic brain injury from Dr. Fucetola on July 16, 2018. Dr. Fucetola testified that Petitioner was at MMI from a neuropsychological standpoint. RX.3. pg.43. He stated that Petitioner was "from a neuropsychological standpoint, that is from a cognitive intellectual and from an emotional or psychological standpoint, able to return to his…preinjury employment…." RX.3. pg.41-42.

Dr. Karbowska-Jankowska examined Petitioner on August 23, 2017. At that time, she determined that Petitioner was disabled from any occupation for at least one year. PX.20. pg.13. She determined that his condition appeared to be more permanent. *Id.* This, however, was her only visit with the Petitioner. PX.20. pg.17.

The evidence establishes that Petitioner's orthopedic conditions have reached MMI. The various doctors treating the orthopedic issues have either released Petitioner from their care with instructions to follow-up as needed or placed him at MMI. As for the traumatic brain injury, Dr. Fucetola placed Petitioner at MMI and Dr. Karbowska-Jankowska noted that Petitioner was disabled from employment for one year and that his condition was permanent. However, there was no follow-up examination to comment on Petitioner's current condition or his ability to work. Accordingly, the Commission finds Petitioner's traumatic brain injury has stabilized. The Commission, therefore, modifies the decision and awards Petitioner TTD benefits through August 22, 2018 only.

As to causal connection, the Arbitrator placed greater weight upon the opinions of Dr. Karbowska-Jankowska as opposed to Dr. Fucetola regarding the head trauma and greater weight upon the opinions of Petitioner's treating physicians regarding the orthopedic issues. Specifically, the Commission agrees with the weight given to Dr. Karbowska-Jankowska. Dr. Karbowska-Jankowska is board-certified in neurology and specializes in neurology and neuro-rehabilitation. Dr. Karbowska-Jankowska demonstrated a thorough understanding of Petitioner's injuries based upon her review of the medical records and her neurologic evaluation. Her neurologic evaluation revealed that Petitioner had cognitive deficits. It was her opinion that his cognitive deficits were causally related to his head injury. While the Petitioner has reached MMI from his injuries, the Commission affirms the Arbitrator's finding of causal connection regarding the head trauma and orthopedic issues.

A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will

increase his earning capacity." *Greaney v. Industrial Comm'n*, 358 Ill.App.3d 1002, 1019, 832 N.E.2d 331, 347, 295 Ill. Dec. 180 (2005) (citing *National Tea Co. v. Industrial Comm'n*, 97 Ill.2d 424, 432, 454 N.E.2d 672, 676, 73 Ill. Dec. 575 (1983)). Factors favoring vocational rehabilitation include: (1) that the employee's injury caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity, (2) that the employee is likely to lose job security due to his injury, and (3) that the employee is likely to obtain employment upon completion of rehabilitation training. *Amoco Oil Co. v. Industrial Comm'n*, 218 Ill.App.3d 737, 751, 578 N.E.2d 1043, 1052, 161 Ill. Dec. 397 (1991). Additional factors to be considered are the costs and benefits to be derived from the program; the employee's work-life expectancy; his ability and motivation to undertake the program; and his prospects for recovering work capacity through medical rehabilitation or other means. *Id.* at 751, 578 N.E.2d at 1053.

The evidence supports that vocational rehabilitation is not appropriate. Both the Petitioner and Respondent obtained vocational opinions in this matter. Mr. Hammond, Petitioner's vocational expert, testified that Petitioner's "physical issues were going to limit his access to the labor market" and his "cognitive issues after his physical limitations would totally eliminate all work in the general economy." T.22. Mr. Hammond further testified that "while he thinks [vocational rehabilitation] could be done," it would be a "waste of time and money." T.28.

Ms. Bose, Respondent's vocational expert, noted that Petitioner had a "below average IQ with some short-term and attention deficits." RX.4. Ms. Bose was of the opinion that Petitioner would best be placed in employment that was "simple and routine and unskilled in nature." *Id.* She stated that Petitioner would be an appropriate candidate for positions such as "light housekeeping, laundry worker, bench assembler, bench packer or bench sorter" as those positions were "simple and routine and do not involve divided attention, multiple steps or judgement." *Id.*

Having reviewed the evidence, the Commission finds that vocational rehabilitation is not appropriate in this matter. The evidence supports that vocational rehabilitation would not increase Petitioner's earning capacity or increase his likelihood of employment. Therefore, the Commission vacates the award of vocational rehabilitation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $600.23 per week for a period of 93 weeks, November 10, 2016 through August 22, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical services as included in Petitioner's exhibit 23 as provided in Sections 8(a) and 8.1 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 calculation to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $55,821.29 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $55,821.29.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize the treatment recommended by Petitioner's treating physicians including, but not limited to, Drs. Feather, Williams, and Johnson.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for vocational rehabilitation is hereby 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.

No bond is required for the removal of this cause to the Circuit Court pursuant to Section 19(f)(2) as Respondent is a school district. 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.

20 I W C C 0 5 5 1

DATED: SEP 2 1 2020
DDM/tdm
O: 7/21/20
052

D. Douglas McCarthy

Stephen Mathis

DISSENT

I, respectfully, dissent. The Commission without providing any additional analysis as to causation simply adopts the Arbitrator's finding "that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of November 9, 2016." *Arbitration Decision*, p. 49, ¶ 1. Petitioner testified to a multitude of injuries to multiple body parts which he associated to his fall resulting in a significant amount of medical treatment. The Arbitrator's Decision, thusly, the Commission's decision provides a lengthy recitation of Petitioner's medical treatment, 48 pages of a 50-page decision but offers a scant four paragraphs, less than one page, analysis as to the causal relationship between Petitioner's fall and his resulting conditions of ill-being. I find Petitioner proved an accident which caused injury to his 1) cervical spine resulting in a strain, 2) lumbar spine resulting in a strain, 3) left wrist resulting in a strain, 4) and traumatic brain injury (TBI)-resolved. I find Petitioner failed to prove a causal relationship to his 1) kidney condition, 2) bilateral elbow conditions- cubital tunnel syndrome, and 3) left knee- meniscal tear. I find Petitioner reached maximum medical improvement (MMI) as of July 16, 2018 as such temporary total disability benefits are not awardable beyond this date. As Petitioner has reached MMI and has been released to full duty, I find Petitioner is not entitled to vocational rehabilitation and maintenance nor prospective medical care.

Regarding Petitioner's kidney condition, he testified to falling and injuring his neck, nose, both elbows, left wrist, kidney, left knee, and back. T. 59-60. Petitioner testified he suffers from Stage 3 kidney disease which he associates to his fall. T. 79. Petitioner only possess one kidney due a prior donation of his other kidney. *Id.* There is little to no medical evidence regarding kidney treatment and no causation opinion from any medical provider. As such, there is no proof of causal relationship save Petitioner's assertion of the same. I find Petitioner failed to prove a causal relationship between his kidney disease and his accident.

Regarding Petitioner's bilateral cubital tunnel syndrome, Dr. Rhode provided his opinion via evidence deposition. PX18. Dr. Rhode testified Petitioner presented for a second opinion due to complaints of numbness and tingling to his bilateral upper extremities. PX18, p. 6. Dr. Rhode opined "I believe that [Petitioner's] cubital tunnel symptomatology is causally connected to his fall." PX18, p. 12. Dr. Rhode was questioned on cross-examination regarding Petitioner's delay in reporting his symptoms and testified as follows: "We have as per [Petitioner] that when he returned to work, he noticed his left hand was numb and tingly. So relative to the gap and [Petitioner], it was from the fall to return to work. Q. It is your belief he returned to work after

the fall in this case? A. As per the intake, yes." PX18, p. 17. Dr. Rhode's causation opinion is flawed as it is based on a faulty assumption that being Petitioner returned to work. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. I find Petitioner failed to prove a causal relationship between his bilateral cubital tunnel syndrome and his accident.

Regarding Petitioner's left knee, Petitioner first sought treatment from Dr. Johnson on May 10, 2017, almost six months after his fall. Dr. Johnson testified via evidence deposition as to the causal relationship between Petitioner's fall and his torn meniscus and need for surgical intervention. PX19, p. 31. Dr. Johnson testified he last evaluated Petitioner on February 2, 2018 at which time Petitioner complained of pain which Dr. Johnson felt was due to peripheral neuropathy. PX19, 29-30. Dr. Johnson released Petitioner on a P.R.N. basis testifying as follows: "Basically it was because I didn't think these problems were coming from the issue with his knee, and if it was a neuropathy, there would be other providers that could treat him for that." PX19, p. 31. No causation opinion was provided regarding Petitioner's fall and his development of peripheral neuropathy.

In opposition to Dr. Johnson, Dr. Li opined no causal relationship exists between Petitioner's fall and his meniscal tear. RX2, p. 16-17. Dr. Li evaluated Petitioner pursuant to Section 12 of the Act at Respondent's request and provided his opinion via evidence deposition. RX2. Dr. Li based his opinion upon Petitioner's failure to complain of symptoms until five months post-fall as well as the mechanism of injury- a fall as opposed to a twisting component. RX2, p. 13; 16-17.

I afford greater weight to Dr. Li's opinions over those of Dr. Johnson's. Petitioner testified he fell, lost consciousness, and remembered waking up in the hospital. T. 58-59. How Petitioner fell is unknown and speculation to all. What is known is there is a significant gap in Petitioner seeking treatment, and Petitioner's current condition of ill-being, peripheral as testified to by Dr. Johnson is unrelated to his fall and allegedly resulting meniscal tear. I find Petitioner failed to prove a causal relationship between his left knee meniscal tear and peripheral neuropathy and his accident.

Regarding Petitioner's traumatic brain injury (TBI), opposing opinions were offered by Dr. Karbowska-Jankowska and Dr. Fucetola. The Majority affords greater weight to Dr. Karbowska-Jankowska as "[she] demonstrated a thorough understanding of Petitioner injuries based upon her review of the medicals and her neurologic evaluation." *Supra*, p. 3, ¶ 5. I believe such weight is misplaced.

Dr. Karbowska-Jankowska evaluated Petitioner on one occasion, August 23, 2017, nine months following his accident. PX20, p. 7. Dr. Karbowska-Jankowska explained if patients present with continued cognitive problems, they are sent to a neuropsychologist for evaluation which in this case was Dr. Watt. PX20, p. 11. Dr. Karbowska-Jankowska testified she relied on Dr. Watt's findings and that based on these findings, Petitioner was disabled. PX20, p. 13. Moreover, Dr. Karbowska-Jankowska relying solely on Ms. Watt's evaluation found Petitioner's condition permanent. *Id.*

Despite the Majority's finding to the contrary, Dr. Karbowska-Jankowska had no recollection of reviewing the medical records specifically those from Ms. Lane, the nurse practitioner who referred Petitioner to Dr. Karbowska-Jankowska. PX20, p. 24-25. Dr.

Karbowska-Jankowska based her opinion on an assumption Petitioner's condition was not improving simply because of the referral, but she failed to recall any of Petitioner's actual treatment records which indicated progress and improvement. PX20, p. 25-26. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC.

In opposition to the opinions of Dr. Karbowska-Jankowsk are those of Dr. Fucetola. Dr. Fucetola is a neuropsychologist who evaluated Petitioner pursuant to Section 12 of the Act at Respondent's request. Dr. Fucetola evaluated Petitioner on July 16, 2018 which involved an extensive interview as well as administration of 15 standard tests lasting approximately 4.5 hours. RX3, p. 10. Dr. Fucetola explained the testing he provided, like that of Dr. Watt, helps to determine if a patient actually suffers from cognitive impairments. RX3, p. 20-21. As part of the standard testing, validity measurements are included to assess a patient's efforts as "in the sense that once someone fails at least one of the performance validity tests, it calls into question whether they were really trying their best." RX3, p. 22.

Dr. Futecola testified in reviewing the results from Dr. Watt's evaluation, Petitioner failed several parts of the validity testing which means Dr. Watt's opinions are flawed. RX3, p. 24-25. Petitioner passed 2 and failed 3 of the validity tests administered by Dr. Futecola which was consistent with Petitioner's performance on the testing provided by Dr. Watts. RX3, p. 25. Ultimately, given Petitioner's failure of the validity testing, Dr. Futecola opined "[i]t just means that we can't tell whether he has any bona fide or true symptoms of depression because his responses are so exaggerated. It doesn't mean that he's not feeling any pain at all. It just means that it's hard to tell how much, if any, pain he's truly experiencing because he's reporting on such an extreme level." RX3, 36-37.

Dr. Futecola diagnosed a mild TBI due to Petitioner's fall. RX3, p. 39. Dr. Futecola found no evidence of lasting cognitive impairment which he based upon his review of the medical records, Dr. Watt's evaluation as well as his own. RX3, p. 41. Dr. Futecola placed Petitioner at MMI and released him to return to work. RX3, p. 42.

I afford greater weight to the opinions of Dr. Futecola over those of Dr. Karbowska-Jankowsk who predicated her opinion on the results of Dr. Watt's evaluation which as Dr. Futecola persuasively explained are flawed. Moreover, Dr. Futecola provided a thorough explanation of the testing he performed as well as the testing performed by Dr. Watt. Dr. Futecola reviewed Petitioner's prior treatment records and possessed a complete understanding of Petitioner's treatment unlike Dr. Karbowska-Jankowsk.

I find Petitioner proved a causal relationship between his accident of November 9, 2016 and his TBI, cervical/lumbar spine strains, and left wrist strain. Based on the opinions of Dr. Li, Petitioner reached MMI on February 8, 2018 as it relates to his strains and based on Dr. Futecola reached MMI on July 16, 2018 as it relates to his TBI. Both physicians find Petitioner is able to return to work in his pre-injury capacity. As such, I would deny the request for vocational rehabilitation and find temporary total disability benefits are not warranted after July 16, 2018. I would deny the request for prospective medical treatment given Petitioner has reached MMI as well as the fact neither Dr. Johnson nor Dr. Williams has recommended further treatment.

20IWCC0551

For the above state reasons, I dissent.

L. Elizabeth Coppoletti

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

JACKSON, LARRY Case# **16WC035798**
Employee/Petitioner

CANTON SCHOOL DIST #66 **20IWCC0551**
Employer/Respondent

On 10/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2337 INMAN & FITZGIBBONS LTD
DANE KURTH
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

20IWCC0551

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Larry Jackson
Employee/Petitioner

v.

Canton School Dist. #66
Employer/Respondent

Case # **16** WC **35798**

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 **Peoria**, on **August 16, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [x] Other **Vocational Rehabilitation**

FINDINGS

On the date of accident, **November 9, 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$46,818.20**; the average weekly wage was **$900.35**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical treatment.

Respondent is entitled to a credit of **$ALL AMOUNTS PAID** for all benefits paid through group insurance under Section 8(j) of the Act.

Respondent shall be given a credit of **$55,821.29** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$55,821.29.**

ORDER

Respondent shall pay the reasonable and necessary medical services as included in **Petitioner's Exhibit 23** 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 **$600.23/week** for **144 weeks**, for the timeframe of **November 10, 2016 through August 16, 2019,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$55,821.29** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$55,821.29.**

The Arbitrator grants Petitioner's request for vocational rehabilitation services.

Respondent shall authorize the treatment recommended by Petitioner's treating physicians including, but not limited to, Drs. Feather, Williams and Johnson.

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.

20IWCC0551

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Melinda M. Rowe-Sullivan — Signature of Arbitrator

10/14/19 — Date

ICArbDec19(b)

OCT 16 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Larry Jackson Case # **16** WC **35798**
Employee/Petitioner

v. Consolidated cases: **N/A**

Canton School Dist. #66
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At arbitration, Petitioner testified that he was 60 years old and had no minor children. He testified that he began working for Respondent on April 10, 1995. He testified that he worked second shift, mostly doing painting and floor tile work.

When asked about physical issues since the incident, Petitioner testified about problems moving his neck side-to-side, that his nose was injured, that his jaw grinds, and that his shoulder was injured. He testified that he had two operations on his nose and that he has trouble breathing. He testified that his jaw grinds but does not cause pain. He further testified that he injured his elbows and left wrist, as well as his kidney, back, and left knee. He testified that his head often throbs.

Regarding his cognitive abilities, Petitioner testified that he feels everything is slower and he complained of memory issues. He testified that he has is capable of taking care of himself, taking his medications, attending doctor's appointments, and that he does some cleaning of the house. He also testified that he tries to help out with mowing and using the self-propelled mower. He testified that his typical day involves eating breakfast, watching TV, feeding dogs, sweeping floors, sometimes napping, sometimes blowing off the driveway, and watching wildlife on the porch. He testified on direct examination that he tries to help with grocery shopping, but that he goes with his wife to do it.

Petitioner offered some testimony regarding his current medical treatment. He testified that he was still treating with Dr. Feather for pain management, that he was seeing a psychiatrist, and that he was treating with Dr. Johnson for his knee.

Petitioner was asked about his ability to work. He testified that he was not capable of "gainful employment." However, Petitioner acknowledged that he had not applied for any jobs since the injury.

On cross examination, Petitioner was asked questions about his residence and he noted it was relatively new and was located on a hill. He testified that he had to walk down the hill to get the mail. He testified that using the lawn mower hurt his back, so he tries to let his wife use it.

On cross examination, Petitioner testified that there is a Dollar General store nearby and that he does some of the shopping there. He testified that he takes care of three dogs when he is at home. He testified that he sometimes goes to pick up the dog food. He also testified that he had no problems driving to the Dollar General store nearby and that he drove himself to some appointments.

Robert Hammond was called as a witness by Petitioner at the time of arbitration. Mr. Hammond testified that he interviewed Petitioner in early April of 2019. He testified that he obtained background information, work history and education, family life, hobbies, Petitioner's perception of his medical condition and disability. He testified that he prepared the report identified as Petitioner's Exhibit 22.

Mr. Hammond testified that he felt Petitioner might have difficulties getting along with others and working in groups. Regarding Petitioner's employability in the general labor market, Mr. Hammond testified on direct examination that due to his physical issues Petitioner would have limited access to the labor market. He further testified that the combination of Petitioner's physical limitations and cognitive issues would eliminate all work in the general economy.

Mr. Hammond testified that Petitioner's age would be a deterrent to employability. He noted that if Petitioner were to try and search for employment, he would probably be limited to light-duty jobs, lifting less than 20 lbs., limited activity and fine motor movement of the left hand, and limited paperwork. He noted that it would need to be close to the point of one-armed work. He further testified that it would be difficult for Petitioner to learn new tasks based on the neurological reports and likely fine-motor problems.

Mr. Hammond testified that if the court were to determine that vocational rehabilitation was awarded, he would first sit with Petitioner and talk about how to look for work appropriately. He testified that they would discuss interviewing techniques and that he would help Petitioner develop a resume. He testified that he would go with Petitioner to apply for work in-person. He testified that Petitioner would likely need a sheltered workshop to do a true assessment to see the types of low-level activities he could perform, but that he believed it was a waste of time and money.

On cross examination, Mr. Hammond testified that his interview was likely the first or second week of April (*i.e.*, 2019), and that his only meeting with Petitioner was on that date. He acknowledged that most of the medical records that he reviewed were from 2017 and 2018, with the most recent medical report he reviewed being from mid-2018.

Sandra Jackson was called as a witness by Petitioner at the time of arbitration. Mrs. Jackson testified that she had been married to Petitioner for approximately 28 years. She testified that she observed changes in Petitioner since November 9, 2016, including depression, emotional changes, and physical changes.

Mrs. Jackson testified that Petitioner has never used the zero-turn mower because he does not have the coordination. She testified about travel and vacations with Petitioner, including a recent trip to Texas, beginning on April 26, 2019. She testified that they went with her sister and she acknowledged that they were thinking of retiring there in Texas or possibly in Florida.

On cross examination, Ms. Jackson testified that their house is somewhat on a hill. She testified that they had a riding mower with a steering wheel before the zero-turn mower. She testified that since the accident Petitioner might push mow, but that he does not mow the slope. She also testified that they lived close to the Dollar General, but that Petitioner did not do shopping for her during the day. She testified that they had three dogs in the house and that they used large-sized bags of food.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Fulton County Emergency Medical Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Fulton County EMA was dispatched to Canton High School for a 57-year-old male at the bottom of the basement stairs who possibly fell with slurred speech. It was noted that they found Petitioner lying on the concrete basement floor at the bottom of the stairs with Canton PD & Canton FD on scene. It was noted that Petitioner opened his eyes

briefly in response to his name, that he said "bottom stairs" with slurred speech initially, and that he was not following commands so they were unable to assess his hand grasps. (PX2).

The medical records of Progressive Vision Center, Ltd. were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on November 21, 2016, at which time it was noted that he stated that he had had a fall at work on November 9th and received a concussion, that he reported falling down roughly 20 stairs with blunt head trauma to the right side of his head, and that he was in the hospital for approximately one week. It was noted that Petitioner stated that his visual acuity had been more blurred and that his eyes had been red, tired, and sensitive to light ever since. It was noted that Petitioner stated that his visual acuity was not double but seemed to "dance around" at times. The assessment was noted to be that of mild hyperopia, moderate presbyopia, reduced visual acuity without signs of traumatic cataract, and very mild glaucoma suspected, among other issues. It was noted that Petitioner was recommended to increase his reader strength. At the time of the December 1, 2016 visit, it was noted that Petitioner was seen for a history of glaucoma suspicions. It was noted that Petitioner had a history of recent head trauma from a fall. It was noted that Petitioner had a normal visual field for the left eye and that the visual field for the right eye showed abnormal left superior and inferior visual field deficit. It was noted that there was no evidence that glaucoma treatment needed to be initiated. (PX3).

The medical records of Graham Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4.[1] The records reflect that Petitioner was seen on November 29, 2016 for a urinalysis. The diagnosis was noted to be that of hematuria. The records reflect that Petitioner was seen on November 30, 2016, at which time he underwent a CT of the abdomen/pelvis, which was interpreted as revealing (1) no renal or ureteral calculus; (2) prior right nephrectomy; (3) enlarged prostate gland. The Clinical History was noted to be that of a 57-year-old with hematuria, left flank pain, and testicular pain; it was also noted that Petitioner had had back pain since a fall on November 9, 2016, and that he had a history of right nephrectomy. The records reflect that Petitioner was seen on January 27, 2017 for a pre-procedural examination. Petitioner underwent chest x-rays on that date, which were interpreted as revealing no evidence of active disease in the chest. (PX4).

The records of Graham Hospital reflect that Petitioner was seen on February 1, 2017 for a cystoscopy with bilateral retrograde pyelograms. The Operative Note dated February 1, 2017 noted that the pre- and post-operative diagnosis was that of gross hematuria. The records reflect that Petitioner was seen on March 13, 2017 for a speech therapy referral. Included within the records of Graham Hospital was a "Scat 2 Concussion Assessment Adult Comprehensive Exam dated February 22, 2017 by Teresa Lane, APN, CNS, which noted that Petitioner presented for follow-up post-concussion and was accompanied by his two sisters. It was noted that Petitioner brought in a diary of his overall progress and had more positive comments, and that he seemed to be progressing on home activities. It was noted that Petitioner continued to report increased stress related to his work situation and needing to return to work, and that he continued to work with Behavioral Health and physical therapy and reported that he felt that these were helping. It was noted that Petitioner's physical therapy was at Haynes Rehab in Canton for his shoulders and knees and for his concussion syndrome. It was noted that Petitioner noted continued improvement in his writing in his diary and less shakiness, but still had rambling thoughts and ideas noted with writings. It was noted that Petitioner related concerns about Neuropsych testing and not being able to be seen until October, and that they discussed that he was offered an earlier appointment in Bloomington which he refused because of the length of the drive. It was noted that they discussed other options and that Petitioner would be willing to see someone in Galesburg or Springfield since his drivers knew those areas better. It was noted that Petitioner reported that he had a cystoscopy for the blood in his urine and was told that his kidneys and bladder looked good and had not had any further issues, and that he did not report any knee pain. It was

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

noted that Petitioner continued to have pain and crepitus in his left wrist and was wearing a left wrist splint. It was noted that Petitioner's severity score continued to increase from 107 to 110 and that he continued to have all 22 of the 22 concussion symptoms. It was noted that a discussion was had regarding the importance of Neuropsych testing for them to determine the etiology of cognitive dysfunction, which would help them to recommend appropriate treatments for cognitive dysfunction that reflected presumed etiology. The assessment was noted to be that of concussion with loss of consciousness of 30 minutes or less, cognitive and behavioral issues, and acute post-traumatic headache. It was noted that Petitioner was recommended to continue behavioral health counseling, that he was to continue to work with physical therapy, and that he was encouraged to undergo cognitive rehab. It was noted that Petitioner needed to attempt to move his Neuropsych testing up since it was not able to be completed until October. It was also noted that Petitioner needed to follow-up with his primary care physician for his disability, medications, and complaints of continued shoulder, left knee, hip pain, and left wrist pain. (PX4).

The records of Graham Hospital reflect that Petitioner underwent a Scat 3 Concussion Assessment Adult Comprehensive Exam on January 18, 2017 by Teresa Lane, APN, CNS, at which time it was noted that he presented for follow-up post-concussion and was accompanied by his two sisters. It was noted that Petitioner stated that he was working with Behavioral Health and believed that this was helping some. It was noted that Petitioner stated that he continued to notice some improvement in his ability to walk and talk, and that he had been doing more activities at home and had noticed improvement in his writing. It was noted that Petitioner had been keeping a list of his activities and reported that he had cleaned the house, played with the dog, slept better, and was remembering to take his medication for pain every six hours. It was noted that Petitioner reported that he was still having continued lightheadedness, that his eyes were blurry and watery at times, and that he had dizziness. It was noted that Petitioner stated that the front of his head was tingling and that he felt drunk with drinking. It was noted that Petitioner was still having short-term memory issues and forgot to let the dog back into the house and felt really bad and started to cry, and that he then laid down by the dog. It was noted that Petitioner stated that he was having continued issues with recall and memory and recently forgot the current year. It was noted that Petitioner continued to receive therapy at Haynes Rehab in Canton for his shoulder, his knees and for his concussion syndrome. It was noted that Petitioner's severity score increased from the last visit from 19 total symptoms back up to 22, and that his severity score increased from 98 to 107. It was noted that Petitioner reported that he had a lot of continued stress related to his work situation and that it was determined not to be workman's compensation. The assessment was noted to be that of concussion with no loss of consciousness; acute post-traumatic headache; cognitive and behavioral changes. Petitioner was recommended to continue Behavioral Health for counseling and anxiety, and was also to continue to work with physical therapy for neck and post-concussion syndrome. Petitioner was noted to need to follow-up with his primary care physician for his disability, medications, and complaints of continued shoulder, left knee, hip pain, left wrist pain, and blood in his urine which he reported occurred since the fall. It was noted that Petitioner refused to start speech therapy and that he was set up for Neuropsych testing to evaluate for competency post-concussion, return to work, and evaluate for other possible causes or contribution of symptoms. It was noted that a letter was received from Petitioner's wife which reported changes going on for the last few years, that he had had a personality change, that he was unable to keep tasks he used to be able to perform, that he had had a personality change from calm to irritable, that he picked at his fingers until they bled, and that he had increased nervousness, concentration issues, memory deficit, and attention deficits. (PX4).

The records of Graham Hospital reflect that a Speech Therapy Report was issued dated March 13, 2017. It was noted that Petitioner was referred to assess cognitive-linguistic function. It was noted that Petitioner demonstrated deficits in the areas of memory, topic maintenance, and verbal sequencing, and that he would benefit from speech therapy to improve his ability to complete activities of daily living related to cognitive-linguistic functioning in the areas of memory and sequencing. At the time of the March 17, 2017 speech therapy visit, it was noted that Petitioner denied pain. At the time of the May 20, 2017 speech therapy visit, it was noted that Petitioner reported that he had a good weekend and that he denied pain. At

the time of the March 27, 2017 speech therapy visit, it was noted that Petitioner complained of back pain, but exhibited no facial grimacing or guarding. (PX4).

The records of Graham Hospital reflect that Petitioner underwent an MRI of the left knee on March 30, 2017, which was interpreted as revealing (1) small radial tear posterior horn medial meniscus at the root with small joint effusion; (2) Grade III and IV chondromalacia patella. The history noted that Petitioner fell down stairs five months ago and had had anterior left knee pain since with no surgery. (PX4).

The records of Graham Hospital reflect that Petitioner was seen in the emergency room on November 9, 2016, at which time it was noted that he was brought in by ambulance, that EMS reported that he was found at the bottom of the stairs at the high school, and that they stated that he was minimally responsive. It was noted that Petitioner initially was very slurred in his speech and had unequal pupillary response, decreased on the right, and that he was a handyman at the school. It was noted that Petitioner expressed that he was in pain but did not convey exactly where it was, and that he could not explain how he fell or the events leading up to it. It was noted that Petitioner stated that he had no history of seizures or leg weakness, and that his family stated that he had a clear reason for doing so in the past (*i.e.*, tripped over a snow blower). The Clinical Impression was noted to be that of a closed head injury. The History and Admission Physical Examination noted that Petitioner presented to the emergency department after calling 911, that he had an argument with his supervisor and then had been working at the high school painting a pole, and that he remembered feeling dizzy and the next thing he knew he was lying on the ground at the base of the stairs. It was noted that Petitioner did not remember if he was on a ladder or on the stairs, and that he did not remember if he fell. It was noted that Petitioner remembered calling 911 and then telling them he was at the bottom of the stairs. It was noted that upon initial evaluation Petitioner demonstrated garbled speech and altered sensorium, and that he was then brought to the emergency department for further evaluation. It was noted that in the emergency department Petitioner had a CT of his head that did not demonstrate any acute abnormalities, and that he also had a CT of his cervical spine that demonstrated a herniated C6- disc with some effacement of the cord that was new from 2014. It was noted that Petitioner had some labs which were unremarkable, and that overnight he had had slow and steady improvement in his mental status. It was noted that Petitioner's wife stated that he had mostly been sleeping and had not told her what happened. It was noted that Petitioner had mild distress (groans when moves), that he had an abrasion on the top of his head, that had a bruise on his left knee, and that his left ankle demonstrated malleolar tenderness medially, otherwise no tenderness or swelling. It was noted that Petitioner had normal mental status. The assessment was noted to be that of closed head injury. It was noted that there was an unclear initial event (syncope, fall, etc.) and that they would keep Petitioner on telemetry. It was noted that Petitioner's MRI demonstrated no intracranial etiology, leaving the possibility of concussion with resultant altered mental status vs. other. It was also noted that given a possible seizure and post-ictal state, they would proceed with an EEG as well. (PX4).

The records of Graham Hospital reflect that a Discharge Summary was issued dated November 15, 2016, which noted that Petitioner was admitted from the emergency department after he called 911 stating that he was at the bottom of the stairs. It was noted that Petitioner did not remember falling down the stairs or any trauma, and that he was brought in to the emergency department with multiple injuries: contusion to elbow, leg, and head. It was noted that Petitioner's thinking was different than his baseline and that he was subsequently admitted for further work-up. It was noted that while in the hospital Petitioner had multiple images done including an MRI of the head, MRI of the lumbar spine, CT of the head x 2, CT of the cervical spine, and x-rays of the elbow. It was noted that none of the imaging demonstrated any fractures and that Petitioner also had an EEG for work-up of a possible seizure disorder given the alteration in his mental status on admission. It was noted that Petitioner's mental status slowly improved but was not back to his baseline. It was noted that Petitioner had continued pain with movement of his arms, legs, and back, that he had altered thinking and fuzziness of his vision at discharge, and that he would need follow-up with neurology and possibly neurosurgery, as well as IPMR for rehabilitation prior to his return to work. A

Certificate to Return to Work dated November 9, 2016 noted that Petitioner had missed work due to a hospitalization and had been physically unable to work, and that he was not to work until Monday, November 22, 2016 at which point he was cleared for light duty. (PX4).

The records of Graham Hospital reflect that Petitioner underwent an MRI of the lumbar spine on November 14, 2016, which was interpreted as revealing (1) findings suggest transitional L5-S1 level (correlation with thoracolumbar spine plain films to assess number sets of ribs/levels could provide more accurate level determination); there are multilevel degenerative disc changes most apparent at the L2-L3 through L4-L5 levels; (2) asymmetric disc/osteophyte complex noted laterally, on the left at L3-L4 and L4-L5 levels does encroach upon the L3 and L4 dorsal root ganglia (particularly the left L4 dorsal root ganglion); uncertain clinical significance and clinical correlation is requested; (3) scattered foci of T1 shortening within the axial skeleton consistent with osseous hemangiomas (dominant focus at L1); contribution from fatty marrow elements not excluded; (4) diminished marrow signal intensity within the axial skeleton, otherwise which might represent a manifestation of marrow reconversion secondary to anemia/anemia of chronic disease; marrow dyscrasia and lymphoreticular neoplasms cannot be completely excluded, however. Petitioner underwent an MRI of the cervical spine on November 11, 2016, which was interpreted as revealing (1) multilevel mild degenerative disc change/spondylosis as described; diminished disc space height posteriorly and uncovertebral joint osteophyte contribute to mild bilateral C7 foraminal narrowing; there is mild diffuse disc bulge at the C6-7 level which flattens the ventral thecal sac but does not produce cord encroachment; mild multilevel facet arthropathy as noted; (2) there is asymmetric increased T2 signal along the medial aspect of the C0/C1 articulation, on the left; a manifestation of degenerative change or trauma cannot be excluded; there is no definite fracture or malalignment in this region on the recent cervical spine CT scan. (PX4).

The records of Graham Hospital reflect that Petitioner underwent an MRI of the brain on November 10, 2016, which was interpreted as revealing (1) no MR evidence of acute infarct, mass or hemorrhage; normal appearance of the brain for age; (2) mild ethmoid air cell disease without aggressive features. Petitioner underwent x-rays of the left wrist on November 13, 2016, which were interpreted as revealing degenerative changes without acute fracture or dislocation of the left wrist. Petitioner underwent x-rays of the left ankle on November 10, 2016, which were interpreted as revealing no acute fracture, dislocation, or significant soft tissue swelling is noted; there is a high plantar arch. Petitioner underwent x-rays of the lumbar spine on November 9, 2016, which were interpreted as revealing no acute traumatic abnormality is identified; if there is continued concern, CT or MRI could be performed for further evaluation. Petitioner underwent x-rays of the pelvis on November 9, 2016, which were interpreted as revealing no acute traumatic abnormality is identified. Petitioner also underwent a CT of the head on November 12, 2016, which was interpreted as revealing no acute intracranial abnormality; no significant change. The Comparison was noted to be that of November 9, 2016. (PX4).

The records of Graham Hospital reflect that Petitioner underwent a CT of the cervical spine on November 9, 2016, which was interpreted as revealing no acute fracture, subluxation, or soft tissue swelling is noted; there is lower cervical spinal stenosis with a herniated disc causing moderate cord effacement at C7/T1; if there is continued concern, MRI could be performed for further evaluation. Petitioner underwent a CT of the head on November 9, 2016, which was interpreted as revealing no acute intracranial abnormality is noted. The Comparison was noted to be that of October 27, 2014. (PX4).

The records of Graham Hospital reflect that a Progress Note dated November 14, 2016 was issued, which noted that Petitioner stated that he ached all over, that he had pain in his left wrist, that he had emesis last night, and that he had not had a bowel movement and felt full. It was noted that Petitioner also stated that the TV looked small. It was noted that Petitioner continued to have many somatic complaints, that he seemed to be improving, and that he still had left lower extremity weakness. It was noted that they would proceed with an MRI of the lumbar spine. The Progress Note dated November 13, 2016 noted that Petitioner looked better that day, that he was more awake and alert, that he stated that he had a bowel

movement, and that he had no complaints of pain except for the left wrist. The assessment was noted to be that of (1) left wrist pain; (2) closed head injury; concussion; (3) constipation secondary to opiates. The Progress Note dated November 12, 2016 noted that Petitioner complained of generalized achiness and not feeling good, that he had no specific complaints or concerns, that he seemed a little bit listless, and that the light seemed to bother his eyes and had apparently been an ongoing complaint. It was also noted that Petitioner had a mild headache. The assessment was noted to be that of (1) constipation, probably opiate-induced; (2) mental status changes. It was noted that Petitioner still was not quite to baseline, that he was not himself, and that since Dr. Krock had not seem him previously they would go ahead and repeat a CT and labs and continue to monitor. (PX4)

The records of Graham Hospital reflect that a Progress Note dated November 11, 2016 was issued, which noted that Petitioner was angry and frustrated that morning and wanted a regular diet, that he stated that he continued to have pain and weakness, that he had a tingling in his left lower extremity, that he had pain in his left knee and ankle, that he had pain in his right shoulder, and that he had pain in the right side of his neck. It was noted that Petitioner had weakness of his left lower extremity that he stated was worse since his fall and that he stated that the pain medication was helpful, although it did not control his pain. The assessment was noted to be that of (1) closed head injury; (2) weakness of left lower extremity. It was noted that an EEG was pending, that the work-up thus far was negative for etiology, and that it was possible that Petitioner tripped and fell with a closed head injury resulting. It was noted that given a cervical disc bulge on CT, they would proceed with an MRI of Petitioner's cervical spine. The records reflect that Petitioner underwent an EEG on November 11, 2016, which was interpreted as revealing a normal EEG; cannot rule out underlying structure disturbance or the diagnosis of seizure disorder; clinical correlation recommended. (PX4).

The medical records of Graham Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 5.[2] The records reflect that Petitioner was seen on May 8, 2018 by Dr. Shaw, at which time it was noted that he presented with complaints of nasal congestion, globus, throat clearing, heartburn, frontal headaches, incapacitating migraines for 2-3 months, snoring, daytime somnolence, and left jaw pain which increased with wide jaw opening. It was noted that Petitioner's symptoms began in November 2016 after a 20-step fall and that his symptoms were chronic in severity. It was noted that a prior work-up CT scan in November 2016 showed marked left septal deviation but that his sinuses were clear. It was noted that Petitioner had not started the TMJ protocol so his ear pain was still present, and that his migraines persisted. The assessment was noted to be that of (1) nasal septal deviation; (2) nasal turbinate hypertrophy; (3) epistaxis; (4) LPRD (laryngopharyngeal reflux disease); (5) otalgia of left ear; (6) migraine with aura and without status migrainosus, not intractable; (7) rhinogenic headache. It was noted that Petitioner was to see the neurologist in July and that if there was no new therapy he may consider corrective nasal surgery. Petitioner was recommended to return in six weeks after his neurology appointment. (PX5).

The records of Graham Medical Group reflect that a Telephone Encounter dated April 24, 2018 was issued, which noted that INI was going to send Petitioner to Dr. Jankowsca to be seen. At the time of the April 10, 2018 visit with Dr. Shaw, it was noted that Petitioner was seen at the referral of Dr. Phillips for snoring and nasal congestion. It was noted that Petitioner presented with complaints of nasal congestion, globus, throat clearing, heartburn, frontal headaches, incapacitating migraines for 2-3 months, snoring, daytime somnolence, and left jaw pain which increased with wide jaw opening. It was noted that Petitioner's symptoms began November 2016 after a 20-step fall and that his symptoms were chronic in severity. It was noted that Petitioner also complained of occasional left nose bleeds. The assessment was noted to be that of (1) nasal septal deviation; (2) nasal turbinate hypertrophy; (3) epistaxis; (4) LPRD; (5) otalgia of left ear; (6) migraine with aura without status migrainosus, not intractable; (7) rhinogenic

[2] Any highlighting or handwritten entries that appear in the exhibit were not made by the Arbitrator.

headache. Petitioner was referred to INI neurology for post-traumatic headaches. It was noted that Petitioner was to start a nasal protocol. Petitioner also underwent a fiberoptic nasopharyngoscopy/laryngoscopy, which noted that all areas appeared within normal limits except interarytenoid edema and erythema; as to the nasal endoscopy, it was noted that all areas appeared within normal limits except left septal deviation, +1-2 "inf turbs," mid meatii patent, and adenoids not enlarged. (PX5).

The records of Graham Medical Group reflect that a Telephone Encounter was issued dated April 5, 2018, which noted that Petitioner called and stated that he was having pain in the one kidney he had left and was wanting a referral to his kidney specialist, Dr. Horinke. Petitioner was recommended to undergo a renal ultrasound with bladder views. At the time of the March 21, 2018 visit with Dr. Feather, it was noted that Petitioner was seen in follow-up of his neck pain, lower back, left leg, and head pain. It was noted that Petitioner's pain was a 7-8/10. It was noted that Petitioner was still considering the medical cannabis program and was also considering a spinal cord stimulator by INI. The assessment was noted to be that of (1) intractable chronic migraine without aura and without status migrainosus; (2) spondylosis of lumbar region without myelopathy or radiculopathy; (3) radiculopathy due to lumbar intervertebral disc disorder; (4) traumatic brain injury, with loss of consciousness of 30 minutes or less, sequela. Petitioner was given a refill of Norco. It was noted that when Petitioner finally decided to fill out his medical cannabis form, he would let Dr. Feather know and they would send in their portion. It was noted that if Petitioner went with the spinal cord stimulator with INI, Dr. Feather would allow them to manage the stimulator but that Petitioner did not really have a qualifying diagnosis to have the stimulator approved. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen on March 9, 2018 by Dr. Phillips, at which time it was noted that he could not breathe through his nose and was not sleeping, that he stated that he had chest pain that came and went, that he had the shakes, that he had nightmares and never felt rested, and that he had sinusitis. It was noted that Petitioner had been seen many times in the last few months with no previous mention of chest pain, that given the number of things that he listed every time that he came in Dr. Phillips found it hard to believe that he did not mention this previously, and that given the seriousness of the complaints he would work it up with an EKG and stress testing. It was noted that Petitioner came in with a list of approximately 15 items and that the first of which was chest pain that he stated he had been having since November, and that the pain was 8/10 and was worse with exertion. It was noted that upon further questioning Petitioner could not put a number to the pain as he stated that he could not differentiate that pain from the rest of his pain including headaches, neck pain, back pain, left wrist pain, and bilateral knee pain. It was noted that Petitioner also stated that he had been sleeping poorly, that he snored and did not feel well rested when he awoke, and that he felt like he tossed and turned throughout the night. It was noted that Petitioner also felt like he could not breathe through his nose, that he stated that he was always congested, and that when he blew his nose it was usually bloody. Petitioner was recommended to proceed with a sleep study in the hospital and was referred to Dr. Shaw (ENT) for epistaxis and nasal congestion. (PX5).

The records of Graham Medical Group reflect that a Telephone Encounter was issued dated February 22, 2018, which noted that Petitioner wanted a referral to Teresa Lane at INI for his TMJ and tremors, and that he also wanted a referral to Gayon High Performance Chiropractor for back pain. At the time of the February 15, 2018 visit with Dr. Phillips, it was noted that Petitioner was seen for tremors. It was noted that Petitioner felt like his left hand and left foot were shaking more than usual, and that he had a physician that he would like to see named Teresa Lane at INI. It was also noted that Petitioner had had discomfort in his left jaw with chewing and opening, and that he stated that he was seeing a back surgeon who wanted him referred to a physical therapist for a formal evaluation of his physical activity levels. The assessment was noted to be that of (1) major depressive disorder with single episode, remission status unspecified; (2) other chronic pain; (3) gross hematuria; (4) essential (primary) hypertension; (5) solitary kidney, acquired; (6) constipation; (7) other intervertebral disc degeneration, lumbar region; (8) spondylosis

of lumbar region without myelopathy or radiculopathy; (9) radiculopathy due to lumbar intervertebral disc disorder; (10) traumatic brain injury, with loss of consciousness of 30 minutes or less, sequela; (11) dry eye; (12) hearing loss; (13) tinnitus; (14) arthritis; (15) post-concussion syndrome; (16) nightmares; (17) intractable chronic migraine without aura and without status migrainosus; (18) cubital tunnel syndrome; (19) tremor; (20) TMJ arthritis. It was noted that as to the major depressive disorder diagnosis, this problem continued and was related to Petitioner's fall and subsequent head injury. As to the other chronic pain diagnosis, it was noted that Petitioner had ongoing chronic pain that may or may not be related to his workers' compensation injury. It was noted that as to the hematuria diagnosis, Petitioner had had hematuria after his fall and had seen urology, and that he was no longer having hematuria. As to the essential hypertension diagnosis, it was noted that this was an ongoing problem that was unrelated to Petitioner's workers' compensation injury. As to the solitary kidney diagnosis, it was noted that Petitioner donated his kidney which was not related to his workers' compensation injury. It was noted that as to the constipation diagnosis, this issue had not been brought up for some time and that Dr. Phillips believed that it was resolved. As to the intervertebral disc degeneration diagnosis, it was noted that this was an ongoing issue for which Petitioner was seen by Dr. Feather and Dr. Kube, as well as chiropractic care. As to the spondylosis diagnosis, it was noted that this was a chronic issue for which Petitioner was seeing Drs. Feather and Kube and that he was given a referral to physical therapy per Dr. Kube. As to the radiculopathy diagnosis, it was noted that this was a chronic issue for which Petitioner was seeing Drs. Feather and Kube. As to the traumatic brain injury diagnosis, it was noted that this was due to Petitioner's fall, that he had been seeing physical therapy, mental health, and neurology at INI, and that he had had lengthy neuropsych testing after which the neurologist told him he was unable to work likely permanently. As to the dry eye diagnosis, it was noted that this was unlikely to be related to Petitioner's workers' compensation injury. As to the hearing loss diagnosis, it was noted that it seemed to be resolved and was unlikely to be related to Petitioner's workers' compensation injury. As to the tinnitus diagnosis, it was noted that it seemed to be resolved and was unlikely to be related to Petitioner's workers' compensation injury. As to the arthritis diagnosis, it was noted that it was chronic and possibly worsened by Petitioner's fall/injury. As to the post-concussion syndrome diagnosis, it was noted that it was likely related to Petitioner's fall/injury, and that he had seen neurology and should consider continuing to see them once a year. As to the cubital tunnel syndrome diagnosis, it was noted that this issue was resolved and unlikely to be due to Petitioner's fall. As to the tremor diagnosis, it was noted that it was mild and likely due to anxiousness, that it was a new issue, and that it was unrelated to Petitioner's workers' compensation injury. As to the TMJ arthritis diagnosis, it was noted that this was a new issue and was unrelated to Petitioner's workers' compensation injury. It was noted that Petitioner was advised that he could see a dentist for further evaluation should he wish to do so, and that otherwise he was to take NSAIDs as needed. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on February 15, 2018, at which time it was noted that he was seen for a medication check. It was noted that Petitioner had pain in the neck, low back, and legs that was 7-8/10. It was noted that Petitioner suffered from post-concussion syndrome, that he had intractable migraines and traumatic brain injury, and that he also suffered from degenerative disk disease, spondylosis, and periodic radiculopathy. It was noted that there was not really much interventionally that could help Petitioner, that physical therapy had been limited, that they had been trying to manage his medications so that he did not increase the dosage, and that he had been maintaining Norco. It was noted that Petitioner had been to see the neurosurgeon who felt that no surgical intervention was available, that he had been to psychiatry because of his cognitive problems and that they had talked to him about nutritionists, that he had been evaluated by neurology and several others and nothing seemed to help, and that every medication and injection had failed him. It was noted that Petitioner still wanted to be made pain-free and that he felt that it was all related to the fall, and that Dr. Feather had reviewed Petitioner's MRI and that there was no evidence of fracture, no evidence of disc herniation, that on his lumbar spine he had a significant degree of degenerative disk disease including vacuum disc, and that he had spondylosis and osteophyte formation. The assessment was noted to be that of (1) long-term current use of opiate analgesic; (2) post-concussion syndrome; (3) intractable chronic migraine without aura

and without status migrainosus; (4) other intervertebral disc degeneration, lumbar region; (5) spondylosis of lumbar region without myelopathy or radiculopathy; (6) radiculopathy due to lumbar intervertebral disc disorder; (7) traumatic brain injury, with loss of consciousness of 30 minutes or less, sequela. It was noted that a long discussion was had with Petitioner, that Dr. Feather really could not do much for him, that he had tried medial branch blocks on that side and that Petitioner said that it did not give him any benefit, and that they had tried other injections with no benefit and that physical therapy had not helped. It was noted that Dr. Feather's concern with medication was that they could further deteriorate Petitioner's cognitive ability. It was noted that Petitioner wanted to see a nutritionist, so they would make a referral. It was noted that Dr. Feather's other suggestion to Petitioner was to consider medical cannabis. It was noted that Dr. Feather believed that Petitioner had an exacerbation of his back with the fall, but that he could not specifically tell him that the back was a result of the fall. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on January 17, 2018, at which time it was noted that he was there to follow-up post-injection. It was noted that Petitioner still had low back pain but was also complaining of some [blank]. It was noted that Petitioner essentially got no benefit from the medial branch blocks and that he had had no relief from other injections in his back. The assessment was noted to be that of (1) other intervertebral disc degeneration, lumbar region; (2) spondylosis of lumbar region without myelopathy or radiculopathy; (3) radiculopathy due to lumbar intervertebral disc disorder. It was noted that Petitioner admitted that he ran out of his medications early and that he took some of his wife's medications, which made her run out early. It was noted that Dr. Feather was not going to perform any further injections and that he was going to send Petitioner to Dr. Fassett for evaluation to see if surgery may be an option. At the time of the November 16, 2017 visit with Dr. Bailey, it was noted that Petitioner was seen for suture removal. It was noted that Petitioner was one-week post-op excision of two warts on the top of his left hand. Petitioner was recommended to return as needed. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on November 16, 2017, at which time it was noted that he was still having pain in his neck and back. It was noted that Petitioner reported that his back pain was such that he was wanting to get it treated, that he had already had his three injections in his knee, and that his knee was stable and now he wanted to work on the back. It was noted that Petitioner had spondylitic changes causing pain, predominantly on the left side. The assessment was noted to be that of (1) spondylosis of lumbar region without myelopathy or radiculopathy; (2) other intervertebral disc degeneration, lumbar region; (3) radiculopathy due to lumbar intervertebral disc disorder. It was noted that Petitioner was to be set up for dorsal medial branch block left L3, L4 and L5 x 2, and that in follow-up afterwards they would determine whether to proceed with radiofrequency lesioning. At the time of the November 9, 2017 visit with Dr. Bailey, it was noted that Petitioner was seen at the referral of Dr. Phillips for a lesion on his hand. It was noted that Petitioner had a history of a fall last year with multiple injuries and that he presented for evaluation of a left hand lesion. It was noted that Petitioner wore a brace on the hand and believed that the rubbing made it worse and also uncomfortable, and that he thought the lesion was a wart and was concerned about how deep the "roots" went. It was noted that Petitioner had several other lesions on the ipsilateral hand that were scratches in various states of healing except for lesion on his fifth metacarpal head which was thickened and irregularly-shaped, and that this lesion was asymptomatic but had also grown in the last year. The assessment was noted to be that of a skin lesion of the hand. It was noted that Petitioner's wart was excised and that the second lesion was biopsied, and that they would await final pathology before excising it. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on October 26, 2017, at which time it was noted that he was seen for a re-check of the sore on his left hand. It was noted that the lesion had increased in size and was rubbing on his brace for his wrist. The assessment was noted to be that of (1) skin lesion; (2) cubital tunnel syndrome. Petitioner was referred to Dr. Bailey in general surgery. It was noted that as to the cubital tunnel syndrome diagnosis, the EMG was positive on

the left and that Petitioner was to be referred to orthopedics. At the time of the October 19, 2017 visit with Dr. Feather, it was noted that Petitioner was seen for a medication refill. It was noted that Petitioner had pain in the neck, shoulder, low back and mostly into the left leg, and left wrist. It was noted that Petitioner had been set up for cervical and lumbar physical therapy on the last visit, and that he had had viscosupplementation put in his left knee the day before. It was noted that Petitioner had been to physical therapy and had gotten improvement in range of motion and function of the neck that had been successful. It was noted that Petitioner's back had helped maintained stability and that his pain level had not increased. It was noted that Petitioner had gotten an injection in the knee and had been working on that. It was noted that once Petitioner got the knee back into shape, then they hoped to be able to work some with the back in terms of injections. It was noted that Petitioner did get an EMG nerve conduction velocity study by Dr. Russo, but that Dr. Feather did not have the results available yet. The assessment was noted to be that of (1) traumatic brain injury, with loss of consciousness of 30 minutes or less; (2) other intervertebral disc degeneration, lumbar region; (3) spondylosis of lumbar region without myelopathy or radiculopathy; (4) radiculopathy due to lumbar intervertebral disc disorder. Petitioner's Norco was refilled and he was recommended to return in one month. Petitioner's physical therapy was also renewed. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on October 5, 2017, at which time it was noted that he was seen for return to work paperwork and that he stated that he had a sore on his left hand that he had had for months and would not go away. It was noted that Petitioner stated that he was not ready to return to work, and that he stated that his neurologist had set him up for Social Security because of his post-concussion syndrome. It was noted that Petitioner was seeing orthopedics on Friday and was not sure if he would be cleared for work from that perspective or not. It was noted that Petitioner still had pain when he knelt down and was unable to kneel or stand for a significant amount of time. It was noted that Petitioner continued to see counseling for his depression. It was also noted that Petitioner would like to return to work but did not feel as if he could at that point, and that he did not believe that he would ever be able to work again. The assessment was noted to be that of (1) post-concussion syndrome; (2) knee pain; (3) depression. It was noted that Petitioner was slowly improving, that he was much better than he was last year, and that they would obtain documentation from neurology in regard to their thoughts on his long-term prognosis. Petitioner was to continue to follow-up with orthopedics and counseling. At the time of the September 21, 2017 visit with Dr. Feather, it was noted that Petitioner was seen for follow-up in his neck, low back, and right leg pain. It was noted that Petitioner had some degenerative disk disease and spondylosis causing back pain and occasionally leg pain, but that he also had a history of traumatic brain injury with post-concussion syndrome and frequent migraines. Petitioner's Norco was refilled. It was noted that Petitioner was to be set up for physical therapy for cervical and lumbar with myofascial release. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on August 8, 2017, at which time it was noted that he was seen for re-evaluation of left wrist pain. It was noted that Petitioner had been wearing a brace and had seen orthopedic surgery, as well as having had an MRI earlier in 2017. It was noted that Petitioner's orthopedic surgeon had recommended possible fusion which he was not ready to proceed with and that he wanted a second opinion. It was noted that Petitioner also had intermittent loose stools followed by constipation. The assessment was noted to be that of wrist pain. Petitioner was given a referral for a second opinion with Dr. Anane-Sefah. Petitioner was recommended to return in three months. At the time of the June 12, 2017 visit with Dr. Phillips, it was noted that Petitioner was having pain from his knee surgery on May 23rd. It was noted that Petitioner's left knee pain started on May 23, 2017, that he had had surgery and then had a fall with strain and possible hyperextension of his left knee, and that after that the knee became more swollen and painful. It was noted that Petitioner then followed-up with his surgeon and that he was given pain medication which he stated did not work. It was noted that Petitioner was angry and wanted an MRI, and that had discussed with him that they had arranged for him to have an office visit with his surgeon later that week. The assessment was noted to be that of knee pain. Petitioner was given pain medication. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on June 1, 2017, at which time he was seen for a medication refill. It was noted that Petitioner was reporting pain in the neck, right hip/groin area, left knee, wrist, top of the head, and left toes. It was noted that the day before Petitioner twisted the knee that he had the surgery on and now was having more pain, but had not contacted the surgeon to discuss it. It was noted that Petitioner wanted physical therapy, that physical therapy felt that he was making great progress but now had maybe had a setback, and that he went to a chiropractor to manipulate his back because he had back pain now as well. The assessment was noted to be that of (1) intractable chronic migraine without aura and without status migrainosus; (2) post concussion syndrome; (3) traumatic brain injury, with loss of consciousness of 30 minutes or less, sequela; (4) other intervertebral disc degeneration, lumbar region; (5) spondylosis of lumbar region without myelopathy or radiculopathy; (6) radiculopathy due to lumbar intervertebral disc disorder. Petitioner's Norco was refilled and he was recommended to return in one month. It was noted that Petitioner needed to contact the surgeon about the knee, and that Dr. Feather did not think that further injections were indicated until his knee was better and until everything settled down. Petitioner underwent pre-operative clearance by Dr. Phillips on May 16, 2017. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on May 3, 2017, at which time it was noted that he was seen at the referral of Dr. Phillips for neck pain and right hand tingling and numbness. It was noted that Petitioner had a cervical MRI from November 11, 2016, that he had multilevel degenerative disk changes, spondylosis as described, mild bilateral C7 foraminal narrowing, and a diffuse disk bulge at C6-C7. It was noted that Dr. Feather initially saw Petitioner on February 23, 2017 as a referral by Dr. Fassett, that he had fallen down some stairs at work, that he had pain at the top of the head all the way to his feet, that it went down into the left leg, across the low back and involved the left arm, and that it was a 7-8/10 at the time with a lateral disk osteophyte complex with facet arthropathy L3-L4. It was noted that at the time of that visit there was indication for traumatic brain injury and that Petitioner was being worked up by neurology, that he had apparently suffered a second concussion exacerbating the condition, and that he was currently taking Norco. It was noted that Petitioner was seen by neurology and by neuropsychology, and that they had indicated that he had at least mild traumatic brain injury pattern, that he was reporting that his worst headache was the frontal and occipital headache that he got, and that it was almost daily nearly 30 days out of the month, lasting all day but that he was able to sleep. It was noted that Petitioner had nausea but no vomiting, and that he had no photophobia or phonophobia. The assessment was noted to be that of intractable chronic migraine without aura and without status migrainosus. Petitioner was given a prescription for Topiramate and Fioricet. It was noted that Dr. Feather thought that a lot of Petitioner's issue was myofascial causing him to have chronic pain with the headache and that he thought Botox would be a reasonable option for him, but that until he had failed certain medications or classes of medications they could not get Botox approved. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on April 26, 2017, at which time it was noted that he was seen in follow-up for burning eyes, headaches, left knee popping, chronic neck pain, and vomiting. It was noted that Petitioner had had headaches since November 9th, that his left knee made a popping noise and that he wanted to see Midwest Orthopaedics, that he wanted to discuss a chiropractor for his neck, and that he was vomiting almost every day. The assessment was noted to be that of (1) eye irritation; (2) constipation; (3) dry eye; (4) radiculopathy due to lumbar intervertebral disc disorder; (5) vomiting; (6) headache; (7) depression; (8) dyspepsia; (9) knee pain. Petitioner was referred to ophthalmology and was also referred to Dr. Feather for chronic neck pain. At the time of the March 23, 2017 visit with Dr. Phillips, it was noted that Petitioner was there for a discussion regarding an MRI. It was noted that Petitioner stated that he had had pain in his left knee since November of 2016 after his accident at work, that he had had an x-ray that did not demonstrate any significant abnormalities, and that prior to his fall at work he stated he had not had any pain in his left knee. It was noted that Petitioner's left knee was giving out and that he fell down getting out of bed. It was noted that Petitioner also listed multiple other symptoms from his notebook, including right nose bleeding that was

intermittent and nothing that lasted very long; nightmares that he stated that he had not had before but would now wake up with them at times; being fatigued and feeling more tired; left ankle tingling that radiated down his left leg from his back; and feeling anxious when he drove by the high school where he fell. The assessment was noted to be that of (1) knee pain; (2) nightmares; (3) epistaxis. Petitioner was recommended to undergo an MRI of his left knee. It was noted that he had a benign exam that day, but that Petitioner stated that the pain was significant and that it was giving way causing falls. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on March 15, 2017, at which time it was noted that he presented with left knee pain, that his knee felt like it was going to give way when going up stairs, that he had no injuries that he was aware of, that he had been hurting since his incident in September, that he had not been previously x-rayed, and that he had a clicking sound that had developed recently. It was noted that Petitioner also complained of right arm spasms, that his left foot was falling asleep, that his eyes were burning and sensitive to light, that his ears were ringing, that he had left hand weakness with grip, that he had depression, and that he had post-concussive syndrome and was seeing neurology. The assessment was noted to be that of (1) dry eye; (2) hearing loss; (3) tinnitus; (4) arthritis; (5) post-concussion syndrome; (6) knee pain; (7) neck pain; (8) back pain. Petitioner was given a referral for hearing loss in the right ear worse than the left. Petitioner was ordered to undergo x-rays of his left knee. Petitioner was also recommended to continue with Dr. Feather for his neck and back pain. It was noted that Petitioner could do simple tasks that did not involve the use of his left wrist or bending of the left knee, that he had been cleared to drive a vehicle by neurology, and that he would continue to be limited with his cognition due to his head injury for 1-3 more months or possibly permanently. It was noted that Petitioner had made significant improvement thus far, and that Dr. Phillips hoped that he returned to normal. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Feather on February 23, 2017, at which time it was noted that he was referred by Dr. Fassett for neck pain since November 9, 2016. It was noted that Petitioner stated that he fell down some stairs at work, that he now had pain from the top of his head all the way to his feet, that it went down the left leg, that it was across the low back and involved the left arm, and that he also reported that his left foot was numb and tingly. It was noted that Petitioner had headaches that were fairly persistent and that he had a loss of consciousness for what he thought was 19 minutes. It was noted that Petitioner had injury to the wrist such that the orthopedic surgeon felt that there was really not much left ligamentous-wise for the wrist to do anything, and that he suggested the possibility of a fusion because he had to wear a wrist brace. It was noted that Petitioner's neck was painful, and that with certain ranges he had limited extension as well as turning the head and tilting the head. It was noted that it gave Petitioner neck pain but that there was no numbness, tingling, or weakness currently in the upper extremities related specifically to the motion in the neck. It was noted that Petitioner's headaches were circumferential. It was noted that as to the low back it was across the back, radiated into the left buttock, posterior thigh, came around the thigh over the knee, and down to the inside of the foot. It was noted that Petitioner had a history of back injury and possible concussion in 2014. The assessment was noted to be that of (1) other intervertebral disc degeneration, lumbar region; (2) spondylosis of lumbar region without myelopathy or radiculopathy; (3) radiculopathy due to lumbar intervertebral disc disorder; (4) traumatic brain injury, with loss of consciousness of 30 minutes or less, sequela. It was noted that Petitioner had a trauma from a fall and that he had a previous injury which did include a concussion and back injury, but that he reported that he was fully back to duty with no restriction by 2014 timeframe. It was noted that Petitioner had since fallen on November 9, 2016 with 19-minute loss of consciousness, that it took a week for recovery, and that he continued to have symptoms of concussion and possible traumatic brain injury, and that his further work-up was going to be performed by the neurologist. It was noted that as to Petitioner's low back, he either had the problem related to the L4 nerve root as it traversed 3-4 before exiting out of 4-5 or as it exited out 4-5, and that they could consider an epidural steroid injection at the L3-L4 level left of midline and then possible transforaminal epidural steroid injection for the L3 and the L4 neural foramen in the future. Petitioner was to get a TENS unit because had tried that in physical therapy

and it seemed to help. It was noted that Petitioner had a new injury that in essence was a second concussion and an exacerbation of a pre-existing condition. It was noted that a fall of that type certainly would cause injury to the back and that there were no acute traumatic changes on the MRI. It was noted that Petitioner had chronic changes, but given the mechanism clearly this was going to cause an acute exacerbation of Petitioner's condition. It was noted that Petitioner had fully recovered based on his own report and was back to full duty before this accident occurred, and that now he was unable to return back to full duty. It was also noted that Petitioner reported this was primarily due to the work not allowing him to have any decreased work load or light duty status. It was noted that given the head injury Petitioner certainly could not operate any kind of machinery or vehicles, and that he should not be allowed to sign any type of legal documents because he had memory issues now and certainly cognitive ability, and that reflexes were going to be subdued. It was noted that as to Petitioner's wrist, Dr. Feather did not think using any type of viscosupplementation was really going to do anything for the wrist and that he did not really want to fuse it at this time. It was noted that Petitioner should consider PRP for the wrist. (PX5).

The records of Graham Medical Group reflect that a Telephone Encounter was issued dated February 20, 2017, at which time it was noted that Petitioner wanted a referral to Dr. O'Leary at Midwest Orthopaedics for his neck and back pain. At the time of the January 27, 2017 visit with Dr. Phillips, it was noted that Petitioner was seen for pre-operative clearance. It was noted that Petitioner continued to have multiple other somatic complaints including left-sided posterior neck discomfort, left thumb pain, bilateral lower back discomfort, right knee pain, and intermittent headache and difficulty thinking. At the time of the January 4, 2017 visit with Dr. Richier, it was noted that Petitioner was seen at the referral of Dr. Phillips for gross hematuria. It was noted that Petitioner stated that his urine was not as dark as it was, that he stated that he had left kidney pains, that he had some double voiding, and that he had testicular pain that was now left-sided. The assessment was noted to be that of (1) gross hematuria; (2) pre-operative testing; (3) screening PSA. Petitioner was recommended to undergo a bladder scan. A Telephone Encounter note dated December 1, 2016 was issued, which noted that Petitioner called and said that he was to go back to work that day but did not because he was seeing Dr. Williams and Progressive Vision Center, and that he needed to see urology as well as another appointment. It was noted that Petitioner stated that he needed to have a note that day and that he said "Tina Strode" told him that he could not go back to work on light duty. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Phillips on November 29, 2016, at which time it was noted that he had noticed blood in his urine at home a few days back, and that it possibly started while he was in the hospital. It was noted that Petitioner felt like his left side was hurting on the posterior and lateral aspect, and that he stated that the pain was a 9-10/10 and constant. It was noted that the pain had been constant from the hospital on, that it did not hurt before the hospital, and that when he took pain medication the pain improved to a 4-5/10. It was noted that Petitioner had chronic pain in his left wrist which worsened after his fall, that he stated that he had a wrist brace and injections in the past which helped his discomfort, and that as for his concussion he had seen neurology. The assessment was noted to be that of (1) hematuria; (2) CVA tenderness; (3) history of nephrolithiasis; (4) head injury, sequela; (5) pain in left wrist; (6) other chronic pain. Petitioner was recommended to continue Norco and was referred to Dr. Williams for his left wrist. At the time of the November 17, 2016 visit with Dr. Phillips, it was noted that Petitioner was seen for a 2-day hospital recheck. It was noted that since getting out of the hospital Petitioner had continued weakness in his left lower extremity, headaches, photophobia, difficulty remembering and concentrating, emotional lability, diffuse myalgias, left wrist pain, neck pain, sweaty palms, tingling, loss of taste, and blurry vision, and that most of these were unchanged from the hospitalization. The assessment was noted to be that of (1) transient weakness of left lower extremity; (2) concussion, with loss of consciousness of unspecified duration; (3) fall, subsequent encounter; (4) others. Petitioner was referred to Dr. Fassett for left lower extremity weakness, physical medicine and rehabilitation for work conditioning/hardening, and Dr. Nersesyan in neurology for his concussion. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Shaw on October 18, 2018, at which time he returned noting that his nasal symptoms had persisted. The assessment was noted to be that of (1) nasal septal deviation; (2) nasal turbinate hypertrophy. It was noted that a discussion was had regarding surgery and post-operative care. It was noted that a discussion was had that they could not say whether the surgery would help with headaches as there were many other factors that may be causing the headaches. It was noted that Petitioner was to undergo septoplasty and turbinate surgery. At the time of the November 27, 2018 visit with Dr. Shaw, it was noted that Petitioner was seen one day post-op follow-up of septoplasty. It was noted that since surgery Petitioner was doing well without complaints. Petitioner was to continue nasal post-op protocol. At the time of the December 4, 2018 visit with Dr. Shaw, it was noted that since surgery Petitioner was doing well without complaints. Petitioner was recommended to continue Mucinex. It was noted that a nasal endoscopic debridement was performed. At the time of the December 12, 2018 visit with Dr. Shaw, it was noted that since surgery Petitioner was breathing well on the right side, but felt some restriction on the left. It was noted that Petitioner initially denied symptoms post-operatively including headaches, but last week had a left frontal headache for hours. The assessment was noted to be that of (1) nasal septal deviation; (2) nasal turbinate hypertrophy; (3) rhinogenic headache; (4) nasal valve collapse. It was noted that Petitioner's persistent headache was likely not rhinogenic in etiology. Petitioner was to start nasal springs. It was noted that a nasal endoscopy was performed. (PX5).

The records of Graham Medical Group reflect that Petitioner was seen by Dr. Shaw on January 4, 2019, at which time it was noted that his nasal valve collapse bilaterally improved with modified Cottle and that a nasal endoscopy was performed. Included within the records of Graham Medical Group was a letter dated February 21, 2017 from OSF Behavioral Health Adult Outpatient Program which noted that Petitioner had been attending bi-weekly individual therapy sessions since January 5, 2017 and that his treatment was focused on managing his diagnoses of depressive disorder due to another medical condition with major depressive-like episode, major neurocognitive disorder, and adjustment disorder with mixed anxiety and depressed mood. Included within the records of Graham Medical Group was a letter from Illinois Neurological Institute dated February 22, 2017, which noted that Petitioner had been diagnosed with a concussion and was currently under their care. Also included within the records of Graham Medical Group was an undated letter from Hanes Physical Therapy, Ltd, which noted that Petitioner had been receiving physical therapy since November 29, 2016. It was noted that Petitioner presented originally after a fall down stairs at his work on November 9, 2016, which had a subsequent hospitalization treating several injuries sustained in the fall. It was noted that given the nature of Petitioner's significant medical complications, both physically and cognitively, he had been receiving extensive therapy in order to address all of these issues. It was noted that Petitioner had definitely made progress with several of his physical insults, including improved neck mobility, decreased intensity of his low back pain and radiating leg pain, and improved core and extremity strength. It was noted that despite Petitioner's progress in these areas, he continued to have some physical deficits that were limiting what he could do and that these included consistent left wrist pain, moderate left knee pain with loaded flexion, and persistent general malaise and fatigue, with or without activity. It was noted that from the onset of care Petitioner had been cognitively "foggy" in processing information and task requirements slowly, slow and low-tone speech with noted difficulty with word finding, and noted abnormality in reaction to light (he always wears sunglasses to combat the issue). (PX5).

Included within the records of Graham Medical Group was an interpretive report for x-rays of the left knee performed on March 15, 2017, which were interpreted as revealing no acute radiographic abnormality of the left knee. The records reflect that Petitioner underwent an MRI of the left wrist on January 20, 2017, which was interpreted as revealing osteoarthritis; no internal derangement identified. The records reflect that Petitioner underwent a neuropsychology consult on March 2, 2017 by Lisa Watt, PhD. The diagnostic impressions were noted to be that of (1) focal cognitive deficits primarily in verbal and visual learning and recall and executive systems functioning in a patient with traumatic brain injury; (2) major depressive disorder, contributing to #1; (3) generalized anxiety disorder, contributing to #1. It

was noted that a review of Petitioner's psychotropic medication was suggested given that his current regiment did not appear to be providing sufficient mood support. It was noted that it was suggested that Petitioner would benefit from counseling related to adjustment to illness, that there did not appear to be a contra-indication to driving a motor vehicle, and that based on significant deficits in short-term learning and recall of verbal and visual information and executive systems functioning, he would be unlikely to maintain competitive employment and as such was a suitable candidate for Disability Benefits. (PX5).

Included within the records of Graham Medical Group was a "Scat 3 Concussion Assessment Adult Comprehensive Exam" dated November 28, 2016 as prepared by Teresa Lane, APN, CNS, which noted that Petitioner presented for follow-up post-concussion and was accompanied by his two sisters. It was noted that Petitioner stated that he was at work on November 9, 2016 and must have tripped over a box and fell down steps, that he stated that he was able to call out after the fall but reported that he had amnesia surrounding the event, and that he stated that he worked second shift and was walking down a hallway and there were a couple of boxes which he believed he tripped over and fell down the bottom of the steps. It was noted that Petitioner stated that he was unsure of the amount of time that he was "knocked out" but had positive loss of consciousness because the fall was unwitnessed and the loss of consciousness. It was noted that Petitioner reported that he had kidney pain and had blood in his urine and only had one kidney because he donated a kidney to a friend; that he reported that had sharp pain on the left side of his flank area; that he had pain in the left wrist so he had been taping it; that he had left shoulder pain; and that he had seen his primary care physician but that his primary care physician did not do any worker's compensation, so he was there for further evaluation and treatment. It was noted that Petitioner reported that he continued to have increased headache and pressure in his head, changes in concentration, memory issues, and balance issues. It was noted that Petitioner reported that he had recently returned to work and felt his new supervisor had "been trying to fire him," and that he had increased anxiety and felt his stress level now and prior to the fall were related to his return to work and pressure from his new supervisor. The assessment was noted to be that of concussion with loss of consciousness of 30 minutes or less, and acute post-traumatic headache, not intractable. It was noted that Petitioner was to be set up with cognitive rehab with speech therapy and physical therapy for post-concussion syndrome, convergence insufficiency, dizziness, diplopia, cervicalgia, and balance problems. (PX5).

Included within the records of Graham Medical Group was an Admission Assessment dated January 5, 2017, which noted that Petitioner reported that he had suffered head injuries several times in the last few years, including a fall with a concussion at work in November 2016, as well as a fall in 2014 and a car accident. It was noted that Petitioner indicated having brain traumas that had impacted his functioning including memory issues, reading trouble, and confusion, and that he reported that his boss and managers at work were emotionally abusive to him (after his injuries), and that he believed that they were trying to make him quit to avoid paying him after his injuries. It was noted that Petitioner reported that he had an untarnished work record for many years and that when the new bosses came on in summer 2016 they told him he was not good at what he did and made fun of him. It was noted that Petitioner's wife wrote a note stating that she had seen him decline from a happy, easygoing man to a depressed and nervous person in the last few years (post-injuries). It was noted that Petitioner reported being easily irritated, fearful, anxious, tense, and nervous especially when thinking about his work situation and how he would be able to provide for his family, and that he indicated his blood pressure rising, being short-winded, and chest pains occurring when dealing with his boss and superintendent. The diagnoses were noted to be that of depressive disorder due to another medical condition with major depressive-like episode; major neurocognitive disorder; adjustment disorder with mixed anxiety and depressed mood. It was noted that Petitioner was recommended to undergo outpatient counseling. (PX5).

Included within the records of Graham Medical Group was a letter dated December 1, 2016, which noted that Petitioner was medically evaluated by Dr. Phillips, and that his absence was medically advised and was due to illness or injury. It was noted that Petitioner should be excused from work for the dates of

December 1, 2016 through December 15, 2016, and that he could return to work on December 16, 2016 with light duty (desk work, clerical, secretarial work). Included within the records of Graham Medical Group was a letter dated November 17, 2016, which noted that Petitioner was medically evaluated on November 9, 2016 by Dr. Phillips and that his absence was medically advised and was due to illness or injury. It was noted that Petitioner should be excused from work for the dates of November 9, 2016 on, and that he could return to work on December 1, 2016 with restrictions including no lifting greater than 10 pounds, no walking greater than 50 feet, no use of the left wrist/arm, no working more than 8 hours at a time, and no prolonged exposure to bright lights. (PX5).

The medical records of Hanes Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. At the time of the January 23, 2017 visit, it was noted that Petitioner stated that he was doing okay and that he further stated that it was hard not to get discouraged and that his emotions had definitely been more erratic. It was also noted that Petitioner stated that he felt a bit of improvement in his back and left knee. At the time of the January 25, 2017 visit, it was noted that Petitioner stated that he tried to sweep out his garage the day before and that it really flared up his left wrist. At the time of the January 27, 2017 visit, it was noted that Petitioner reported that he continued to struggle with his emotions and his memory. It was also noted that Petitioner's core strength and stability were improving as was his balance, and that he was still having significant complaints of memory and emotional distress. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on January 30, 2017, at which time it was noted that he stated that he had been pretty depressed for the last day or so, but that he was hopeful that the session would help him to feel better. At the time of the February 3, 2017 visit, it was noted that Petitioner stated that he was feeling about the same and that he stated that the therapy continued to help him physically. At the time of the February 6, 2017 visit, it was noted that Petitioner stated that he had been depressed lately, that he was feeling like the school district was against him, and that it was just causing him to be distressed. At the time of the February 8, 2017 visit, it was noted that Petitioner stated that he continued to feel like he was strengthening physically. It was also noted that Petitioner continued to have consistent complaints of cognitive shortcomings. At the time of the February 10, 2017 visit, it was noted that Petitioner stated that he continued to look forward to the sessions because he felt better as a result. At the time of the February 13, 2017 visit, it was noted that Petitioner stated that he was doing about the same, and that he stated that he was pretty depressed by the way things were playing out. It was also noted that Petitioner just did not feel like the people in the school district were treating him well through this process. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on February 15, 2017, at which time it was noted that he stated that things were about the same and that he stated that he felt stronger in many ways, but that in general he did not have much energy. At the time of the February 17, 2017 visit, it was noted that Petitioner stated that his head was pretty "foggy" for some reason that day. At the time of the February 20, 2017 visit, it was noted that Petitioner stated that he was doing about the same and that the cortisone shot he was given in his left wrist did not seem to help, just made him sore in the area where it was injected. It was noted that Petitioner continued to have the same issues with processing and memory, which he felt just fed into his anxiety about everything that was going on. At the time of the February 22, 2017 visit, it was noted that Petitioner reported that he was going to the neurologist and had a list of things that he wanted to talk to him about. At the time of the February 24, 2017 visit, it was noted that Petitioner stated that he was feeling better in the back and not having much pain to speak of there on that date. At the time of the February 27, 2017 visit, it was noted that Petitioner stated that his symptoms in his back continued to be better and that he stated that the left wrist was still problematic, but better since he had an injection. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on March 1, 2017, at which time it was noted that he stated that he felt that he continued to get stronger and have lesser pain musculoskeletally, and that he stated that he was going for his neuropsychology assessment that

week and was curious how that would go because he continued to "not feel right in his head." At the time of the March 6, 2017 visit, it was noted that Petitioner stated that his back had been feeling better and that his neurological screening last week really made him feel "dumb." At the time of the March 8, 2017 visit, it was noted that Petitioner reported that he was feeling pretty good that day, and that he stated that he felt like the therapy was doing a lot for him in regard to his strength and musculoskeletal pain. It was noted that Petitioner stated that he was nervous about the outcome of his neurological screening. It was also noted that Petitioner did well with the session and continued to have excellent rehab potential. At the time of the March 10, 2017 visit, it was noted that Petitioner stated that although he had made progress he did not feel that he was at his best level of recovery, and that he needed to continue. It was noted that Petitioner stated that he desired heavily to return to work but that he was not in shape physically or mentally to do so at that point, and that he stated that he just could not give up on it at that point. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on March 13, 2017, at which time it was noted that he reported that he had started in speech therapy for some cognitive training and that he had an upcoming hearing where a judge would decide something regarding his work comp case. It was noted that Petitioner stated that he was anxious about how that would go. At the time of the March 15, 2017 visit, it was noted that Petitioner had no new complaints and continued to convey desires to get strong and be stable enough to return to work. At the time of the March 17, 2017 visit, it was noted that Petitioner stated that he received the results of his neurological screening and was not sure how to read them, and that he stated that he had to get to where he could get back to work. At the time of the March 20, 2017 visit, it was noted that Petitioner stated that he was doing okay, that he had his memory therapy that morning with the speech pathologist, and that he felt like she had some good tricks to help him out. At the time of the March 22, 2017 visit, it was noted that Petitioner stated that he kept trying to increase the resistance and difficulty to his activity because he desired to build back up to returning to work. It was also noted that Petitioner continued to report some complex symptoms both physically and mentally, and that he did state that he felt his physical condition was improving steadily in the areas that were a concern including his neck, low back, left knee, and left wrist. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on March 24, 2017, at which time it was noted that he stated that he fell onto his knees pretty hard at home and jolted his back pretty good, and that he stated that he hoped that he did not "screw anything up." At the time of the March 27, 2017 visit, it was noted that Petitioner stated that his back was still sore but better than last time, and that he stated that most of the pain was on the left side of the lumbar spine. At the time of the March 30, 2017 visit, it was noted that Petitioner stated that he went to the neurologist yesterday, that she said that his balance was improving, and that he should keep at what he was doing. At the time of the April 3, 2017 visit, it was noted that Petitioner stated that he was feeling a bit stronger all the time and that he was to see Dr. Fassett that week for a follow-up. At the time of the April 5, 2017 visit, it was noted that Petitioner brought in the results from the MRI on his left knee which showed a meniscus tear in the medial posterior horn, and that he wondered if that was why he continued to have some pain in the left knee, particularly with squatting or stairs. The Discharge Summary dated April 7, 2017 noted that Petitioner stated that he did not really think that he had reached his maximum potential at this point, but that he understood a discharge to see how he would do on his own. It was noted that Petitioner did make progress in therapy, but continued to have some lingering symptoms in his left knee, low back, and left wrist. It was also noted that Petitioner was going to have injections in his back and get a consultation on his left knee in the near future, and that they would discontinue therapy to see how he managed on his own for a while and until the other things were addressed. (PX6).

The records of Hanes Physical Therapy reflect that a Plan of Care was issued dated November 29, 2016, at which time it was noted that Petitioner presented to physical therapy with weakness, low back pain, radiating pain in the left lower extremity, left wrist pain, cervical pain, impaired vision, and poor balance with an onset date of November 9, 2016. It was noted that Petitioner reported complaints of global

pain and weakness and significantly-affected function. It was noted that Petitioner appeared to be in a "fog" and was able to communicate, but admittedly was just not quite right. At the time of the December 2, 2016 visit, it was noted that Petitioner reported that he was pretty "foggy" and sore. At the time of the December 6, 2016 visit, it was noted that Petitioner reported that he was pretty stressed with all that was going on and that he stated that he looked forward to the therapy session because he felt like it helped him to loosen up. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that he had continued to be a little foggy but that he looked forward to coming in because he felt better when they were done. It was noted that Petitioner remained pretty stiff and guarded at the onset of treatment, but was loosening up well as the treatment went on. It was also noted that Petitioner continued to have excellent rehab potential. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on December 13, 2016, at which time it was noted that he stated that he continued to look forward to coming in to therapy because he felt that it was helping. At the time of the December 15, 2016 visit, it was noted that Petitioner stated that he was about the same and that he was still frustrated with his memory. At the time of the December 19, 2016 visit, it was noted that Petitioner stated that he continued to get frustrated with some of his word recall and "fogginess," and that was still having significant pain in his back like knives slashing sideways, but that he had been getting relief from his therapy sessions. At the time of the December 21, 2016 visit, it was noted that Petitioner stated that he liked coming in because he felt like it improved his blood flow and helped him feel better. It was also noted that Petitioner stated that he struggled with still being "foggy." At the time of the December 23, 2016 visit, it was noted that Petitioner stated that he was still very sore, but felt like his back and knee might be improving slightly. It was also noted that Petitioner stated that his head and his left wrist continued to be pretty bad. At the time of the December 30, 2016 visit, it was noted that Petitioner reported that his symptoms remained pretty similar. (PX6).

The records of Hanes Physical Therapy reflect that Petitioner underwent physical therapy on January 4, 2017, at which time it was noted that he stated that he just could not seem to shake the forgetfulness and that the left wrist was still very sore. It was noted that Petitioner stated that the back and left knee did not seem quite as bad. It was also noted that Petitioner was wearing sunglasses on that date because he stated that the lights were a bit hard on him. At the time of the January 6, 2017 visit, it was noted that Petitioner stated that his back and left knee pain were continuing to ease up a bit, but that he stated that he continued to have significant pain and reduced strength of the left wrist and that his neck/head issues were still significant. It was also noted that Petitioner was continuing to wear sunglasses during the sessions because of the light bothering his eyes. At the time of the January 9, 2017 visit, it was noted that Petitioner stated that his head and neck felt about the same, that he stated that he got some relief in the neck for the day of therapy but then it stiffened back up, and that as for his cognition he stated that his wife was still noticing that he was not himself. At the time of the January 11, 2017 visit, it was noted that Petitioner stated that he had a little more stiffness in his upper back/low neck (upper trapezius) the last day or so, and that for some reason he was very irritable/agitated yesterday which he stated was not like him. At the time of the January 13, 2017 visit, it was noted that Petitioner reported that he was about the same and that the doctor was going to do an MRI on his left wrist/hand. It was also noted that Petitioner felt like the range of motion was good, but that the pain he continued to have was concerning. At the time of the January 16, 2017 visit, it was noted that Petitioner stated that he was feeling like his physiological symptoms were improving and that he was getting a bit stronger, but that he continued to worry about the clarity of his thoughts and memory. (PX6).

Various medical records of Illinois Regional Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent a lumbar epidural steroid injection on April 11, 2017 for a chief complaint of chronic low back and left leg pain. The pre-operative and post-operative diagnosis was noted to be that of (1) lumbar disc displacement; (2) radiculopathy. At the time of the April 25, 2017 visit, it was noted that Petitioner stated that he had great

pain relief for the first 24 hours and then the pain came back. It was noted that Petitioner stated that he may have gotten about 10% pain relief from the epidural and that he was currently using Hydrocodone for pain control. Petitioner was recommended to repeat the L3-L4 lumbar epidural steroid injection. At the time of the May 12, 2017 visit, Petitioner was seen for therapeutic injection #2 in a series. (PX7).

The medical records of Klinedinst Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on May 4, 2017, at which time it was noted that he was seen for a chief complaint of cervical discomfort which he rated an 8/10 and was noticeable approximately 100% of the time. It was noted that the onset of pain was sudden and was first noticed November 9, 2016, that since the complaint began the symptoms had generally been worse, that he complained that he had moderate decreased range of motion in his cervical and mid-thoracic area, and that he had additional complaints of headache, mid-thoracic, and lumbar tightness and tenderness. It was also noted that Petitioner also had pain in his left knee, that he began hurting after falling down some concrete steps at work, and that he was knocked out and was taken to the hospital by ambulance. Petitioner was instructed to begin a walking program. It was noted that Petitioner would need to follow-up for eight visits. (PX8).

The records of Klinedinst Chiropractic reflect that Petitioner was seen on May 9, 2017, at which time it was noted that he had felt the same since the last visit. At the time of the May 16, 2017 visit, it was noted that Petitioner had felt the same since the last visit. It was noted that Petitioner was wearing a brace on his left wrist, that he reported that he got a shot from Dr. Feather in his lower back, and that he stated that he had a reaction to the shot. It was noted also that Petitioner was getting migraines at times, that he stated that he felt a little more flexibility in his neck, and that he was having left knee surgery on the 24th for a meniscus tear. At the time of the June 1, 2017 visit, it was noted that Petitioner had felt poor since the last visit. It was also noted that Petitioner stated that his lower back was hurting more since he had been walking on crutches following his knee surgery, and that his knee was doing pretty well until yesterday when he twisted it. At the time of the June 8, 2017 visit, it was noted that although Petitioner continued to show improvement he still had pain and weakness in his cervical region(s). At the time of the June 13, 2017 visit, it was noted that Petitioner was feeling some pain into his left buttock and that he thought it may be related to walking with the crutches. (PX8).

The records of Klinedinst Chiropractic reflect that Petitioner was seen on June 20, 2017, at which time it was noted that he stated that he had been diagnosed with a fracture in the left knee and that he stated that he was supposed to stay in bed for four weeks. At the time of the June 28, 2017 visit, it was noted that Petitioner had felt better since the last visit. It was also noted that Petitioner stated that doing his exercises before bed seemed to help him. At the time of the July 19, 2017 visit, it was noted that Petitioner stated that he had six more weeks on crutches. At the time of the July 26, 2017 visit, it was noted that Petitioner had felt worse since the last visit and that he had increased pain. At the time of the August 2, 2017 visit, it was noted that Petitioner stated that he had not been able to sleep very well lately because of all his pain. At the time of the August 8, 2017 visit, it was noted that Petitioner stated that he had been doing his exercises and was able to turn his head a little better to the right. At the time of the August 16, 2017 visit, it was noted that Petitioner stated that he woke up with a "nasty" headache that morning. At the time of the August 31, 2017 visit, it was noted that Petitioner was no longer using his crutches, and that he was going to be starting another round of physical therapy and was to go back to the knee specialist on October 6th. At the time of the August 23, 2017 visit, it was noted that Petitioner stated that he was to see Dr. Johnson for his knee on August 25th and that he was not sleeping well. (PX8).

The medical records of UnityPoint Proctor were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent surgery by Dr. Johnson on May 23, 2017, which was that of (1) left knee arthroscopy, partial medial meniscectomy; (2) chondroplasty of patella trochlea for a pre-operative diagnosis of left knee medial meniscus tear and a post-operative diagnosis of left knee medial meniscus tear with grade III/IV chondrosis of patella and trochlea. (PX9).

The Interpretive Report for an EMG at Illinois Neurological Institute dated October 16, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that the chief complaint was that of bilateral upper extremity paresthesias, some degree of pain, weakness, and clumsiness over the last several months duration, and that Petitioner related a history of sustaining a fall with multiple injuries including some injuries to his head and neck, left upper extremity, left lower extremity including a fracture of his knee, and residual complaints of numbness and tingling involving predominantly the ulnar distribution of both hands and a lesser extent the hands more diffusely. It was noted that Petitioner complained of decreased grip and clumsiness in both hands, that he additionally had some complaints of headache, neck pain, and some pain at times radiating down the entire left upper extremity. It was noted that Petitioner did have electrodiagnostic studies performed at IPMR in 2014 which documented the presence of mild left carpal tunnel syndrome and mild left cubital tunnel syndrome. The impression was noted to be that of (1) electroneuromyographic findings compatible with bilateral ulnar neuropathy at the elbow; left ulnar nerve function appears similar to somewhat improved when compared to the study of 2014; there are no comparison studies for the right upper extremity; (2) normal electromyographic findings of left median nerve; right median nerve shows mild abnormalities consistent with median neuropathy at the wrist; this may well represent residuals from previous carpal tunnel syndrome and surgery; less likely it represents a recurrence; no previous values for comparison with the right median nerve; (3) studies otherwise within normal limits with no evidence of cervical radiculopathy, brachial plexopathy, or other focal or generalized neuropathy at this time. (PX10).

The medical records of OSF Multi Specialty Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 11.[3] The records reflect that Petitioner was seen for an Initial Psychiatric Evaluation on May 8, 2017, at which time it was noted that he was referred by his provider at INI Neurology for stress, PTSD, anxiety, and depression. It was noted that Petitioner reported that all the symptoms started after his accident on November 9, 2017 [*sic*] where he fell down 20 stairs at work and suffered a concussion with loss of consciousness. It was noted that Petitioner suffered from chronic pain in his head, neck, and back, that he saw a neuropsych on March 2, 2017 because he had issues with memory and recall, and that he was sad most of the day every day, had not gained or lost weight in the last month, slept around four hours at night and woke up 2-3 times per night. It was noted that Petitioner reported that he had problems going to sleep, that he did not feel worthless or guilty, that he had fatigue during the day, that he had a decreased interest in hobbies, and that he had no thoughts of harming himself or others. It was noted that Petitioner did have anxiety he reported about going to doctor's appointments and suffered from panic attacks two times daily, that he had anxiety and panic attacks about his accident, and that he reported he got anxious when walking down stairs and when he drove by the school where the accident happened. It was noted that Petitioner reported that he had nightmares about every night of him falling down stairs and then waking up in the hospital, that he reported that he had flashbacks about the accident, and that he did not feel that he had inflated self-esteem, felt people were worthless and guilty, and that he did have an increase in goal-directed activities that he did not complete and that he got agitated and irritable but did not act out. It was noted that Petitioner had problems concentrating, got easily distracted, and had problems focusing. It was also noted that Petitioner felt like the superintendent of the high school that he worked at followed him at times to spy on him because he was trying to get workman's compensation. The assessment was noted to be that of moderate episode of recurrent major depressive disorder, generalized anxiety disorder, panic disorder, psychophysiological insomnia, and PTSD. Petitioner was recommended to undergo blood work and to increase his Celexa. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on June 5, 2017, at which time it was noted that he shared that on May 23rd he had meniscus surgery on his left knee, that he had been having increased pain, and that his pain medications were not helping. It was noted that Petitioner's sleep was not good because of his knee pain and that he reported that he was up every two hours because of the

[3] Any handwriting or highlighting that appears in the exhibit was not made by the Arbitrator.

pain. It was noted that Petitioner reported that Trazadone did not help since starting it, and that he was still dealing with workman's compensation and his lawyer to figure it out. It was also noted that Petitioner was still having depression and anxiety. The assessment was noted to be that of (1) psychophysiological insomnia; (2) moderate episode of recurrent major depressive disorder; (3) generalized anxiety disorder; (4) panic disorder; (5) PTSD. Petitioner was recommended to stop taking Celexa and to start Zoloft, as well as to increase the Trazadone. Petitioner was also informed to call his doctor if his pain medications were not helping. At the time of the July 26, 2017 visit, it was noted that Petitioner shared that he had still been on crutches because on June 12, 2017 he fractured his tibia and had been on no weightbearing since June 7th. It was noted that Petitioner reported that he should be off his crutches in a couple of weeks and that since having to stay in bed and not do anything, his anxiety and depression had worsened. It was noted that Petitioner had been having nightmares 1-4 times per week, that he had not been sleeping well because of his back pain, and that he had been waking up every hour. It was noted that Petitioner recently applied for disability and should get a check next week, and that his appetite had decreased and that he felt that he needed to see a dietician. It was noted that Petitioner had been getting irritated and having difficulty concentrating and focusing, that he had been having diarrhea and stomach pains, and that he reported that he did not take his pain medications with food. It was noted that Petitioner had been having increased stress and that the worker's compensation case had not ended yet, and that the next hearing was in August. The assessment was noted to be that of (1) moderate episode of recurrent major depressive disorder; (2) generalized anxiety disorder; (3) panic disorder; (4) PTSD; (5) psychophysiological insomnia. Petitioner was recommended to increase the Trazadone and Zoloft, and to call his primary care physician about a dietary referral. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on August 25, 2017, at which time it was noted that he shared that he recently received his first worker's comp check so he was happy about this, that he had applied for disability, and that he was continuing going to the chiropractor, physical therapist, and counselor. It was noted that Petitioner's depression, panic attacks, and anxiety were "a little bit better," that his nightmares did not last as long, and that he did not wake up sweating as bad. It was noted that Petitioner's sleep was not good, that he reported that he was up every two hours because of his back pain, and that his left knee was getting stronger. The assessment was noted to be that of (1) moderate episode of recurrent major depressive disorder; (2) panic disorder; (3) PTSD; (4) psychophysiological insomnia; (5) generalized anxiety disorder. Petitioner was recommended to increase the Trazadone and to continue Zoloft. At the time of the October 6, 2017 visit, it was noted that Petitioner shared that he had been having increased stress because worker's comp was not paying his medical bills, that his sleep was still "the same," and that he was awakened by back and knee pain. It was noted that Petitioner did feel depressed at times and got anxious and had a panic attack whenever he passed the school where he used to work at and got hurt. It was noted that Petitioner avoided driving by that school and that he was getting tired of going to so many doctor's appointments. The assessment was noted to be that of (1) moderate episode of recurrent major depressive disorder; (2) generalized anxiety disorder; (3) panic disorder; (4) PTSD; (5) psychophysiological insomnia. Petitioner was recommended to continue his medications as ordered. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on November 30, 2017, at which time it was noted that he was still depressed and still had trouble sleeping, that he was seeing "Liz" for counseling every two weeks at OSF and reported it was going well, and that he woke up roughly every two hours because of his pain. It was noted that Petitioner had been having increased left knee pain and was going to go for more testing soon, and that at times he felt very overwhelmed keeping up with appointments and therapy. The assessment was noted to be that of (1) adjustment disorder with mixed anxiety and depressed mood; (2) panic disorder; (3) PTSD; (4) psychophysiological insomnia. Petitioner was recommended to increase the Zoloft and to continue Trazadone. At the time of the December 28, 2017 visit, it was noted that Petitioner had not noticed a difference since the Zoloft was increased and that he did report that there was a problem at the pharmacy so he did not have his Zoloft for 1.5 weeks. It was noted

that Petitioner's symptoms worsened, that he got more agitated and "shaky," and that reported the Zoloft was helping. It was noted that Petitioner's sleep was not good, that he woke up 2-3 times per night due to pain, and that he did sleep during the day taking 1-2 naps a day. It was also noted that Petitioner's anxiety was the same. The assessment was noted to be that of (1) generalized anxiety disorder; (2) panic disorder; (3) PTSD; (4) adjustment disorder with mixed anxiety and depressed mood; (5) psychophysiological insomnia. Petitioner was recommended to continue his medications as ordered. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on February 28, 2018, at which time he was seen for a follow-up visit. It was noted that Petitioner was to continue on the same medications. It was noted that education was given for Petitioner to not take naps during the day. It was also noted that Petitioner's wife helped him with his medications. At the time of the March 1, 2018 visit, it was noted that Petitioner came in with a briefcase and that he had many papers out. It was noted that Petitioner was very hard to follow, that she tried to explain to him that they were psychiatry, and that everything was medical. It was noted that Petitioner shared that his doctor would not treat him, that he had been to other specialists, that since it was a worker's compensation case no one would treat him, and that he did not sleep well. It was noted that Petitioner was going to find a new primary care physician for him and his wife, and that his wife was not comfortable there either. It was noted that Petitioner's mood was more said due to the situation, that he listed about every medical problem and that as soon as she could get him back on track, he went into more medical problems and she could not keep track of all of them. It was noted that Petitioner stated that he could not walk more than a block because his hip to his knee hurt, and that he had many head problems, ringing in his ear, jaw pain, nose pain, problems of carpal tunnel syndrome, cubital tunnel syndrome, tremors in his hands and feet, and kidney problems. It was noted that Petitioner carried a big calendar, that he pulled out multiple papers trying to read what other doctors had said, and that he shared his wife was a good support for him and helped keep him organized. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on May 16, 2018, at which time it was noted that he was very depressed when he came in. It was noted that Petitioner shared that he kept messing up. It was noted that Petitioner shared that he only slept 42% of the time, that he was upset with himself somewhat that day because he forgot his cellphone, and that he forgot how to get there as the phone had directions. It was noted that Petitioner stated that his mood was sad, that he talked a lot about church, that he talked about the Bible, and that he used to be able to quote Bible verses but since his accident it was very hard for him. It was noted that Petitioner stated that the worst thing was that sometimes he felt like his body emotionally and physically was shutting down, and that this was why he needed to keep active. Petitioner was recommended to continue his medications of Cymbalta and Trazodone, and was to discontinue the Zoloft. At the time of the August 8, 2018 visit, it was noted that Petitioner came in an hour late for his appointment. It was noted that Dr. Blume was not sure if Petitioner was having fine tremors from the head injury or from Trazodone and Zoloft together. It was noted that Petitioner had a sleep study and reported that he slept 42.6%. It was noted that Petitioner had some blurred vision and did not want to lose his driver's license. It was noted that Petitioner was not using his eyedrops as directed. It was also noted that Petitioner stated that the migraines he was having were only lasting about two days instead of three days, that he shared that his therapist thought they may be psychological as they only happened on the weekends when his wife wanted to do things, and that he had a hard time being around people since his accident. It was noted that Petitioner shared that his nightmares were better and that he still woke up sometimes shaking, but that they were not as bad as they used to be and not as often. It was noted that Petitioner shared that he vomited a lot and that he had seen his primary care physician about it. It was also noted that Petitioner's hands had fine tremors, as did his right foot. Petitioner's medications were adjusted. (PX11).

The records of OSF Multi Specialty Group reflect that Petitioner was seen on September 18, 2018, at which time it was noted that he was seen for a medication check. It was noted that Petitioner shared that his primary care physician "fired" him, that he said he was not taking worker's comp anymore, and that he

was somewhat upset. It was noted that Petitioner was having memory problems, that he had to write down everything he did, and that he hoped that his next primary care physician would address this and start him on the appropriate medications. It was noted that when asked about his mood, Petitioner said that his mind would not let him do anything but worry. It was noted that Petitioner stated that he saw big circles every once in a while and that it scared him because they were not supposed to be there floating through the air. It was noted that Petitioner seemed open to some of the suggestions made about his sleep and that he needed to find a new primary care physician as soon as possible. It was noted that Petitioner needed more therapy due to his obsessive thinking. It was also noted that Petitioner was asked not to pick up his worker's comp briefcase paperwork for two days. At the time of the December 18, 2018 visit, it was noted that Petitioner shared that it had been somewhat rough, that he had a hard time with direction, and that he had a map that he used to get there. It was noted that Petitioner was invited to go to Christmas and that he said he always had good intentions and then just could not leave the house. It was noted that Petitioner shared that since his nose surgery his tremors had gotten worse, and that he was seeing a new doctor for his sleep. Petitioner was recommended to continue his medications. (PX11).

The medical records of OSF St. Francis Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent an EMG/nerve conduction studies of the left lower extremity on January 18, 2018. It was noted that Petitioner had complaints of low back pain and left lower extremity pain, as well as weakness and parethesias involving the left leg. The testing was interpreted as revealing (1) electromyographic findings are suggestive of mild peripheral neuropathy involving the lower extremities; (2) electrodiagnostic studies are otherwise within normal limits with no clear evidence of significant lumbar radiculopathy, lumbar plexopathy, or other focal neuropathy, particularly with regard to the left femoral nerve. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on January 19, 2017, at which time it was noted that he shared some stressors related to physical issues stemming from his accident. It was noted that they talked about his moods and feelings and that Petitioner reported having negative feelings related to his work situation but was trying to not dwell on it because of the increase in stress. At the time of the February 2, 2017 session, it was noted that Petitioner discussed progress and setbacks regarding his physical conditions and his thoughts. It was noted that they explored the fears Petitioner had regarding being able to provide for his family, as well as fears about his physical and mental limitations. At the time of the February 21, 2017 session, it was noted that Petitioner discussed his fears and anxiety regarding his treatment by his former boss and dealing with workman's compensation. It was also noted that Petitioner discussed ways to avoid ruminating on negative thoughts and reported success with focusing on positives. At the time of the March 14, 2017 session, it was noted that Petitioner shared stress related to losing his job and his desire to feel productive and go back to work. At the time of the March 28, 2017 session, it was noted that Petitioner reported some increased frustrations with financial issues related to not being able to work, and that they focused on the progress he was making regarding memory work and feeling productive. It was also noted that Petitioner reported talking to a friend about symptoms of PTSD and feeling maybe he had this, and that they explored symptoms of flashbacks, nightmares, and avoiding traumatic events and how they impacted his functioning. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on April 13, 2017, at which time it was noted that he reported some progress as well as frustrations. It was noted that Petitioner remained largely frustrated over dealing with insurance and not being able to have an income, and that he reported having fears that he was being watched by his old supervisor and insurance companies to try and catch him doing things he should not be doing. At the time of the April 27, 2017 session, it was noted that Petitioner indicated continued frustration with his unemployment/worker's compensation situation, and that he recently received a letter informing him that he was honorably dismissed from his position. It was noted that Petitioner indicated having anger over the way he was being treated and the impact it had on his functioning. It was also noted that Petitioner reported that his wife was

stressed as she was the sole breadwinner. At the time of the May 18, 2017 session, it was noted that Petitioner reported having an increase in depressive symptoms and nightmares related to falling or getting hurt, and that he expressed frustrations regarding his physical limitations as well as not being able to earn any income. It was noted that a discussion was had as to how Petitioner's emotional issues could be impacting his physical ailments as well. Petitioner was encouraged to utilize relaxation skills to decrease negative symptoms. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on July 28, 2017, at which time it was noted that he reported having an increase in depression within the last several months. It was noted that Petitioner had knee surgery and subsequently fractured his tibia causing pain and extra injury, and that he indicated staying in bed for a month due to pain. It was noted that Petitioner was tired of dealing with all the issues that kept coming up and feeling worthless due to not bringing in an income. It was also noted that Petitioner indicated being hopeful that things would settle soon as to his worker's compensation and financial issues. At the time of the August 15, 2017 session, it was noted that Petitioner shared having some relief as he was supposed to start getting paid for worker's compensation. It was noted that Petitioner also reported receiving a settlement from an accident four years ago that had helped lighten his load financially. It was noted that Petitioner identified gaining some acceptance over his limitations and was finally acknowledging that he would not be returning to work. At the time of the September 28, 2017 session, it was noted that Petitioner discussed having some increasing frustrations within the last month, that he reported getting benefits from seeing a chiropractor but now the claims were being denied from worker's comp, and that they brainstormed some ways to be able to manage this and receive benefits. It was noted that Petitioner indicated that he and his wife were potentially planning a trip and that he indicated that he did not believe he could go anywhere due to ongoing worker's comp and litigation. It was noted that Petitioner shared that getting away would be helpful to allow him to relax and enjoy himself for once in the past year. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on October 20, 2017, at which time it was noted that he reported feeling "lighter" as he had been trying to have more exercise and had been laughing more. It was noted that they discussed continued stress related to dealing with worker's comp, doctors, and lawyers, and that Petitioner indicated being more cynical and not trusting others as intentions were never clear. At the time of the December 14, 2017 session, it was noted that Petitioner presented with his wife, and that they talked about increasing depressive symptoms including lack of motivation to leave the house, decrease in socialization, and constant focus on the negatives. At the time of the December 29, 2017 session, it was noted that Petitioner reported continued frustration in dealing with worker's comp and insurance, and that they examined things in his life that had changed and how to look at things with a level of acceptance. At the time of the January 19, 2018 session, it was noted that Petitioner discussed having continued physical pain related to back issues and that he shared that he was feeling more limited in activities, which increased depression. It was noted that Petitioner was educated on grounding techniques to manage rising stress and frustration levels. At the time of the February 13, 2018 session, it was noted that Petitioner indicated that he was feeling depressed related to dealing with worker's compensation and doctor's appointments, and with not being able to provide for his family. It was noted that Petitioner was educated on ways to make small steps in an effort to accomplish things and feel productive. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on February 27, 2018, at which time it was noted that he indicated continued stress and frustration, that he believed he was getting the run around from his doctors, and that they were working against him concerning worker's compensation. It was noted that Petitioner reported he had morbid thoughts but did not want to share this with his wife as she was already burdened enough. It was noted that Petitioner identified a busy schedule with appointments he had to keep or else worker's comp would go after him. At the time of the March 13, 2018 session, it was noted that Petitioner reported that he was constantly busy with doctor's

appointments and that worker's comp continued to push him to attend all types of exams and assessments. It was noted that Petitioner reported feeling fed up and like all anyone wanted to do was treat him like he was on a conveyor belt, and that he was upset with getting the run around and only being offered more medications. It was noted that Petitioner struggled with acceptance and reported feelings of defeat. At the time of the March 30, 2018 session, it was noted that Petitioner identified increased depressive symptoms. It was noted that Petitioner's irritability and anger were increasing related to constantly being told his issues were not related to the accident he endured, and feeling like doctors were out to get him. At the time of the April 13, 2018 session, it was noted that Petitioner reported increasing depressive symptoms and that he was frustrated with medical issues and felt like there was no end in sight. It was noted that Petitioner indicated minimal positives in his life and stated that he was lying in bed most days and in constant physical pain with his back, headache, knees, etc. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for a Psychiatric Evaluation on April 20, 2018, at which time it was noted that he was referred to PHP by his therapist. It was noted that Petitioner reported that his problems started after he fell down 20 stairs at work in November 2016, that he reported that he lost his job, that he had been struggling with pain, and that he reported that since then he had been struggling with depression. It was noted that Petitioner felt frustrated and disappointment and that he had problems with sleep, but that he reported that some of his medications were helping with sleep. It was noted that Petitioner reported having significant PTSD symptoms and that he reported having flashbacks and memories of the accident. It was noted that Petitioner reported that he also wakes up at night with terror and sweating, and that every time he passes the school he feels panicky. It was noted that Petitioner denied having psychiatric symptoms prior to the accident. The assessment was noted to be that of (1) depression, major, single episode, moderate; (2) PTSD; (3) generalized anxiety disorder; (4) cognitive disorder. Petitioner was recommended to change medications. At the April 24, 2018 visit with Dr. Bitar, it was noted that Petitioner reported that he was going to try to get Cymbalta as soon as possible and that he reported that PHP groups were helpful. It was noted that Petitioner continued to report problems with depression, that he was focused on his accident and his physical limitation, and that he continued to report some PTSD symptoms and generalized anxiety. It was noted that Petitioner was frustrated about his cognitive difficulties. Petitioner was advised to get his Cymbalta prescription filled as soon as possible. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen by Dr. Bitar on May 1, 2018, at which time it was noted that he was not able to start Cymbalta due to insurance, that he reported that PHP groups were helpful, and that he continued to be depressed. It was noted that Petitioner continued to have problems with pain, that he reported occasional fleeting suicidal ideation but reported that he would not harm himself because of his beliefs, and that he continued to report PTSD symptoms and problems with anxiety. Petitioner was recommended to send the appropriate documents for authorization for Cymbalta and to continue his current medications. The PHP/IOP Discharge Summary dated May 1, 2018 noted that Petitioner had limited insight and reported no change in symptoms and that he had reached maximum benefit. Petitioner was recommended to continue individual counseling and to continue medication management. At the time of the May 24, 2018 psychotherapy session, it was noted that Petitioner reported that he enjoyed the IOP program but continued to feel the same regarding depression and anxiety. It was noted that Petitioner indicated that he was in physical pain and continued to have physical maladies caused by the accident at work, and that there did not appear to be any relief. It was noted that Petitioner felt put off by his physician and did not feel heard when explaining his issues. It was also noted that Petitioner struggled with identifying anything positive. Petitioner was recommended to return in three weeks. (PX12).

The records of OSF St. Francis Medical Group reflect that Petitioner was seen for psychotherapy on June 12, 2018, at which time it was noted that he reported continued symptoms of depression. It was noted that Petitioner was upset and frustrated with his physical issues and also difficulty with acceptance

of his limitations. It was noted that Petitioner reported he continued to have trouble with his memory and physical limitations. It was also noted that Petitioner shared that he was too old to change and that his life was coming to an end as he was growing older. Petitioner was recommended to return in three weeks. (PX12).

The medical records of Midwest Orthopaedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen by Dr. Johnson on February 2, 2018, at which time it was noted that he was seen to re-check his left knee. It was noted that Petitioner was seven months status post left knee arthroscopy with partial medial meniscectomy performed on May 23, 2017, and that he finished the Euflexxa series and stated that his anteromedial left knee pain resolved with the viscosupplementation. It was noted that Petitioner's physical therapy for strengthening was ongoing, but that he reported significant shooting pain and numbness from his lateral knee to his feet. It was noted that Petitioner described severe numbness and burning pain after sitting for prolonged periods of time or crossing his legs, and that he noted that he had stumbled and fallen due to the pain and numbness in his lower leg. It was noted that Petitioner also noted significant weakness in his knee and lower leg and was unable to weight bear at times due to his pain. The assessment was noted to be that of neuropathy. It was noted that a discussion was had that pain could be from patellofemoral arthritis but that Dr. Johnson also believed that Petitioner had peripheral neuropathy. Petitioner was recommended to strengthen the leg and to follow-up as needed. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen by Dr. Johnson on November 29, 2017, at which time it was noted that he had finished his last round of Euflexxa injections in the left knee four weeks prior. It was noted that Petitioner stated that his anteromedial left knee pain resolved with the viscosupplementation, and that physical therapy for strengthening was ongoing. It was noted that Petitioner reported significant shooting pain and numbness from his lateral knee to his feet. It was noted that Dr. Johnson believed that Petitioner's symptoms were neurological and that he recommended an EMG/ nerve conduction test for further evaluation. Petitioner was to continue in physical therapy for strengthening of his knee. The records reflect that Petitioner underwent his third Euflexxa injection on November 1, 2017. It was noted that Petitioner denied any complication from the second injection and that he thought he may have seen some slight improvement, but was still having lateral-sided proximal tibia pain. At the time of the October 25, 2017 visit, Petitioner underwent his second Euflexxa injection. It was noted that that after the last injection Petitioner had about three days of feeling like he had bugs on him and a headache for a day. It was noted that a discussion was had that the feeling of bugs would be an uncommon reaction from Euflexxa. At the time of the October 18, 2017 visit, Petitioner underwent the first Euflexxa injection. It was noted that Petitioner noted continued pain and difficulties, and that he noted pain over the anterior aspect of the knee when walking any extended distance. It was noted that Petitioner was also getting treated for back issues by Dr. Feather and noted occasional pain, numbness, and tingling going all the way down the leg. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen by Dr. Johnson on October 6, 2017, at which time it was noted that he returned to re-check his left knee. It was noted that Petitioner stated that he had moved to full weightbearing, but that he still noted pain and difficulty with his exercise bike and taking the stairs. It was noted that Petitioner noted medial numbness and tingling in his knee, and that the pain was too severe to kneel. It was noted that Petitioner reported nocturnal pain and intermittent swelling. It was noted that physical therapy was ongoing. It was noted that future treatment options were discussed including more physical therapy, receiving a cortisone injection, viscosupplementation, and surgical intervention failing non-operative measures. It was noted that Petitioner wished to proceed with more physical therapy and Euflexxa series injections. A return to work slip was issued by Dr. Johnson on August 25, 2017, allowing Petitioner to return to work sit down/sedentary work only until his next scheduled appointment. At the time of the August 25, 2017 visit with Dr. Johnson, it was noted that Petitioner stated that he had been attending therapy which had improved his pain, strength,

swelling, and range of motion, and that he reported continued aching, throbbing, burning, and pulsating in the anteromedial aspect of his left knee that had improved with physical therapy. It was noted that Petitioner had a history of depression and PTSD, but had not followed-up with his primary care physician. It was also noted that Petitioner was progressing well and that he was recommended to continue physical therapy. Petitioner was recommended to return in six weeks. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen by Dr. Johnson on July 14, 2017, at which time it was noted that he had remained non-weightbearing for a stress fracture, that his knee was aspirated at the last visit, and that he noted that the swelling in the ankle had decreased since the last office visit. It was noted that Petitioner noted feeling depressed recently and that he had a history of depression and PTSD, but that he had not followed-up with his primary care physician. It was noted that Petitioner was progressing well and that he was to start partial weightbearing with crutches, increasing the weight on his left knee as tolerated, and to continue physical therapy. At the time of the June 23, 2017 visit with Dr. Johnson, it was noted that Petitioner had remained non-weightbearing for a stress fracture and that he noted his knee had been swelling. It was noted that Petitioner was requesting that the knee be aspirated and that he also was complaining of night sweats, depression, and fatigue. Petitioner's knee was aspirated, and he was recommended to remain non-weightbearing and to return in four weeks. Petitioner was also advised to follow-up with his primary care physician regarding his other complaints. At the time of the June 16, 2017 visit with Dr. Johnson, it was noted that Petitioner stated that his pain was unchanged since his previous visit and that it was continuing to radiate to the left foot. It was noted that to allow the stress fracture to heal Petitioner must remain non-weightbearing at all times, and that he could do his home exercise program to continue to strengthen the leg. Petitioner was recommended to return in four weeks. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on June 14, 2017 for an MRI of the left knee for a history of lateral left knee pain that radiated down the leg, status post twisting and buckling while walking May 31, 2017, recent meniscal repair surgery May 23, 2017. The interpretive report reflects that the films were interpreted as revealing (1) the dominant finding is posterolateral tibial and fibular head and neck osteoedema (partially imaged) and associated microtrabecular fractures but no displaced microfracture noted; correlate with radiographs; (2) moderate suprapatellar mildly proteinaceous effusion; (3) status post medial meniscal posterior horn trimming; no recurrent medial meniscus tear; (4) 1 cm tear of the posterior horn to posterior root lateral meniscus best seen on coronal images; (5) patellofemoral moderate to focally severe chondromalacia (grade 3-4); a small grade 4 erosion noted in the superior patella; (6) swelling of the posterolateral stabilizers; no lateral collateral ligament tear. At the time of the June 14, 2017 visit with Dr. Johnson, it was noted that Petitioner stated that he was walking without the crutches and that his knee twisted without known cause, which caused him to fall. It was noted that Petitioner stated that his pain was now becoming worse and was radiating down to the ankle, and that he was taking pain medication every two hours but that it was not relieving the pain. Petitioner was recommended to undergo an MRI for further evaluation for a possible loose body or meniscus tear. It was noted that Petitioner was to refrain from therapy for the time being. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen by Dr. Johnson on June 7, 2017, at which time it was noted that he reported that on May 31, 2017 he was using his crutches and that he felt like his knee twisted, buckled, and hyperextended, and that since that incident the pain had increased. It was noted that Petitioner was taking Norco which was providing limited relief, and that he denied hearing a pop. It was also noted that Petitioner was still ambulating with crutches. Petitioner was to continue in therapy and work on straightening the leg. Petitioner was given a prescription for Percocet and was recommended to return in three weeks. At the time of the May 26, 2017 visit with physician's assistant Holman, it was noted that Petitioner was having minimal post-operative pain and was having more pain in his back and wrist from previous injuries. Petitioner was recommended to work with therapy for range of motion and strengthening and could slowly progress activities. Petitioner was also recommended

to return in six weeks. At the time of the May 10, 2017 visit with Dr. Johnson, it was noted that Petitioner stated that he sustained a fall in November 2016 where he injured his left knee, that since then he had been having pain that was sharp, dull, stabbing, throbbing, aching, and burning in nature, and that it may increase to 8/10 in severity at its worst. It was noted that Petitioner got the sensation of popping and locking in his left knee which had caused him to fall recently, and that he was currently taking pain medication for his pain with limited benefit. It was noted that Petitioner had also had physical therapy with limited benefit. The assessment was noted to be that of derangement of posterior horn of lateral meniscus of knee due to old tear/injury. Petitioner was recommended to undergo left knee arthroscopy for meniscus tear repair. (PX13).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen by Dr. Williams on February 16, 2017, at which time it was noted that he presented for left wrist pain. It was noted that Petitioner had been seen before for the same, during which time he reported that he fell down concrete steps while working. It was noted that Petitioner had a history of right carpal tunnel syndrome and cubital tunnel releases done on November 10, 2015 and that he had had x-rays done which showed arthritis, no fractures. It was noted that a discussion was had regarding the recent MRI and that Petitioner wished to proceed with a cortisone injection. Petitioner was recommended to return as needed. At the time of the January 12, 2017 visit with Dr. Williams, it was noted that Petitioner presented approximately six weeks after last being seen for left wrist and hand pain. It was noted that at the last office visit x-rays showed arthritis, no fractures. It was noted that Petitioner had been going to therapy to work on motion and strengthening, and that he reported that he was still having pain and stiffness. The assessment was noted to be that of contusion with intact skin surface of the right [*sic*] wrist and sprained right [*sic*] wrist. Petitioner was recommended to undergo an MRI to determine the cause of his pain. At the time of the December 1, 2016 visit with Dr. Williams, it was noted that Petitioner stated that on November 9, 2016 he fell down concrete steps while working at Canton School District, that he stated that he had a concussion and had pain in his head, neck, left shoulder, left wrist, and hand. It was noted that Petitioner had a history of right carpal tunnel syndrome and cubital tunnel release done on November 10, 2015. The assessment was that of ecchymosis of the right [*sic*] wrist and sprained right [*sic*] wrist. Petitioner was to start therapy for motion and strengthening and was recommended to return in surgery weeks. (PX13).

The medical records of OSFMG Illinois Neurological Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The Arbitrator notes that many of the records were duplicative of those as contained in Petitioner's Exhibits 4, 5, 10 and 12. In addition, however, the records of OSFMG Illinois Neurological Institute reflect that Petitioner was seen on March 20, 2018, at which time it was noted that he was seen for tremor. It was noted that Petitioner was referred by Dr. Phillips. It was noted that the onset happened after a head injury, and that it seemed to either be a new tremor related to events associated with his head injury or a bringing out of an underlying tremor that had not previously been identified. It was noted that Petitioner's tremor was, to some extent, distractible, suggesting there was a volitional or psychogenic component. It was noted that Petitioner was started on medications that may be associated with tremor at the time of his head injury. It was noted that if adjusting Petitioner's current medications either did not help with tremor or he could not have current medications adjusted, the treatment options were currently very poor for him. It was noted that Petitioner's daytime sleepiness with what sounded like possible sleep apnea as well as parasomnias was recommended to be evaluated. It was also noted that Petitioner's closed head injury with neuropsychometric testing indicated moderate deficits. (PX14; PX4; PX5; PX10; PX12).

The records of OSFMG Illinois Neurological Institute reflect that Petitioner underwent a "Scat 3 Concussion Assessment Adult Comprehensive Exam" on December 14, 2016. It was noted that Petitioner stated that he had seen the ophthalmologist for his vision issues and had an appointment with Behavioral Health the next day, and that he stated that he noticed some improvement in his ability to walk and talk. It was noted that Petitioner stated that he was having continued issues with recall and memory but felt maybe

some slight improvement, but had not started any formal speech therapy for the cognitive rehab. It was noted that Petitioner continued to receive therapy at Haynes Rehab in Canton for his shoulders and knees and was pleased with the progress. It was noted that Petitioner continued have headaches and pressure in his head, balance issues, changes in vision to include blurry vision, double vision, neck pain, dizziness, fatigue, changes in concentration, memory issues, and balance, but that he rated these down from the last visit from a 6 to a 5 in severity. Petitioner was recommended to start speech therapy and to work with physical therapy on balance issues and post-concussion symptoms. (PX14).

The records of OSFMG Illinois Neurological Institute reflect that Petitioner underwent a "Scat 3 Concussion Assessment Adult Comprehensive Exam" on March 29, 2017, at which time it was noted that he brought his personal diary of his overall progress and had more positive comments, thoughts and seemed to be progressing with completion of home activities and tasks. It was noted that Petitioner stated that he was having panic attacks and fear of stairs, driving past the school where he worked, and was questioning if he had PTSD. It was noted that Petitioner reported that he was still having memory issues and lost the keys to his new truck, and that his wife found it on the key chain where Petitioner had placed it himself. It was noted that Petitioner continued to report a lot of symptoms on the concussion symptoms table, but was also reporting improvement per his journals or diary. Petitioner was recommended to continue to work with speech and physical therapy. At the time of the April 3, 2017 visit with Dr. Fassett, it was noted that Petitioner reported that since his fall he had noted neck pain with some headaches and low back pain. It was noted that Petitioner's treatments had included physical therapy with some modest temporary improvement, and that he had had an evaluation with Dr. Feather with pain management. It was noted that Petitioner presented with symptoms out of proportion to his imaging findings, and that Dr. Fassett did not feel that any surgery should be considered. It was noted that Dr. Fassett also informed Petitioner that chiropractic therapy would be very reasonable to consider. It was noted that in terms of Petitioner's return to work issues, Dr. Fassett would strongly recommend consideration of an occupational health specialist, and that he would not personally be involved with any of his return to work issues. (PX14).

The records of OSFMG Illinois Neurological Institute reflect that Petitioner underwent a "Scat 3 Concussion Assessment Adult Comprehensive Exam" on May 17, 2017, at which time it was noted that Petitioner's writing had improved, that he still had all 22 symptoms of severity score post six months, and that he reported that he was working with physical therapy, behavioral health, and speech therapy. It was noted that Petitioner still complained of left wrist pain and was wearing a splint. It was noted that Petitioner reported that he had a scope scheduled for May 23, 2017 for his left knee, and that he had continued stomach issues. It was noted that Petitioner reported increased stress with his worker's compensation claim which had been recently denied and that he was seeking legal counsel. It was also noted that a discussion was had that this was not the typical recovery with concussion and that Petitioner would need further follow-up with neurology for protracted recovery. Petitioner was recommended to follow-up with his primary care physician for complaints of stomach/GI issues, orthopedics for wrist and knee issues, and Dr. Fassett for back issues. Petitioner was recommended to follow-up with the pain center, follow-up with neurology, follow-up with psychiatry, follow-up with behavioral health, and continue both speech therapy for cognitive rehab and physical therapy for concussion symptoms. (PX14).

The records of OSFMG Illinois Neurological Institute reflect that Petitioner was seen by Dr. Karbowska-Jankowska on August 23, 2017 at the referral of Teresa Lane, APN, CNP. It was noted that Petitioner was seen for a neurologic evaluation because of prolonged post-concussion syndrome and cognitive difficulties related to an accident he sustained at work on November 9, 2016, where while walking down the hallway he tripped over boxes and fell down, hitting his head on the concrete stairs. It was noted that Petitioner reached maximum neurologic recovery, that he was to continue to follow-up with psychiatry and the pain clinic, and that he was to start swimming and exercises to improve overall endurance and decrease muscle tension. It was noted that Petitioner was disabled due to cognitive impairment for any occupation for at least one year and needed to apply for Social Security Disability. (PX14).

The medical records of OSFMG Psychiatry & Psychology were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records were duplicative of those as contained in Petitioner's Exhibit 11. (PX15; PX11).

The medical records of Prairie Spine & Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The records reflect that Petitioner was seen on March 27, 2018, at which time it was noted that Dr. Kube had reviewed the FCE which was noted to have been valid. It was noted that the only unexpected "results" were the items of how high Petitioner's pain was which did not really speak to an inconsistency or an exaggeration, just what his perception of pain would be. It was noted that Petitioner performed very well and consistently across the board with all issues and effort placed, and that Dr. Kube would indicate that he performed a valid effort. It was noted that Dr. Kube thought the results of the FCE were consistent with what he would have expected with Petitioner being in the roughly 30-pound range long-term, and that his recommendation would be for him to continue in that regard and use the activity modification to help control his pain. It was noted that Petitioner was placed at maximum medical improvement and discharged. (PX16).

The records of Prairie Spine & Pain Institute reflect that Petitioner underwent a FCE on March 8, 2018, which noted that the preponderance of the evidence indicated full participation, that the performance criteria profile was consistent with acceptable effort, and that demonstrated impairment data likely was the worker's true status. It was noted that Petitioner should be able to function on a full-time basis at levels identified in the Medium work demand level. It was noted that as to material handling, Petitioner could function on a full-time basis at occasional 30#, frequent 25#, and constant 20#; and that as to non-material handling occasional standing, walking, bending, grip/fine motor (limited with left wrist), climbing stairs, and frequent sitting, reaching. (PX16).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen on February 9, 2018, at which time it was noted that his problems seemed to be predominantly lumbar regional pain, that it was in the lower left lumbar left side, L4-5 and L5-S1 region, out over the top of the crest of the pelvis in the lower erector spinal muscular region. It was noted that it was hard to determine a radicular pattern for Petitioner and that he had some weakness in the leg, some of which Dr. Kube thought was from the patella injury as well. It was noted that given the acute onset of the leg symptoms and some of the sensations that Petitioner had he did not have a fulminant radiculopathy on the nerve study, and that it was possible that it was just very mild. It was noted that it was also possible, given that Petitioner was knocked out for a good half hour, that the traumatic brain injury maybe had helped bring out some of the peripheral neuropathy as the items that caused a peripheral neuropathy were not really acute in nature. It was noted that the imaging did not demonstrate a specific significant disc degeneration in the area of pain that would lead Dr. Kube to recommend any kind of surgical intervention or fusion or stabilization procedure or the like. It was noted that Dr. Kube thought that given the time out from the injury Petitioner was more or less approaching maximum medical improvement, and that he would recommend a functional assessment to determine what his long-term activity level should look like. (PX16).

The records of Prairie Spine & Pain Institute reflect that Petitioner was seen on January 25, 2018, at which time it was noted that he presented with low back pain as a result of a work injury that he sustained on October [*sic*] 9, 2016 and was referred by Dr. Phillips. It was noted that since Petitioner's fall he had low back pain with left leg and buttock pain as well as left leg numbness and weakness symptoms, that he also suffered from a traumatic brain injury from the accident, that he had pain with sitting, standing, and walking, and that he was only able to stand or walk for about 0-10 minutes without having a significant increase in pain. It was noted that Petitioner had done several conservative measures as far as medications, physical therapy, and massage, and that he had had what he thought was an L3 through L5 injections and facet blocks. It was noted that Petitioner stated that he did not get any relief from these whatsoever, and that he had not had any leg relief. It was noted that Petitioner had some degenerative findings in his back as well as what appeared to be some neurocompression due to osteophytes, as well as some degenerative

disc compromise. It was noted that Petitioner was to follow-up with Dr. Kube to go over his MRI and EMG. (PX16).

The transcript of the deposition of Dr. Glen Feather dated July 25, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. Dr. Feather testified that he is board-certified in anesthesiology and in pain management. (PX17).

Dr. Feather testified that he first saw Petitioner on February 23, 2017 at the referral of Dr. Fassett, a neurosurgeon. He testified that at that time Petitioner was complaining of some neck pain, that he had fallen down some stairs at work, and that he had pain from the top of his head all the way down to his feet. He testified that he recalled that Petitioner had problems with some memory and questioning, but that he was able to recall some things. He testified that Petitioner's affect was flat and a little bit slower. He testified that he was able to tell by talking to him that that Petitioner had a head injury, and that he suspected that it might be more than just a concussion. He testified that treatment options discussed included injections at the L3-4 level, a TENS unit, and continued therapy. (PX17).

Dr. Feather testified that he saw Petitioner again in April and May when he performed injections. He testified that the injections helped with some of the low back pain but that they did not continue to do injections on Petitioner because of his knee. He testified that Petitioner started having issues with his knee, and rather than continuing the steroid injections for his back he recommended that he see the orthopedic surgeon. He testified that they held off and told Petitioner to come back after he had the knee taken care of. He testified that it was his understanding that Petitioner was at Midwest Orthopaedics for his knee treatment. (PX17).

Dr. Feather testified that Petitioner had not reached maximum medical improvement as they held off on further treatment simply because his knee needed to be dealt with, and that once it was dealt with they could take a look at his back and see what they needed to do from that point forward. When asked of the plan after Petitioner's knee was worked up, Dr. Feather responded that it depended on his pain complaints. He testified that part of the reason they were doing the epidurals was because Petitioner had pain going down his leg, and that based on his MRI they were looking at the possibility that there was encroachment for the L4 nerve roots and narrowing for the lateral recess for the L4 foramen. He testified that Petitioner had a disc osteophyte complex so they were treating for that, and that he had a slight impingement for the left L3 nerve root. He testified that they would do some blocks to see if they were effective and that they could do radiofrequency to try to help relieve some of Petitioner's back pain. (PX17).

Dr. Feather testified that it was his opinion that Petitioner had an exacerbation of his pre-existing condition with the fall, and that he had a prior back injury and concussion. He testified that if Petitioner were having trouble after the knee he would like to see him back. When asked whether he thought Petitioner was capable of working now, Dr. Feather responded that he was not an expert in traumatic brain injury but that with his time in Iraq he dealt with a great deal of traumatic brain injury, and that when someone developed traumatic brain injury symptoms they could sometimes recover enough to go back to work but that other times they could not and did not have the cognitive ability in order to hold anything more than a very simple job. He testified that as of the last time that he saw Petitioner, he did not think that he could work. (PX17).

Dr. Feather testified that Petitioner was still struggling with speech and memory issues, that he had to struggle with his vocabulary, and that this was with regard to the head trauma. He testified that he could not speak of the knee until after the orthopedic surgeons had dealt with it. He testified that after treatment to the back, Petitioner's back could improve enough that it was possible. He testified that as of the last time that he saw Petitioner, putting the head injury aside he was not in a position to work in light of the pain issues because of his knee. (PX17).

On cross examination, Dr. Feather agreed that he was not an expert in traumatic brain injury. He testified that he did not recall treating Petitioner for any of his prior back injuries and that he did not have anything in the records that he was treating him. He agreed that he had never met Petitioner before he started treating him. He agreed that he did not know if Petitioner always had a flat affect. He agreed that he had not met Petitioner before the alleged incident occurred. (PX17).

On cross examination, Dr. Feather agreed that Petitioner was not referred to him for a concussion or traumatic brain injury. He agreed that he was not treating Petitioner for the knee and wrist. He agreed that he was not asked to treat Petitioner for his headaches because of the concussion. He testified that Petitioner was referred primarily for the neck and low back when he came to see him. He testified that he last saw Petitioner on June 1, 2017, at which point he complained of right hip and groin area pain as well as his left leg/knee. (PX17).

On cross examination, Dr. Feather testified that prior to his first appointment with Petitioner he had not reviewed any of his prior medical history or medical records. When asked if he was familiar with any history of chiropractic care that Petitioner had, Dr. Feather responded that he did not recall specifically. He agreed that Petitioner told him that in 2014 he had a back injury and a concussion, but further testified that he did not have the records or MRIs related to those injuries. (PX17).

On cross examination, Dr. Feather agreed that it was safe to say that he did not review any of the scans from Petitioner's initial hospital stay right after the alleged incident. He agreed that by the time that he saw Petitioner it was about three months after the incident occurred, and that he did not have any opportunity to observe any physical injuries, abnormalities, swelling, or bruising on his person immediately following the incident. (PX17).

On redirect, Dr. Feather agreed that he made judgments all the time about whether patients were "being up front" with him. He testified that he believed that Petitioner was "up front" and that he had said he had had a concussion and that it was a previous work comp injury. He testified that it was his understanding that Petitioner had gone back to work after the first work comp claim. (PX17).

The transcript of the deposition of Dr. Blair Rhode dated July 25, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. Dr. Rhode testified that he is an orthopedic surgeon and is board-certified in orthopedics and sports medicine. (PX18).

Dr. Rhode testified that he saw Petitioner twice and that his physician's assistant saw him once. He testified that Petitioner presented for evaluation of a work-related injury of his bilateral elbows and wrists secondary to a fall sustained on November 9, 2016. He testified that it was his understanding that he was a second opinion. He testified that Petitioner presented with complaints of numbness and tingling to his bilateral extremities, left greater than right, and that he stated that his symptomatology began after he fell down 20 concrete stairs on November 9, 2016. He testified that Petitioner stated that the stairway was dark and that the light switch was hidden behind the door, that he tried to flip it on and pick up boxes when he fell, and that he sustained a head injury as well as neck and back injuries. He testified that Petitioner stated that he required a week-long hospitalization secondary to the fall, and that after returning to work he noticed that his left hand was tingly. He testified that Petitioner had a history of bilateral carpal and cubital tunnel releases performed in 2014, and that he stated that after his surgeries he recovered completely and went back to full duty and was without symptoms until his fall down the stairs. (PX18).

Dr. Rhode testified that after Petitioner's fall he underwent a repeat EMG and continued to progress in his symptomatology, including decreased grip strength. He testified that Petitioner noticed that he was dropping items and that his hands were falling asleep. He testified that on physical examination Petitioner had positive findings suggestive of residual carpal and cubital tunnel syndrome, specifically a positive Tinel's and Phalen's at the bilateral wrists as well as a positive Tinel's at the elbow suggestive of cubital

tunnel syndrome. He testified that his working diagnosis was subjective residual bilateral carpal and cubital tunnel syndrome with EMG evidence of bilateral cubital tunnel syndrome. (PX18).

Dr. Rhode testified that on physical examination Petitioner had some tenderness over the first CMC joint of his left thumb. He testified that at Petitioner's index visit a left elbow cubital tunnel injection was performed for both diagnostic and therapeutic purposes, and then he was to follow-up and was off duty at that point. He testified that when he saw Petitioner at the second visit he stated that the injection provided temporary relief, he again reiterated his injury stating that he had had a 20 to 30-minute loss of consciousness, and that he had undergone some treatment on his left knee by Dr. Johnson. He testified that Petitioner continued to be symptomatic bilaterally, and that his exam was similar to his prior evaluation. (PX18).

Dr. Rhode testified that Petitioner was seen again on November 29, 2017, that he continued to have symptomatology, and that based upon the fact that he had had an *in situ* transposition he would be a candidate for conversion to a submuscular transposition. He testified that the transposition sometimes had to be done after an *in situ* procedure was first performed, but was rare. (PX18).

When asked to assume that the history Petitioner reported to him was accurate that he, after having had his prior carpal and cubital tunnel releases returned to work with no difficulties and then sustained this fall, and whether the fall was a competent mechanism for aggravating or re-causing the symptomatology and conditions he diagnosis in Petitioner's bilateral arms, Dr. Rhode testified that a traumatically-induced cubital tunnel syndrome was a competent cause. When asked if the patient made complaints about the numbness, tingling, carpal/cubital tunnel-type symptoms at the same time as he initially had the injury versus if those complaints did not appear in the medical records for several months afterwards and whether that affected his opinion on causation, Dr. Rhode responded that he would say in an isolated instance (*i.e.*, that he hurt his elbows and did not report it at the index visit yet he reported it several months later) that would make it less likely, but that in this situation Petitioner sustained multiple injuries that he may have been paying more attention to such as a closed head injury and tibia fracture, and not necessarily reported his elbow or wrist symptomatology. (PX18).

Dr. Rhode testified that, based on what Petitioner described which was that he had a prior carpal and cubital tunnel injury that underwent appropriate management with complete resolution of symptoms and that he subsequently sustained a traumatic fall with a new onset of symptomatology worse on the left than the right, he believed that Petitioner's cubital tunnel symptomatology was causally connected to his fall. He testified that it would be impossible to fall 20 feet without multiple impacts. (PX18).

On cross examination when asked what type of force it would take to cause the type of traumatic injury that would cause a traumatic cubital tunnel syndrome to develop, Dr. Rhode responded that it would be someone's weight impacting or driving down on the elbow. When asked if one would expect to see some bruising if someone's weight were driving down on that particular area of the elbow, Dr. Rhode responded that one would expect to. He testified that it would not be uncommon to see some scraping, abrasion, or marking on the elbow if someone fell on concrete on that part of their elbow. (PX18).

On cross examination, Dr. Rhode testified that he did not review any medical records from Petitioner's initial stay at the emergency room or the following week. He agreed that the operative reports that he reviewed from Dr. Williams pre-dated the incident involving the traumatic fall. He testified that he did not review any medical records after the fall that were prepared by Dr. Williams, nor was he aware of any treatment that Petitioner received from Dr. Williams after the fall. (PX18).

On cross examination when asked of the doctor for whom he was providing a second opinion, Dr. Rhode responded that he did not know. He testified that his records suggested that it may have been

Petitioner seeking a second opinion. He testified that he did not know that Petitioner had received treatment from Dr. Vander Naalt at OSF Orthopedics. (PX18).

On cross examination, Dr. Rhode testified that it was his belief that Petitioner returned to work after the fall in this case based on the intake. He testified that he was not aware of the type of treatment that Petitioner was receiving from the date of the incident until he saw him other than his having undergone some treatment for his knee with Dr. Johnson. He testified that he noted that Petitioner sustained a concussion, a neck/back injury, a left upper extremity injury, and a knee injury, and that he also required hospitalization for a week. He testified that he did not know how many doctors Petitioner had seen before he saw him, that he did not know how many different visits Petitioner had had before he saw him, that he did not necessarily know how many other hand, wrist or elbow surgeons that Petitioner had seen before he saw him, and that he did not know how many opportunities Petitioner had to complain about numbness in his bilateral hands before he saw him. (PX18).

The transcript of the deposition of Dr. Brent Johnson dated September 7, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Dr. Johnson testified that he is a board-certified orthopedic surgeon and that he specializes in sports medicine, particularly the knee and shoulder. (PX19).

Dr. Johnson testified that he first saw Petitioner on May 10, 2017 at which time he had a complaint of left knee pain. He testified that Petitioner reported that he sustained a fall in November 2016 where he injured his left knee, that since then he had been having sharp, dull, stabbing, throbbing, aching, and burning-type pain, that the pain would be 8/10 at its worst, and that he would get sensations of popping and locking in his knee which caused him to fall recently. He testified that Petitioner was currently taking pain medication with limited benefit and that he also had physical therapy with limited benefit. He agreed that he would defer to Dr. Williams with regard to any treatment on the right hand. He testified that he did not offer treatment to Petitioner other than for his left knee. (PX19).

Dr. Johnson testified that the MRI dated March 30, 2017 showed a radial tear in the posterior horn in the medial meniscus and a small effusion, and that x-rays from their office showed normal joint space and no fractures. He testified that the pertinent findings on physical examination were that of slight decreased range of motion in Petitioner's left knee, a small effusion, posterior joint line tenderness to palpation, and a positive McMurray's test. He testified that his assessment was that of a medial meniscus tear, and that there was an error in the records when referencing the lateral meniscus and that it should have referred to the medial meniscus going along with Petitioner's symptoms and the MRI. (PX19).

Dr. Johnson testified that the plan was to proceed with surgery for knee arthroscopy since Petitioner already had conservative treatment, medication, and therapy without relief. He testified that he did not believe that he gave Petitioner a work note at that point, but that he felt that he would be able to be capable of some work and that it would depend on his job description. When asked to assume that Petitioner was a custodian at a school and whether he thought there would be any limitations on his ability to do that solely based upon his presentation to him for the left knee on May 10, 2017, Dr. Johnson responded that he thought he would have had some restrictions about his ability to lift, stand, and climb based on his amount of pain as well as his knee giving out. (PX19).

Dr. Johnson testified that he performed surgery on May 23, 2017.[4] He testified that the pre-operative diagnosis was left knee medial meniscus tear and that the post-operative diagnosis was the same plus grade III and IV chondrosis of the patella and trochlea. He testified that he thought that the chondrosis was a multi-factorial thing and was not strictly from Petitioner's injury that he described. He testified that

[4] The Arbitrator notes that clarification was made on the record that the surgery in fact took place on May 23, 2017, rather than the May 31, 2017 date as originally indicated.

his physician's assistant saw Petitioner post-op day three on May 26th. He testified that he saw Petitioner on June 7th, at which time he reported that he was having some difficulties, that he reported that he was using crutches, felt like he twisted his knee and hyperextended it, and that since that incident had had increased pain. He testified that Petitioner was taking Norco with limited relief. When asked whether it was an uncommon incident in post-operative patients using crutches (*i.e.*, to twist the knee while using crutches), Dr. Johnson responded that it was possible and that it was not common that he had patients saying that they had another injury with the crutches afterwards. He testified that Petitioner's history was not what he would have wanted or expected, and that his physical examination looked like a normal two-week post-op physical examination. (PX19).

Dr. Johnson testified that when he saw Petitioner on June 14, 2017, he indicated that he was getting worse and worse, that his pain was becoming worse, that it was radiating down to the ankle, that he was taking pain medications every two hours with no relief, and that he was having night pain. He testified that his plan at that point was to reevaluate Petitioner and perform an MRI. He testified that the MRI was done that day on June 14th, and that Petitioner had some edema in the posterolateral tibia, fibula head, and neck, associated with what they called bone bruise or micro trabecular fracture. He testified that he would not have seen this at the time of surgery and that it did not appear on the pre-operative MRI. He testified that there were two possibilities, with one where there was a problem with after an arthroscopic surgery patients did a lot of walking on it right away and they got a stress fracture or stress reaction in that area, and that the other possibility was that the injury Petitioner described where he twisted the knee on crutches and hyperextended it caused the findings they were seeing. He testified that the reference to the 1 cm tear of the posterior horn of the posterolateral meniscus was from the radiologist's report, and that he at that time was not concerned with the lateral meniscus being torn. (PX19).

Dr. Johnson testified that a meniscus tear did not typically cause radiating pain, but that a stress fracture or acute bone bruise could cause radiating pain. He testified that it was possible that radiating pain could be explained by a low back injury. He testified that Petitioner was next seen on June 23, 2017, at which time he reported that he had been non-weightbearing, that his knee had been swelling, and that he was also complaining of night sweats, depression, and fatigue. He testified that they proceeded with a knee aspiration at that visit. He agreed that he told Petitioner to be non-weightbearing for treatment of the stress fracture, and that there was no other treatment other than to basically take the weight off it. He testified that at the time of the July 14, 2017 visit, Petitioner reported that his swelling had been decreasing in the ankle, that he was still experiencing some pain, that had been using a compression stocking, that he was still taking Norco for his pain, and that he still reported being depressed. He agreed that he was not treating Petitioner for depression, PTSD, or any of those issues. (PX19).

Dr. Johnson testified that it would be unusual for someone to be on Norco after a knee arthroscopy six weeks after surgery. He testified that if one were still having symptoms of a stress fracture, it would be reasonable to be on Norco. He testified that if one had a stress fracture and was non-weightbearing, he would find it unusual that one would have that much pain to require Norco. He testified that the fact that Petitioner had only one kidney would limit the types of medications he could take and that you would not want to give him any type of anti-inflammatory medication. He agreed that anti-inflammatories would often be the medication used in lieu of a medication like Norco. He testified that his plan as of the July 14th visit was to start Petitioner with a partial weightbearing, continue with physical therapy, and give him a script for Norco. (PX19).

Dr. Johnson testified that at the August 25, 2017 visit, Petitioner reported that he had been improving with his pain, strength, swelling, and range of motion, and that he still continued with aching, throbbing, and burning in the anteromedial aspect of the left knee. He testified that Petitioner still felt like his knee would buckle occasionally and that he had been ambulating with crutches and partial weightbearing. He testified that the physical examination was that of normal range of motion and a small effusion. He testified that the plan was to continue physical therapy, increase activity, and follow-up in six

weeks. He testified that he next saw Petitioner on October 6, 2017, and that he reported that he was full weightbearing, that he had pain and difficulty with his exercise bike and taking the stairs, and that he now reported numbness on the medial aspect of his knee as well as tingling. He testified that Petitioner reported that he had pain that was too severe so that he could not kneel directly on the knee, that he reported pain and swelling at night, that he reported his symptoms had stopped improving, and that he had tried massage therapy with some relief. He testified that Petitioner's physical examination looked good and that at that point they were going to proceed with viscosupplementation. (PX19).

Dr. Johnson testified that the viscosupplementation would not be for the medial meniscus tear or stress fracture. He testified that Petitioner was seen on October 18, 2017, when an injection was performed by his physician's assistant. It was noted that a discussion was had that the pain that was going down Petitioner's leg might be related to his back. He testified that when Petitioner returned on October 25, 2017, he saw his physician's assistant again for the second injection. He testified that the series that they used was a series of three injections, with an injection every week for three weeks. He testified that Petitioner received the final injection on November 1, 2017. He testified that when Petitioner was seen on November 29, 2017, his knee pain had resolved with viscosupplementation and his physical therapy and strengthening was ongoing. He testified that Petitioner still reported significant shooting pain and numbness from the lateral knee down to his feet, that he described severe numbness and burning and pain after sitting for long periods of time and crossing his legs, and that he had stumbled and fallen due to pain and numbness in his lower leg. He testified that Petitioner also had significant weakness in his knee and lower leg and was unable to bear weight at times due to his pain. He testified that Petitioner also stated that his pain was not worsened with walking. He testified that if Petitioner's pain was not worsened with walking, it made him think that it was less likely his stress fracture or the meniscus or possibly the arthritis as opposed to other causes. He testified that he recommended a knee EMG and nerve conduction study. (PX19).

Dr. Johnson testified that the EMG was done on January 19, 2018, and that the impression was suggestive of mild peripheral neuropathy involving the lower extremities. He testified that this would not have anything to do with the treatment he had been rendering for Petitioner's knee. He testified that he last saw Petitioner on February 2, 2018 and that he appeared to be similar to the last office visit. He testified that Petitioner still reported significant shooting pain and numbness, burning pain after sitting prolonged periods of time, that and his exam revealed normal range of motion and no swelling. He testified that based on everything that he had, he thought the source of Petitioner's pain was most likely due to the peripheral neuropathy. He testified that he released Petitioner on an as needed basis, and that he did so because he did not think these problems were coming from the issue with his knee and that if it was a neuropathy, there would be other providers that could treat him for that. (PX19).

Dr. Johnson testified that he thought that the fall would be consistent as a causative factor or an aggravating factor for the medial meniscus tear of Petitioner's knee. He testified that he did not think that the fall was a causative factor for the stress fracture. He testified that as to the cause of the stress fracture, there were two possibilities: a complication of surgery or from the injury Petitioner described when he fell on his crutches, twisted, and hyperextended his knee in the early post-op period. As to the issue of causation with regard to the mild osteoarthritis that Petitioner had in the knee, Dr. Johnson testified that he did not feel that the fall was causative of the osteoarthritis in the knee. He testified that it could be an aggravating factor in the fact that Petitioner had pain in his knee, got atrophy, had problems with the stress fracture, and that because of all this, his symptoms of osteoarthritis began to show up. He further testified that he believed that the treatment that he provided Petitioner had been reasonable, necessary, and causally related. (PX19).

On cross examination, Dr. Johnson agreed that the first time he examined Petitioner was on May 10, 2017. He testified that he did not recall whether he examined any medical records for treatment Petitioner received prior to May 10, 2017. He testified that he doubted that he reviewed the emergency

room records or records from the time of the incident. He testified that he did review the MRI that Petitioner had before he saw him. (PX19).

On cross examination, Dr. Johnson agreed that at the May 10th visit, there were no specific work restrictions mentioned. He agreed that the grade III and IV chondrosis was not something that happened overnight or as a result of one specific incident. He agreed that as to the subsequent incident around May 2017 after Petitioner's surgery, he reported that he was using crutches at the time of that incident. When asked whether he recalled the June 14, 2017 note that indicated that Petitioner had a fall when he was not using crutches, Dr. Johnson testified that he saw that in the note. He testified that he believed that it was a separate incident, because the one was clearly described with crutches and the one was clearly described without. (PX19).

On cross examination, Dr. Johnson agreed that they started the viscosupplementation injections around October 2017 and that it was primarily for treatment of osteoarthritis. He agreed that osteoarthritis was not something that occurred or developed overnight. He testified that a meniscus tear would commonly occur with a twisting-type of injury of the leg or knee, and that sometimes they could not identify a cause. He agreed that meniscal tears could be degenerative in nature. (PX19).

The transcript of the deposition of Dr. Maria Karbowska-Jankowska dated November 28, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 20. Dr. Karbowska-Jankowska testified that she specializes in neurology and neurorehabilitation and that she is board-certified in neurology. (PX20).

Dr. Karbowska-Jankowska testified that she first saw Petitioner on August 23, 2017 at the referral of Teresa Lane, APN, who is one of the nurse practitioners with the neurosurgery concussion clinic. She testified that Petitioner had post-concussion syndrome and cognitive difficulties related to an accident that he sustained at work on November 9, 2016. She testified that Petitioner told her that he worked on second shift and that while walking in the hallway, he tripped over boxes, fell down, hit his head against the concrete stairs, lost consciousness, and was taken to the emergency room by ambulance. She testified that Petitioner developed some difficulties with concentration, memory, headache, back pain, knee pain, balance, and dizziness. She testified that Petitioner kept telling her about his occupational problem, that he was dismissed from work, and that his occupation was layering tiles. (PX20).

Dr. Karbowska-Jankowska testified that the neuropsychology cognitive evaluation results indicated that Petitioner had significant cognitive deficits in verbal visual learning, recall, and executive system functioning that was thought to be a brain injury, including difficulties with mental flexibility, maintenance of mental set, executive planning, and complex problem solving. She testified that Petitioner had moderately to severely impaired visual task performance and number sequencing, that his spatial construction was also impaired, and that his delayed recall was severely impaired. She agreed that she was not treating Petitioner for his neck, shoulder, arm, knee, back, or any other type of physical or orthopedic injury. (PX20).

When asked whether it was possible to have a traumatic brain injury in the absence of positive findings on a CT of the head or MRI of the brain, Dr. Karbowska-Jankowska responded that that was the definition for concussion and that there were no macro-spectro changes that they could see actually on the images. She testified that Lisa Watt was a licensed neuropsychologist who worked at the time at OSF. She testified that usually when patients had persistent cognitive problems, they sent them to a neuropsychologist and that they did a battery of intense standardized tests to evaluate the function of each part of the brain to determine what may be the cause of the person's cognitive problems. (PX20).

When asked of her diagnosis of Petitioner as of August 23, 2017, Dr. Karbowska-Jankowska testified that it was listed as a concussion; that Petitioner had cognitive behavioral changes; acute post-

traumatic headaches; moderate episodes of recurrent major depressive disorder; and general anxiety disorder. She testified that her treatment recommendations were to follow up with psychiatry and the pain clinic, and that on the basis of his neuropsychologic evaluation she determined that Petitioner was disabled for any occupation for at least one year and needed to apply for Social Security Disability. When asked whether it would be necessary for her to re-evaluate Petitioner in the future to determine if those disabilities were ongoing, Dr. Karbowska-Jankowska responded that it was not necessary because the neuropsychologic evaluation was done almost a year after Petitioner's injury and that it appeared to be more permanent. (PX20).

When asked of her opinion as to whether the fall that Petitioner described caused the condition of ill-being that she was treating him for, Dr. Karbowska-Jankowska responded that Petitioner had cognitive deficits due to his head injury. (PX20).

On cross examination, Dr. Karbowska-Jankowska agreed that the scans that she reviewed revealed no acute findings or any findings that would have been related to the incident that Petitioner said occurred on November 9th. She agreed that the neuropsychology report that she reviewed was dated March 2, 2017, and that the exam would have occurred less than a year after the incident. She agreed that there was a period of about four months. She agreed that she was referring quite a bit to the report that Lisa Watt prepared with regard to the cognitive issues. She agreed that the issues that she discussed including mental flexibility and visual task performance were based on Ms. Watt's report and not her own observations. (PX20).

On cross examination, Dr. Karbowska-Jankowska agreed that her only visit with Petitioner was on August 23, 2017. She testified that she did not recall reviewing the emergency room records. She testified that she was not aware of the results of any other x-rays or scans that were taken in the emergency room around the time of the incident. When asked if she was aware of any other bodily injuries that Petitioner suffered or claimed to have suffered from the fall, Dr. Karbowska-Jankowska responded that he indicated that he had headache, back pain, and knee pain, and that he had left hand and wrist pain and could not use it much due to injury. (PX20).

On cross examination, Dr. Karbowska-Jankowska testified that she did not review any medical records from any prior incidents or injuries before November 2016. She testified that she had not met Petitioner before the examination on August 23, 2017. She agreed that she indicated a disability for at least a year. She agreed that it had been over at year as of the time of the deposition since she last saw Petitioner. (PX20).

On cross examination, Dr. Karbowska-Jankowska testified that Petitioner indicated that he was having problems with depression and anxiety disorder under the Review of Systems. She agreed that this was not necessarily her findings or her opinions, and that it was part of the patient history that they provided. She testified that the cognitive and behavioral changes diagnosis was based on the neuropsychology testing, which was superior to their testing they could perform in the office. She testified that the moderate episode of recurrent major depressive disorder diagnosis was provided by the psychiatrist who saw Petitioner, and that the same was true was well for the generalized anxiety disorder diagnosis. (PX20).

On redirect, Dr. Karbowska-Jankowska testified that it was not necessary for her to see a patient prior to their injury to be able to evaluate their post-injury state. She testified that neuropsychological testing was one of the best diagnostic tools that they had to use in reaching their conclusions and treatment evaluations for a patient. She testified that her opinion about whether she needed to see Petitioner again before determining if his restrictions were permanent did not change in that the testing was done only four months after his accident. (PX20).

On further cross examination, Dr. Karbowska-Jankowska agreed that she reviewed notes from Teresa Lane with the concussion clinic as part of her preparations or overall examination of Petitioner. She agreed that Petitioner saw Ms. Lane several times after the neuropsych evaluation. She testified that she did not recall the specific dates that Ms. Lane saw Petitioner. When asked whether she recalled reading notes from Ms. Lane indicating that Petitioner was making progress or improvement in his condition, Dr. Karbowska-Jankowska responded that she did not remember specifics but that when he did not improve, she sent him to her. She testified that Petitioner was referred to her because of the prolonged recovery from concussion, and that he did not improve enough to be followed by the APN. (PX20).

The transcript of the deposition of Dr. James Williams dated February 6, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 21. Dr. Williams testified that he holds a board certificate from the American Board of Orthopedic Surgery in orthopedic surgery, and that he also holds a certificate of added qualifications in hand and upper extremity surgery. (PX21).

Dr. Williams testified that he first saw Petitioner on December 1, 2016, at which time he told him that on November 9, 2016 he had fallen down concrete steps while at work, that he stated that he suffered a concussion, and that since then he had pain in his head, neck, left shoulder, left wrist, and hand. He testified that Petitioner told him that he had a history of a right carpal tunnel release as well as right cubital tunnel release done around November 2015. He testified that Petitioner was there to treat for his left wrist and hand. He testified that after performing the physical examination, it was his impression that Petitioner had suffered a sprain to the left wrist. (PX21).

Dr. Williams testified that he recommended to initially try conservative treatment, to start Petitioner with therapy for motion and strengthening and to see him back in six weeks. He testified that Petitioner returned on January 12, 2017, at which time he explained that he had been going to therapy and was still having pain and stiffness in the left wrist. He testified that at that point he felt that Petitioner could have suffered some type of ligamentous injury to the wrist, and that it would be worthwhile to obtain an MRI since he had not had improvement with the trial of therapy as well as resting of the wrist. (PX21).

Dr. Williams testified that he reviewed the films for the MRI dated January 20, 2017 at Graham Hospital and that all it showed was arthritis, and that it did not show any kind of ligamentous injury nor any fractures. He testified that in the joint space there was an effusion noted with a small amount of fluid in the distal radioulnar joint, and that he thought one could attribute it to the fall. He testified that this could have been an acute on chronic onset of pain in Petitioner's wrist, and that it had been inflamed by this injury. He testified that he next saw Petitioner on February 16, 2017, at which time he said that he had gotten some relief from the steroid injection but that now his pain was increased and that he was wanting to talk about something more permanent, such as a possible surgery for the wrist. (PX21).

Dr. Williams testified that because Petitioner's arthritis was mainly in the mid carpal joint, and that he spoke to him about doing a scaphoid excision four-bone fusion. He testified that there was often a significant limitation in motion but that it was very good in retaining strength without pain. He testified that he believed that this would be an appropriate treatment for Petitioner. He testified that Petitioner had not been back to see him since that date, and that he did not have any reason to understand why he had not been back. (PX21).

Dr. Williams testified that without any records saying anything different it appeared as though Petitioner had a significant injury falling down concrete steps and that the arthritis was preexisting, but that it seemed as though this could have aggravated the arthritis and made it symptomatic enough that he now needed surgery. He testified that if Petitioner did not have the surgery, he would continue to suffer diminishment of strength and pain. He agreed that it was fair to say that before he could actually make a recommendation about doing any surgeries, he would need to see Petitioner again. (PX21).

On cross examination, Dr. Williams testified that the last time that he saw Petitioner was on July 2, 2018. He testified that there were errors in the records as to the right wrist, and that Petitioner was being seen for the left wrist. He testified that the last time that he saw Petitioner prior to the July 2, 2018 visit was that of February 16, 2017, which was when he gave him a cortisone injection in the left wrist. He agreed that he released Petitioner to follow-up as needed in February of 2017. He testified that he was not aware of any other treatment that Petitioner received from any other hand or wrist specialist after February 2017. He testified that he did not review the medical records from the emergency room on the day of the incident, nor did he review any other records for treatment prior to the first visit on December 1, 2016. (PX21).

On cross examination, Dr. Williams agreed that he had previously treated Petitioner for left and right wrist complaints back in 2014 or 2015, and that he performed a right carpal tunnel release and right cubital tunnel release as well as a cortisone injection for the CMC joint on his left thumb. He agreed that the right carpal tunnel and ulnar nerve decompression was performed on November 10, 2015, and that on April 24, 2015 he performed a left carpal tunnel and left ulnar nerve decompression. (PX21).

On cross examination, Dr. Williams agreed that the only things Petitioner complained to him about were his left wrist and hand. He agreed that Petitioner did not complain of right wrist or right hand pain, nor did he complain of right wrist or right hand numbness. He agreed that Petitioner did not make any complaints of left hand numbness in his fingers. He agreed that at the first visit he diagnosed a contusion and sprain, as well as some arthritis within Petitioner's wrist on the x-rays. (PX21).

On cross examination, Dr. Williams testified that at the July 2nd visit Petitioner had complaints related to pain which had been increasing and pain with picking up objects and problems with strength and motion. He agreed that he was not aware of what type of activities or level of activity Petitioner had been involved with between February 2017 and July 2018. He agreed that he was not aware of any treatment that Petitioner had with Dr. VanderNaalt or Dr. Rhode. (PX21).

On redirect, Dr. Williams agreed that for all the other conditions that Petitioner identified he would defer to those treating physicians since he provided no treatment. (PX21).

The Hammond Vocational Consultant Report dated April 25, 2019 was entered into evidence at the time of arbitration as Petitioner's Exhibit 22. The report reflects that Petitioner had significant cognitive issues which would limit his access to the general labor market, that he would not be able to learn new and varied tasks, that he would not be able to maintain persistency and pace, and that he would be eliminated for all work in the local general economy. It was noted that it was Mr. Hammond's opinion that Petitioner was unable to return to his usual and normal position as a maintenance repairer, that he was also restricted from all work in the local general market, and that he would not be able to sustain employment. (PX22).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 23.

The Dr. Noam Stadlan IME Report dated June 29, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Petitioner was seen for an IME on June 29, 2017, at which time it was noted that he had a fall on November 9, 2016, that apparently he was carrying some material, tripped over some boxes, and fell down 20 stairs. It was noted that Petitioner called 911 himself and that at the scene he had initially slurred speech and was not following commands. It was noted that Petitioner had had ongoing complaints of difficulty with thinking and memory, that he had had issues with his left knee which required surgery and now a brace and non-weightbearing on the left leg, and that his main complaints had been memory and emotional lability. It was noted that Petitioner also complained of lower back pain, left wrist pain, and that he had numbness in both hands and felt run down and "puny." It was noted that Petitioner reported that prior to the accident he was fine and engaged in hiking to the lake,

and that subsequent to the accident he had gone to the lake but walked less. It was noted that Petitioner also noted frontal headache. (RX1).

The report reflects that Dr. Stadlan indicated that Petitioner appeared to have complaints consistent with post-concussion syndrome and that from a neurosurgical point of view, there was nothing worrisome or concerning. It was noted that Dr. Stadlan did not see any neurosurgical basis for Petitioner's diffuse complaints of pain, and that from the reports it appeared that his subjective complaints had increased somewhat over time. It was noted that from what Petitioner described it appears that his symptoms began with the fall, and that if there were records of treatment for similar symptoms prior to the fall those would be relevant and could be influential. It was noted that it appeared the major issues were the mental status symptoms and the left knee. It was noted that regarding any diagnosis and treatment, Dr. Stadlan would defer to specialists in those areas to determine exactly what was related to the accident and what was not. It was noted that it would be unusual to have a fall result in such significant problems in the absence of significant trauma on studies, and that Dr. Stadlan would defer to the psychologists and psychiatrists regarding any determination of symptom magnification or other issues. It was also noted that from a neurosurgical point of view it was safe for Petitioner to be fully active without any restrictions. (RX1).

The transcript of the deposition of Dr. Lawrence Li dated June 3, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Li testified that he has a general orthopedic practice and focuses his practice on the shoulder, hands and knee. He testified that he treats upper and lower extremity problems both operatively and non-operatively, and that he treats spinal conditions only non-operatively. (RX2).

Dr. Li testified that he performed an IME on Petitioner on or about February 8, 2018. He testified that Petitioner was a very poor historian, that he stated that he did not recall a lot of details of his accidents, that he stated he had a brain injury from the falls that he suffered at work, and that he explained that he had had three injuries that were work-related. He testified that the first one occurred when Petitioner was in a work van and was hit by another car, that the second was when he tripped over a snow plow and suffered loss of consciousness, and that third one was from falling down the stairs from the first floor to the basement. He testified that Petitioner indicated that he suffered loss of consciousness and that he hurt his back, neck, shoulders, and elbows. He testified that Petitioner was able to tell him that he had left knee surgery and that helped his knee but that now he had pain in the center of his knee, and that he also had elbow surgeries which were cubital tunnel releases that went well but that he stated that he did develop recurrent numbness after his fall. He testified that Petitioner told him that he was still in therapy and that he had been scheduled to see Dr. Kube. He testified that Petitioner's current complaints were that he had pain in the lumbar spine and the left buttock, numbness and tingling in his left toes, left knee pain in the center of the knee, and neck pain that radiated into both his shoulders. He testified that it was very difficult to get any other information from Petitioner and that he just repeated. (RX2).

Dr. Li testified that the latest injury that Petitioner told him about was that of the fall down the stairs. When asked which body parts were impacted on Petitioner's prior claims, Dr. Li responded that he did not know specifically from Petitioner but that he had records indicating that he had issues with his left wrist, that he had cubital tunnel, and that he had issues with his lumbar spine. He testified that on physical examination Petitioner's range of motion of his cervical spine was slightly limited, that he reported pain on the left side with a Spurling's test, that he had full range of motion of the shoulder, that he had normal strength from C5 to C7, that he had slightly decreased strength at C8 and T1 on the left but normal strength C8 to T1 on the right, and that he had tremors in both upper extremities. He testified that Petitioner also had surgical scars on the upper extremities that were from surgeries prior to November 9, 2016. (RX2).

Dr. Li testified that some of Petitioner's reporting was consistent with the records that he reviewed and that some of it was not. He testified that in terms of the numbness and tingling in the ulnar nerve distribution bilaterally Petitioner stated that that occurred right after his fall, but that he did not really see

anything in the records until approximately ten months later that he actually went and saw a doctor for the numbness and tingling. He testified that as to the knee the first evidence of any complaint was in the March 13, 2017 visit to Dr. Phillips, which was a good five months after Petitioner's injury. He testified that one would expect if someone had a significant knee injury that they would present in the first couple of weeks. He testified that he felt that Petitioner fell down the flight of stairs and that it did not seem that would be an injury where his foot would be engaged and he would twist his knee, and that it seemed like that would be an injury where he hit his knee and not one that would cause a meniscus tear. (RX2).

Dr. Li testified that the diagnoses that he rendered included cervical spondylosis, recurrent and persistently symptomatic bilateral cubital tunnel syndrome, bilateral carpal tunnel syndrome, radial carpal arthritis and first CMC joint arthritis, medial meniscectomy of the left knee with a subsequent injury to the left knee that caused bone bruise, a stress fracture, lateral tibial plateau, lateral meniscus tear, and lumbar spondylosis and spinal stenosis. He testified that as to the subsequent knee injury, there were references in June 2017 that Petitioner suffered some type of twisting injury either walking with or without his crutches when he twisted his left knee and caused a new tear, as well as a new stress fracture of the lateral tibial plateau. (RX2).

Dr. Li testified that as to the left knee diagnoses, it was his opinion that the left knee injury was not related to the November 9, 2016 fall because it was reported approximately four months after the alleged incident. He testified that a meniscus tear typically occurred with the foot engaged as opposed to just falling down the stairs where the foot was up in the air and flying. He testified that it was his opinion that the bilateral upper extremity conditions were not causally related to the November 2016 incident because Petitioner had had the surgeries prior to November 0216. He testified that Petitioner had a previous EMG in 2014 and then a subsequent EMG in October 2017, and that the ulnar nerve appeared actually similar or somewhat improved compared to the previous study in 2014. He testified that he did not see any evidence that the fall in November 2016 would have accelerated or permanently aggravated Petitioner's left wrist or his cubital tunnel. (RX2).

Dr. Li testified that as to Petitioner's spine, his diagnoses were that of cervical spondylosis and also lumbar spondylosis and spinal stenosis. He testified that he thought that Petitioner suffered contusions and strains of both his lumbar and cervical spine as a result of the November 2016 incident, and that he did not see any acute structural injury or any disc herniations. He testified that he saw no evidence of any permanent aggravation or acceleration of those underlying conditions. He testified that at the time that he examined Petitioner he did not see a need for any further treatment, and that if he received further treatment or continued to treat for any of the conditions discussed it would not be related to the incident of November 2016. He testified that this would be the case for Petitioner's left knee and his upper extremities including the wrists, fingers and thumbs. He further testified that he saw no benefit for any further treatment regarding Petitioner's spine. (RX2).

Dr. Li testified that he thought that all the services that were initially provided after the November 2016 work injury were all related and necessary, and that this would apply for the first three months. He testified that he did not think that the left knee surgery or the left wrist evaluation was related because they occurred so many months after the initial injury, and that any treatment for Petitioner's left knee that occurred after May 31st was due to an injury that he suffered from either walking with or without crutches and twisting his knee after his surgery. He testified that he opined that Petitioner reached maximum medical improvement for his cervical spine, lumbar spine, left knee, left wrist, and thumb, and that for Petitioner's elbows and cubital tunnel syndrome he did not think that they were related. He testified that he saw no reason to have any restrictions and that Petitioner could work full duty. He testified that as to the cubital tunnel syndrome symptoms Petitioner was having and a surgery that may require him to be off work for a period of time, this would be for a condition unrelated to the November 2016 accident. (RX2).

On cross examination, Dr. Li testified that he did not know how many stairs Petitioner fell down. He testified that he assumed that the stairs were concrete, but that he did not know. He testified that he did not know the specific reason as to why Petitioner fell. He agreed that it was fair to say that he did not know whether Petitioner's feet got tangled up and he fell down or he tripped over something else. He testified that Petitioner indicated to him that he had a loss of consciousness as a result of the fall, but that he did not know how long that loss of consciousness was because he did not really provide much history. (RX2).

On cross examination, Dr. Li agreed that when a patient was seen for a variety of injuries following a trauma that medical providers and/or the history that was taken oftentimes focused upon the major complaint. He agreed that Petitioner was either 62 or 63 at the time of his fall. He testified that he would say that Petitioner was more susceptible to a fracture than someone that was 30, but that that would be the only type of injury he would be more susceptible to. (RX2).

On cross examination, Dr. Li testified that he did not have a formal job description to review. He testified that Petitioner indicated that he told him that he did maintenance for a school, and that he did painting and floor tile work. He testified that his opinion regarding Petitioner's ability to work was solely based upon his physical capability. He agreed that he was not rendering any opinion as to whether the brain injury would have any impact upon Petitioner's ability to work, and that he had no opinions about any diagnoses or the condition of Petitioner's brain. He agreed that it would be fair to say that he would defer to the neurologist who treated or examined Petitioner for that condition. (RX2).

On redirect, Dr. Li testified that he was not aware of any x-rays of the spine, upper or lower extremities or any other body parts that indicated fractures as a result of the November incident. (RX2).

The *Curriculum Vitae* of Dr. Lawrence Li was entered into evidence at the time of arbitration as Respondent's Exhibit 2(a). The IME Report of Dr. Lawrence Li dated February 8, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 2(b).

The transcript of the deposition of Dr. Robert Fucetola dated June 5, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Fucetola testified that he earned a Ph.D. in clinical psychology and neuropsychology. He testified that he is a professor of neurology and the chief of clinical neuropsychology at Washington University School of Medicine. He testified that he is a clinical psychologist with specialized training in assessing and treating people who have some sort of disease of or injury to the brain. (RX3).

Dr. Fucetola testified that Petitioner and his wife came to his office in mid-July 2018 for a neuropsychological evaluation. He testified that he interviewed Petitioner and his wife so that he could understand the event he had been through in November 2016 from his perspective, and then symptoms he had reported after that event. He testified that after the interview was the bulk of the examination, which involved Petitioner taking standardized tests of different brain functions and abilities, like memory, attention, reasoning, and also tests of his emotional functioning. (RX3).

Dr. Fucetola testified that Petitioner told him that he basically fell down some concrete steps while he was at school which was his work site, that he said he thought he lost consciousness but did not know how long, and that he told him that he had some memory loss right after the fall insofar as he was unable to recall the ambulance ride to the hospital, although he did remember going into the hospital emergency room in Canton. He testified that he reviewed various medical records, including those from the emergency room visit in Canton, as well as the neuropsychological evaluation by Dr. Watt in March of 2017. (RX3).

Dr. Fucetola testified that he interviewed Petitioner in the presence of his wife, although he forbade her from speaking or answering questions. He testified that Petitioner told her not to talk but that at the end, his wife spontaneously said that she felt like Petitioner's biggest problem was his depression and

especially not having much drive or motivation. He testified that he found Petitioner to be curt with himself and the technician who was with him, and that he found him to be abrasive and accusatory. He testified that Petitioner was a good communicator and that he did not see any problems. He testified that Petitioner never complained of pain and that he sometimes stood up and stretched and walked around the room, but that he did not see any physical limitation. He testified that the biggest issue that he saw was just Petitioner's demeanor or the way he seemed to try to establish a relationship with him and his assistant, as well as the way he related to his wife. (RX2).

Dr. Fucetola testified that through the various testing they were trying to see if the person actually had cognitive impairments. He testified that a standard part of this kind of testing was to give what they called effort or performance validity testing, and that they were important because these tests made sure the person was putting forth enough effort and putting their best foot forward on the testing. He testified that once someone failed at least one of the performance validity tests, it called into question whether they were really trying their best. He testified that if they were not trying their best the whole time that was going to make some of their scores on the testing look artificially low, even though they really were not truly that bad. (RX2).

Dr. Fucetola testified that he had concerns about the effort or the validity in some of the responses that Petitioner gave in his examination. He testified that Dr. Watt pointed out that Petitioner failed one of the effort or performance validity tests during her evaluation, that Petitioner failed one of the two that she gave and that he did not fail the other one. He testified that this contaminated her evaluation, and that it meant that Petitioner did not put forth enough effort consistently and probably earned some low scores that were not really reflective of what he was really capable of. He testified that one of his other concerns was that Petitioner earned some scores on Dr. Watt's testing that were extremely low, and that some of them were so low that it was hard to reconcile that with someone who had a concussion. He testified that Dr. Watt pointed out in her report that Petitioner did okay on some of the effort testing and did badly on one of them, but that she seemed to chalk it up to a lack of focus. He testified that he was afraid that was not the case here. He testified that they were designed to be so easy that even someone with a severe dementia could pass them, so when someone failed them it was really a red flag. (RX3).

Dr. Fucetola testified that his concern about Dr. Watt's interpretation was that she wound up diagnosing Petitioner with a major cognitive disorder due to the head injury despite the fact that he failed the performance validity test, and that he did not believe that she really had a basis for that. He testified that on Dr. Watt's evaluation, Petitioner failed one of the two standalone performance validity tests. He testified that with his, Petitioner passed two and failed three. He testified that it was mixed but that it raised concerns about the amount of effort that Petitioner was putting forth on both of the exams. (RX3).

Dr. Fucetola testified that Petitioner's processing speed performance was dramatically lower than it was when Dr. Watt tested him sooner after the injury, which was kind of unexpected. He testified that there was a time lag of about 16 months between the exams, and that it was unusual with the passage of time. He testified that one did not lose that much ground in 16 months when you were in your late 50's and that it was not normal aging, and that it was not the concussion because concussions never get worse. He testified that this was a two-standard-deviation decline. He testified that he thought this reflected the fact that Petitioner did not put forth consistent effort, and that he thought part of why his score looked so low with him as opposed to Dr. Watt was because the effort just was not there. (RX3).

Dr. Fucetola testified that Dr. Watt's examination was about four months after the incident with the stairs. He testified that Dr. Watt tested Petitioner at a good time in the sense that at four months after a mild traumatic brain injury or concussion, one expected recovery. He testified that people attempted to recover within the first three months. He testified that one certainly would not expect a decline from four months after the concussion to when he saw Petitioner, which was 20 months after the concussion. (RX3).

Dr. Fucetola testified that another area with a high level of variability was that of learning and memory. He testified that there were a number of things that could cause that kind of variability, such as whether something happened during one of the tests that contaminated it such as a cell phone going off. He testified that in this case the concern would be that it reflected variability in effort, that maybe Petitioner was trying a little bit harder during the tests he did in the average range and showed what he was capable of and maybe not so much on the other one. He testified that in Petitioner's case, his MMPI test was flagged on the validity scales because there was significant over-reporting of emotional and physical symptoms. He testified that the reason it got flagged was because Petitioner reported essentially a severity of physical and emotional problems that was far above that which one would expect even in a person who had a really serious medical or psychiatric illness. He testified that it was a kind of exaggeration. He testified that it did not mean that Petitioner did not have any symptoms of depression, but that it just meant that they could not tell whether he had any *bona fide* or true symptoms of depression because his responses were so exaggerated. (RX3).

Dr. Fucetola testified that in sitting with Petitioner he never complained of pain, but that on the McGill Pain Questionnaire and the MMPI he reported a disabling level of pain. He testified that this was not the sort of man that he saw for 4½ hours in the sense that he never complained of pain. He testified that Petitioner may have been feeling it, but he did not say anything. He testified that he did not observe that pain interfered with the test performance and that Petitioner was able to do all the tests they asked of him without pain getting in the way. He testified that he was surprised about the level of pain Petitioner was subjectively reporting because it did not seem to fit with behaviorally what he was like that day. (RX3).

Dr. Fucetola testified that based on the medical records he reviewed and his examination of Petitioner, he concluded that he sustained a concussion, also known as a mild traumatic brain injury, as a result of the work event. He testified that he was not able to determine if there was a valid emotional or psychological condition, largely because of Petitioner's exaggerated reports of his own emotional condition on the MMPI. He testified that Petitioner was treated for depression first by Dr. Phillips after the fall with medications that were reasonable for depression, and that that was very appropriate. He testified that he was unable to determine what the true severity of Petitioner's depression was because they did not have a valid picture from him about what his true emotional state was. When asked if he believed the severity to be enough to impact Petitioner's functioning and daily living, Dr. Fucetola responded in the negative and testified that if there was a true depression, it was certainly being treated appropriately. (RX3).

Dr. Fucetola testified that as to residual cognitive or intellectual impairment, he did not see any evidence of permanent lasting cognitive impairment. He testified that he concluded that Petitioner was able, from a neuropsychological standpoint (from a cognitive intellectual and from an emotional or psychological standpoint), to return to his pre-injury employment for the school district. He testified that he believed that, from a neuropsychological standpoint, Petitioner was at maximum medical improvement. He testified that he did not believe that any further medical care was needed for any cognitive or intellectual difficulties, but that he was unable to determine if counseling and antidepressant medication was still necessary given the question marks about Petitioner's true emotional functioning. (RX3).

On cross examination, Dr. Fucetola agreed that he found the treatment Petitioner had received to that point when he was seen to have been reasonable and necessary to diagnose and treat his work-related injury from a neuropsychological-related care standpoint. When asked what he would expect to see in a moderate or severe traumatic brain injury on the initial evaluation, Dr. Fucetola responded that one would expect to see a GCS score lower than 13 for a moderate to severe injury, and that one was likely to see a more prolonged loss of consciousness and a more prolonged period of post-traumatic amnesia greater than 24 hours. He further testified that almost always one was likely to see radiological evidence of a structural injury to the brain on the head CT or MRI. (RX3).

On cross examination, Dr. Fucetola testified that a normal CT or MRI of the head following a concussion/mild traumatic brain injury did not mean that a person was not going to have any level of impairment. He agreed that when he talked about expected trajectory or recovery or prognosis, he was speaking in generalities of what was customarily expected. When asked whether the initial diagnosis of a mild traumatic brain injury ruled out permanent or longstanding difficulties related to that injury, Dr. Fucetola responded in the affirmative and testified that essentially you expected, assuming no other complications, good recovery with no permanent or lasting effects. (RX3).

On cross examination, Dr. Fucetola testified that Petitioner was of low average intelligence, and that he was at the high end of the low average with an IQ of 88. He testified that an IQ should not change over the course of a person's lifetime. He testified that educational level was correlated with IQ in that individuals with higher IQs tended to attain higher levels of education. When asked whether an individual could experience personality change as a result of a traumatic brain injury, Dr. Fucetola responded that it depended on the severity of the injury. He testified that change in a person's fundamental personality had never been described in the scientific literature after a mild traumatic brain injury or concussion like Petitioner had, but that people who had had moderate or severe traumatic brain injuries could show changes in personality. (RX3).

On cross examination, Dr. Fucetola testified that he did not note any indications of test fatigue in Petitioner. He testified that there can be a relationship between depression and motivation, whether it was testing or any other sphere of life. He testified that depression did not cause people to fail the performance validity tests, and that they were designed to be insensitive to conditions that were common in the population like depression or test anxiety. He testified that when someone was depressed they could seem apathetic or unmotivated, but that depression alone or apathy alone did not make someone fail one of the performance validity tests and that they actually had to consciously do badly. (RX3).

On cross examination, Dr. Fucetola testified that he was not aware of any objective tests that could measure an individual's level of pain. He testified that an individual's IQ could play a part in their ability to accurately self-evaluate things like pain or depression at the low end of the IQ range, but not in the 80-120 range that he characterized as normal. (RX3).

On cross examination, Dr. Fucetola testified that he was not sure why Petitioner exaggerated his symptoms and that he exaggerated so much that it was really impossible to know what his true symptoms are. (RX3).

The *Curriculum Vitae* of Dr. Robert Fucetola was entered into evidence at the time of arbitration as Respondent's Exhibit 3(a). The IME Report of Dr. Robert Fucetola dated July 16, 2018 was entered into evidence at the time of arbitration as Respondent's Exhibit 3(b).

The Vocational Rehabilitation Evaluation Report of Julie Bose dated June 28, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The report reflects that an initial vocational rehabilitation assessment of Petitioner was performed on June 21, 2019. It was noted that Petitioner drove to his attorney's office for the appointment without difficulty, that he was not utilizing any type of ambulatory aids, and that he came in carrying a large briefcase containing what appeared to be file folders containing medical records and journal notebooks. It was also noted that Petitioner took notes throughout the initial evaluation. (RX4).

The report reflects that Petitioner was cooperative answering all the questions that he was asked in an appropriate manner, that the consultant noted no evidence of aphasia or any other speech or word-finding difficulties, and that he did appear to have a flat affect. It was also noted that Petitioner also appeared to be very focused on multiple medical conditions that he indicated affect his activities of daily living. It was noted that Petitioner indicated that he completed the 12th grade and received a high school diploma, and

that until he reached high school age he was in a special education program. It was noted that Petitioner stated that he was not given a formal diagnosis but indicated that he just had a harder time learning, and that the record materials reflected that Petitioner had advised other professionals that he had no pre-injury difficulty with learning or special education needs. (RX4).

The report reflects that Petitioner indicated that his primary complaints included concussion, neck pain, back pain, shoulder pain, left wrist and elbow pain, and knee pain. It was noted that Petitioner indicated that he had other injuries as well, including hurting his nose and being diagnosed with a deviated septum; affect to his eyes as they watered and burned; a grinding sensation in his left wrist; and bilateral elbow pain for which he needed surgery. It was noted that Petitioner also indicated that he had had issues with his stomach since his injury, that his left kidney was "messed up" due to the injury, that he had left buttock numbness while sitting, that the pain radiated down to his left knee into his toe, and that his feet went numb. It was noted that Petitioner also indicated that he had a heart condition related to his injury and that he now has TMJ causing left jaw grinding and pain. It was noted that Petitioner also complained of neck, back, leg, and shoulder cramps, that he had elevated blood pressure as a result of the injury, and that he had chronic pain and migraines. It was noted that Petitioner complained of a number of conditions affecting his mental health, that he had a difficult time sexually and thus slept on the couch rather than with his wife, and that he felt like someone was "kicking him in the nuts all the time." It was noted that Petitioner further stated that he had hand tremors. It was noted that Petitioner also stated that he suffered from PTSD, anxiety, and depression, and that he had been treated for suicide prevention in the past. (RX4).

The report reflects that an FCE was performed on March 13, 2018, which found Petitioner capable of lifting 30 pounds floor to waist, frequently sitting, occasionally standing, and occasionally walking. It was noted that based on the FCE, Petitioner was capable of light-medium work activities with a sit-stand option from a physical viewpoint. It was noted that Petitioner indicated that he was offered a custodial position shortly after a "legal dispute" but that he declined the position. It was noted that Petitioner stated that he declined the position as he felt he was not mentally or physically able to perform the custodial position. It was noted that Petitioner stated that he had not searched for any employment and that he indicated that he did not feel like he was either physically or mentally able to work. It was noted that Petitioner was currently collecting Social Security Disability benefits, which could act as a deterrent for an individual to obtain alternative employment. (RX4).

The report reflects that there were differing opinions regarding Petitioner's limitations due to cognitive deficits and/or mental illnesses. It was noted that it appeared that Petitioner had a below average IQ with some short-term and attention deficits, but that it was thought that his cognitive limitations as reported by Dr. Fucetola did not rise to the level which would prohibit employment altogether. It was noted that given Petitioner's below average IQ and attention deficits it was thought that he would best be placed in employment that was simple and routine and unskilled in nature. It was noted that it was Ms. Bose's opinion that Petitioner would be an appropriate candidate for position such as that of a light housekeeper, laundry worker, bench assembler, bench packer, or bench sorter, and that these positions were simple and routine and did not involve divided attention, multiple steps, or judgment. It was noted that the positions offered a wage of approximately $10.00-15.00 per hour. (RX4).

The IMPG Claim Payments was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

CONCLUSIONS OF LAW

The parties stipulated that on November 9, 2016, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of November 9, 2016.

At the outset, the Arbitrator notes that Petitioner claims to have sustained injury to multiple body parts after the fall on November 9, 2016, including those to his neck, back, left shoulder, left wrist and elbow, and left knee, as well as having issues with a concussion and traumatic brain injury along with issues such as depression and anxiety. Having reviewed the considered the entirety of the medical evidence in this case, the Arbitrator places greater weight upon the opinions proffered by Dr. Karbowska-Jankowska in this case as compared to those proffered by Dr. Fucetola as it pertains to the head trauma aspect of Petitioner's claim, as well as placing greater weight upon the opinions of Petitioner's treating physicians such as Dr. Williams, Johnson and Feather as to the various orthopedic-related injuries sustained in the accident at issue. (AX1).

As to the head trauma aspect of Petitioner's claim, the Arbitrator notes that Dr. Karbowska-Jankowska testified that she specializes in neurology and neurorehabilitation and that she is board-certified in neurology. (PX20). The Arbitrator further notes that Dr. Fucetola testified that he earned a Ph.D. in clinical psychology and neuropsychology and that he is a clinical psychologist with specialized training in assessing and treating people who have some sort of disease of or injury to the brain. (RX3). Dr. Karbowska-Jankowska testified that the neuropsychology cognitive evaluation results indicated that Petitioner had significant cognitive deficits in verbal visual learning, recall, and executive system functioning that was thought to be a brain injury, including difficulties with mental flexibility, maintenance of mental set, executive planning, and complex problem solving. (PX20). She further testified that Petitioner had moderately to severely impaired visual task performance and number sequencing, that his spatial construction was also impaired, and that his delayed recall was severely impaired. (*Id.*). When asked of her opinion as to whether the fall that Petitioner described caused the condition of ill-being that she was treating him for, Dr. Karbowska-Jankowska responded that Petitioner had cognitive deficits due to his head injury. (*Id.*). She further testified that her treatment recommendations were to follow up with psychiatry and the pain clinic, and that on the basis of his neuropsychologic evaluation she determined that Petitioner was disabled for any occupation for at least one year. (*Id.*). Placing greater weight upon the opinions held by a board-certified neurologist, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of November 9, 2016.

As to the orthopedic aspects of Petitioner's claim, the Arbitrator notes that it appears from Dr. Li's testimony that a basis on which he opined that Petitioner's ongoing left knee and left upper extremity conditions were not found to be causally related to the accident of November 9, 2016 was the lack of timely reporting of complaints involving the body parts at issue. (RX2). The Arbitrator notes, however, that the medical records for Petitioner's inpatient admission at Graham Hospital immediately after the accident at issue documented a multitude of ongoing complaints involving the neck, back, left knee, and left upper extremity, among others. (PX4). These medical records, when coupled with Petitioner's documented ongoing issues with post-concussion symptomatology, cause the Arbitrator to place greater weight upon the opinions held by Petitioner's treating physicians in this case including Dr. Williams, Dr. Johnson, and Dr. Feather, among others.

Having considered and reviewed the entirety of the extensive medical evidence, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of November 9, 2016.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of December November 9, 2016. As a result

thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 23 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Petitioner's treating physicians including, but not limited to, Drs. Feather, Williams, and Johnson.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner claims that he is entitled to temporary total disability benefits for the timeframe of November 10, 2016 through August 16, 2019. (AX1). In light of the Arbitrator's findings as to causation and based upon the evidence submitted at the time of trial regarding Petitioner's work status, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the timeframe of November 10, 2016 through August 16, 2019, a period of 144 weeks.

With respect to disputed issue (O) pertaining to vocational rehabilitation, the Arbitrator grants Petitioner's request for vocational rehabilitation services. The Arbitrator notes that while Mr. Hammond believed vocational rehabilitation in this case was a waste of time and money, Respondent's vocational expert, Julie Bose, noted that given Petitioner's below average IQ and attention deficits it was thought that he would best be placed in employment that was simple and routine and unskilled in nature. (RX4). Ms. Bose noted that it was her opinion that Petitioner would be an appropriate candidate for position such as that of a light housekeeper, laundry worker, bench assembler, bench packer, or bench sorter, and that these positions were simple and routine and did not involve divided attention, multiple steps, or judgment. (Id.). In light of Petitioner's request for vocational rehabilitation services at the time of hearing, the Arbitrator grants Petitioner's request for vocational rehabilitation services.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS	)		
	) 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

ANDREW QUATTROCHI,

Petitioner,

vs. NO: 19 WC 1369

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION,

Respondent.

20IWCC0552

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability (PPD) and penalties and attorney's 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 October 18, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

20IWCC0552

DATED: SEP 2 1 2020

DDM/pm
O: 8/5/2020
052

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

QUATTROCHI, ANDREW Case# **19WC001369**
Employee/Petitioner

STATE OF ILLINOIS/DEPT OF TRANSPORTATION
Employer/Respondent

20 I W CC0552

On 10/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% 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:

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

OCT 18 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g))
☐	Second Injury Fund (§8(e)18)
☒	None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Andrew Quattrochi
Employee/Petitioner

Case # **19** WC **1369**

v.

Consolidated cases: ____

State of Illinois/Dept. of Transportation
Employer/Respondent

20IWCC0552

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **June 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ____

FINDINGS

On **November 27, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**75,384.00**; the average weekly wage was $**1,449.69**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on November 27, 2018.

Petitioner's injury to his left head and neck are causally related to the November 27, 2018 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$966.46 per week** for **1-2/7 weeks**, commencing **December 1, 2018 through December 9, 2018**, as provided in Section 8(b) of the Act. The Petitioner was temporarily totally incapacitated from work for less than 14 days from the date of the accident, and therefore benefits are paid beginning with the fourth day of such temporary total incapacity pursuant to Section 8(b).

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$4,232.00 to Alexian Brothers Medical Center** and **$1,022.00 to Amita Occupational Health**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any awarded medical benefits that have been paid by Respondent prior to the hearing, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$813.87 per week**, the maximum allowable statutory rate, for **17.5 weeks**, because the injuries sustained caused the **3.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Petitioner has failed to prove entitlement to penalties and attorney fees pursuant to Sections 16, 19(k) and 19(l) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **November 27, 2018** through **June 14, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

October 11, 2019
Date

OCT 1 8 2019

STATEMENT OF FACTS

Petitioner worked for the Respondent as a Highway Maintainer. He would punch in at the Biesterfield District 1 Bridge office in Elk Grove Village, IL, after which he would be dispatched to job sites. Petitioner generally works a daily shift from 6:30 a.m. to 3:30 p.m., unless he works overtime. On 11/27/18, he clocked in, put his boots on and sat down and waited for his orders from the lead worker. He testified he had his safety jacket and vest in his personal vehicle after taking them home to launder them. After receiving his work assignment, he walked out to his truck to get them and slipped on a patch of ice on the concrete apron just outside of the entry/exit door. He testified this area is just before you get into the parking lot, noting the concrete is slanted. He testified that it was very icy and he fell as he took his first step outside of the building, with one foot still in the building. He testified the left side of his posterior head and neck struck the ground. He did not have a laceration. He testified he initially was dizzy when he got up and he started to develop neck pain by the time he got to the emergency room. He reported the incident to the Respondent, completed all paperwork, which included witness statements, and called Tristar to report what happened. His foreman took him to Alexian Brothers Hospital.

Petitioner testified he is required to have his safety vest or jacket while on the job, if "out on the pavement", or he would be written up, so he needed to retrieve these items from his vehicle before he could start working. He testified his personal vehicle was in the parking lot where he parks daily. When he left the building to grab his gear he testified he used the exit that was closest to his vehicle, estimating the vehicle was about 25' away from the door. He testified the Respondent is responsible for the maintenance of the lot, including the salting of icy pavement, but that no one had been instructed to do that yet prior to his fall. Petitioner testified that the Respondent kept equipment and road salt at the facility.

At Alexian Brothers, the records reflect a history of slipping and falling on ice and striking the left posterior head on the pavement with no loss of consciousness. He complained of a sharp, piercing left posterior headache, left neck soreness and mild dizziness. Cervical x-ray and head CT scan were normal. Petitioner was diagnosed with a neck strain and closed head injury, was prescribed Flexeril and ibuprofen and advised to follow up with occupational health. Upon discharge, Petitioner was advised that occupational health would determine any need for work restrictions. (Px1).

On 11/28/18, Petitioner saw Dr. Kirschner at Amita Occupational Health, reporting he slipped on ice and hit the back of his head and left neck. He complained of a dull headache where he hit his head and left posterior trapezius pain. The diagnoses were head injury and trapezius strain. Dr. Kirschner restricted Petitioner to seated work only and continued Flexeril. (Px2). Petitioner testified he notified Respondent about his restrictions and that Respondent did not accommodate the restriction and he was sent home.

On 11/30/18, Petitioner returned to Amita, reporting ongoing head and shoulder pain, as well as a left eye twitch and mild dizziness. The doctor recommended an updated head CT and continued seated work only. Petitioner underwent the CT scan that same day and it reportedly showed no change from the prior exam from the ER. (Px2).

On 12/3/18, Petitioner followed up at Amita and was issued the same restrictions of sitting work only, with the report noting he had not been working due to the work restriction. On 12/5/18, Petitioner saw Dr. Kirschner again, reporting continued pain in his head, particularly when turning his head. Dr. Kirschner prescribed a course of physical therapy and continued the work restriction. (Px2).

Petitioner testified that he was not able to complete the recommended therapy because he was informed that his claim was being denied by Respondent. A 12/6/18 letter was issued by Respondent (Tristar) indicating that Petitioner's claim was denied based on the injury not having arisen out of and in the course of the Petitioner's employment. (Rx1). On 12/7/18, Petitioner was released to return to his full work duties. The final diagnoses were unspecified head injury and a neck strain. (Px2). Petitioner testified that he requested the return to full work duties since he wasn't getting paid due to the claim being denied, and that he initially returned to work on 12/10/18.

Petitioner testified he's had no further medical treatment since 12/10/18 and has no visits scheduled. He testified that he had no problems with his head or his neck prior to the accident.

As of the hearing date, Petitioner testified he continues to have more headaches/migraines than he had before the accident occurred, which he self-treats. He continues to work his regular duty job for Respondent, which he acknowledged includes breaking concrete, removing loose pieces from under bridges, pouring concrete and working at emergency sites such as holes in bridge deck. He estimated that 90% of the job involves concrete installation work, and the rest involves demolition. Petitioner testified he takes short breaks when he gets dizzy, noting he performs work in booms and buckets. He drives to job sites in vehicle that require a CDL license. He testified he generally doesn't really notice much problem in his neck and head at work because he is paying attention to his job. He noted he works with a lot of significant vibration.

On cross examination, Petitioner testified that on 11/27/18 his personal vehicle was parked in an assigned area in Respondent's parking lot but did not have an assigned spot. He didn't pay attention to whether there was ice when he entered the building that day but testified that it was noticeable while driving that morning, and the Respondent had a full group of workers out that day. He agreed that there were multiple doors available to exit Respondent's facility building, including at the mechanical bay, the office and the garage. He did tell the doctor

how he got hurt, and that he injured the back of his neck into the left shoulder. Petitioner testified that John Bilski is his direct supervisor, and he is the one he reported the incident to on 11/28/18 and to whom he provided his light duty release paperwork. Petitioner agreed he operates a bucket truck to get underneath a bridge, and that he wouldn't be allowed to operate machines if he was not able to do so.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent placed the issue of accident in dispute at the time of hearing. Petitioner's injury occurred as a result of slipping on a patch of ice located in the entryway to the building on Respondent's property where he has to clock in for work with Respondent each day. When he slipped, Petitioner was retrieving his safety jack and vest, which Respondent requires Petitioner to wear when he works.

Illinois case law supports the finding that injuries occurring on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the condition of the employer's premises. *Archer Daniels Midland Co. v. Industrial Comm'n*, 91 Ill. 2d 210, 216, (1990) ("Where the claimant's injury was sustained as a result of the condition of the employer's premises, this court has consistently approved an award of compensation." See also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1040 (2004) ("The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim.").

In the case at bar, the Petitioner's testimony supports the finding that he sustained injury due to slipping and falling on ice outside of an entry/exit door on the sidewalk outside of Respondent's building. Petitioner's unrebutted testimony is that Respondent was responsible for maintaining and salting the premises, and that the sidewalk was part of the Respondent's premises. As a result of this slippery condition on Respondent's premises, Petitioner sustained an injury which he reported to his supervisor. At the time the injury occurred, Petitioner had already begun his workday and testified he was retrieving the safety equipment from his car that was parked within an area designated for employees to park, again on Respondent's premises. Petitioner's testimony was that he would be unable to work at a road location without wearing this safety equipment. He testified the safety equipment was in his car because he had taken it home to launder it, but he did not explain why he didn't bring these items with him into work when he initially reported that morning.

The Arbitrator also finds the cases of *Litchfield Healthcare Center v. Industrial Comm'n*, 349 Ill.App.3d 486, 812 N.E.2d 401, 285 Ill.Dec. 58 (2004) and *Homerding v. Industrial Comm'n*, 327 Ill.App.3d 1050, 765 N.E.2d 1064, 262 Ill.Dec. 456 (2002) to involve similar facts, and both ultimately were found compensable in favor of the claimants by the Appellate Court.

Based on the noted facts, the Arbitrator finds that the Petitioner's injury stems from an employment-related risk on Respondent's property. As such, the Arbitrator finds that the Petitioner sustained accidental injury which arose out of and in the course of Petitioner's employment with Respondent on 11/27/18.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that prior to the 11/27/18 accident he was not having any problems with his head or neck. Immediately after falling on the ice and hitting his head, he experienced dizziness and increasing pain. The records of Alexian Brothers and Amita reference a consistent history of the incident and complaints. He was diagnosed the following day at Amita with a head injury and trapezius strain. The records of Amita reference the injury as being work related. Respondent offered no medical opinion to rebut Petitioner's treating physicians.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the witness. Based on the unrebutted facts and a chain of events analysis, the Arbitrator finds a causal connection between Petitioner's present condition of ill-being in the head and neck and the work accident of 11/27/18.

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:

On its face, the treatment rendered to Petitioner at both Alexian Brothers Medical Center and Amita Occupational Health was reasonable given the injury and diagnoses. He treated at Amita through 12/7/18. Respondent did not offer any medical opinion contradicting the reasonableness or necessity of any of the treatment rendered at these facilities. The Arbitrator finds all of the medical treatment to be reasonable and necessary.

Petitioner presented his claimed medical expenses as Petitioner's Exhibit 3. With reference to the Arbitrator's findings regarding accident and causation, Petitioner is awarded the following expenses:

1. Alexian Brothers Medical Center—DOS 11/27/18: $4,232.00
2. Amita Occupational Health—DOS 11/28/18-12/7/18: $1,022.00

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 Petitioner claims that he is entitled to TTD benefits for the period of 11/28/18 through 12/9/18, a period representing 1-5/7 weeks. Following the accident, on 11/27/18 the Petitioner was prescribed Flexeril at Alexian Brothers Medical Center and instructed not to drive. On 11/28/18, Dr. Kirschner restricted Petitioner to seated work only, which Petitioner testified was not accommodated by Respondent after he provided them with this restriction. He remained on the same restrictions until 12/7/18, at which point he was released to full work duties. He was not able to return to work full duty until 12/10/18.

The Arbitrator has reviewed the evidence and finds Petitioner is entitled to TTD benefits for 1-2/7 weeks. While the period off work was between 11/28/18 and 12/9/18, because this period totaled less than 14 days, pursuant to Section 8(b) of the Act the Petitioner is not entitled to TTD for the first three days of this period. As such, the awarded TTD period, pursuant to Section 8(b), is from 12/1/18 through 12/9/18, a period of 1-2/7 weeks.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (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 neither party has presented an AMA permanent partial impairment rating or report into evidence. Therefore, this factor carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Highway Maintainer at the time of the accident and that he was released to return to full duty work in his prior capacity. The Arbitrator does note that the Petitioner testified he requested this return to work when he did because the Respondent was denying benefits and he therefore had no income while he was off work. The Arbitrator also notes that the Petitioner complained of some ongoing pain, and that his job appears to be very heavy and physical. This factor carries some weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Neither party has submitted evidence in to the record which would indicate the impact of the Petitioner's age on any permanent disability that may result from the 11/27/18 accident. This factor carries no significant 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 returned to his regular job with the Respondent. He was released to return to unrestricted work duties in December 2018, which had continued through the hearing date, and there was no other evidence presented which would indicate that he sustained a loss of earning capacity. This factor carries some 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 the Petitioner fell and struck his left head and neck on the ground. No laceration was noted. He was diagnosed with a closed head injury and a neck strain, and this essentially remained his diagnosis, though the neck strain was also diagnosed later as a trapezial strain. After being referred for therapy on 12/5/18,

the Respondent denied the claim and Petitioner testified he then requested a full duty work release, which was provided to him on 12/7/18. He complains of some ongoing headaches, which he treats on his own. He has continued to work his regular duty job with no indication that he has any inability to do so. This factor carries the greatest degree of 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 the loss of use of 3.5% 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:

Petitioner has failed to prove that there was unreasonable and vexatious delay in the payment of benefits pursuant to Section 19(k). Petitioner has failed to prove that the Respondent has failed to pay benefits without good and just cause pursuant to Section 19(l) of the Act. A reasonable issue was raised regarding whether the Petitioner sustained an accident that arose out of and in the course of the Petitioner's employment with Respondent, as he was going back out to his car to retrieve outerwear, and this was communicated to Petitioner on 12/6/18 (Rx1). As such, penalties as well as attorney fees pursuant to Section 16 of the Act are denied.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF MADISON	)		

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK EVANS,

Petitioner,

vs. NO: 18 WC 6800

HANSEN TRUCKING,

Respondent.

20 I W CC0553

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability (PPD) and being advised of the facts and 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 23, 2020 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 the removal of this cause to the Circuit Court by the Respondent is hereby fixed at the sum of $69,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

20IWCC0553

DATED: SEP 2 1 2020

D. Douglas McCarthy

DDM/pm
D: 9/9/2020
052

Stephen J. Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EVANS, MARK
Employee/Petitioner

Case# **18WC006800**

HANSEN TRUCKING
Employer/Respondent

20IWCC0553

On 3/23/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.30% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA CT
MARYVILLE, IL 62082

1433 McANANY VAN CLEVE & PHILLIPS
DANIEL SCHMITZ
505 N 7TH ST SUITE 2100
ST LOUIS, MO 63101

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
NATURE AND EXTENT ONLY

Mark Evans
Employee/Petitioner

v.

Hansen Trucking
Employer/Respondent

Case # 18 WC 06800

Consolidated cases: n/a

20 I W C C 0 5 5 3

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 Collinsville, on February 20, 2020. By stipulation, the parties agree:

On the date of accident, January 8, 2018, 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 $59,833.28; the average weekly wage was $1,150.64.

At the time of injury, Petitioner was 52 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 $21,468.43 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $21,468.43.

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

Pursuant to the stipulation entered into at trial, Respondent shall pay reasonable and necessary services as identified in Petitioner's Exhibit 11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $690.38 per week for 75 weeks because the injury sustained caused the 15% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from September 19, 2019, through February 20, 2020, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator

March 20, 2020
Date

MAR 23 2020

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 by Respondent on January 8, 2018. According to the Application, Petitioner "Fell while making delivery" and sustained an injury to his "Neck, left shoulder, left arm & hand and body as a whole" (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that the only disputed issue was the nature and extent of disability. There were some medical bills which had not been paid; however, Respondent stipulated it would pay them pursuant to the Act and fee schedule (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as an over the road truck driver. Petitioner's regular route was St. Louis/Chicago. On January 8, 2018, while in Chicago, Petitioner slipped/fell off of the end of his trailer because of an accumulation of ice. At trial, Petitioner testified he fell approximately five feet and sustained a laceration to his head and an injury to his low back.

Following the accident, Petitioner was treated in the ER of Franciscan Health. At that time, Petitioner advised he fell backward off of a truck. Petitioner complained of low back pain and had a laceration in his scalp. Petitioner denied having neck pain. The scalp laceration was closed with staples. A CT scan of Petitioner's head and an x-ray of Petitioner's lumbar spine were obtained. Both were negative (Petitioner's Exhibit 2).

On January 11, 2018, Petitioner was seen in the ER of Jersey Community Hospital. At that time, Petitioner complained of neck pain as well as numbness in his left hand, thumb and index finger. Petitioner was diagnosed with acute cervical radiculopathy and a sprain of the left AC joint. A CT scan of the cervical spine was obtained which revealed severe degenerative changes, worse at C6-C7. It was also noted Petitioner had severe bilateral neuroforaminal stenosis (Petitioner's Exhibit 3).

Petitioner was again seen at Franciscan Health on January 18, 2018. At that time, the staples in his scalp were removed (Petitioner's Exhibit 2).

Petitioner subsequently sought medical treatment from Dr. Matthew Gornet, an orthopedic surgeon, who initially evaluated Petitioner on March 1, 2018. At that time, Petitioner advised Dr. Gornet of the accident of January 8, 2018, and the medical treatment he received afterward. Petitioner's primary complaint was neck and left shoulder/upper arm pain as well as numbness in his left forearm and index finger. Dr. Gornet reviewed the CT scan of January 11, 2018, and opined it revealed a disc herniation at C6-C7. He ordered an MRI scan of Petitioner's cervical spine (Petitioner's Exhibit 4).

The MRI was performed on March 1, 2018. According to the radiologist, the MRI revealed foraminal protrusions at C6-C7, disc material extending beyond the margin of endplates spurs on the left at C6-C7 and severe left foraminal stenosis at C6-C7 (Petitioner's Exhibit 5).

Dr. Gornet reviewed the MRI scan and opined it revealed a "fairly massive" disc herniation on the left at C6-C7. He referred Petitioner to Dr. Kaylea Boutwell for an injection at that level (Petitioner's Exhibit 4).

Petitioner was seen by Dr. Boutwell on March 22, 2018. At that time, Dr. Boutwell administered an epidural steroid injection on the left at C6-C7 (Petitioner's Exhibit 6).

Dr. Gornet saw Petitioner on April 9, 2018, and noted Petitioner had undergone an injection on March 22, 2018, but it only gave Petitioner temporary relief of his symptoms. Dr. Gornet recommended Petitioner undergo disc replacement surgery at C6-C7 (Petitioner's Exhibit 4).

Dr. Gornet saw Petitioner on May 10, 2018, and renewed his recommendation Petitioner undergo disc replacement surgery. When Dr. Gornet subsequently saw Petitioner on July 12, 2018, the surgery had been approved (Petitioner's Exhibit 4).

Dr. Gornet performed surgery on September 25, 2018. The procedure consisted of disc replacement at C6-C7 (Petitioner's Exhibit 10).

Dr. Gornet continued to treat Petitioner following surgery and Petitioner's condition gradually improved. When Dr. Gornet saw Petitioner on April 1, 2019, he released Petitioner to return to work without restrictions on April 8, 2019 (Petitioner's Exhibit 4).

Dr. Gornet last saw Petitioner on September 19, 2019. At that time, Petitioner complained of numbness/tingling in his hands, particularly with extension of his neck. Dr. Gornet ordered a CT scan of Petitioner's cervical spine which was performed that same day. Dr. Gornet opined the CT scan revealed grade 4 heterotopic ossification around the prosthesis at C6-C7. He opined this could put stress on the adjacent segments and treatment might be required in the future. However, he noted Petitioner was working full duty and opined Petitioner was at MMI (Petitioner's Exhibit 4).

Petitioner testified he still experiences tightness in his neck as well as persistent numbness in his left index finger. Petitioner was able to return to work for Respondent as an over the road truck driver and agreed the injury has not adversely affected the performance of his job. Petitioner agreed he has not received any negative job performance reviews since the time he returned to work.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked for Respondent as an over the road truck driver, a position which requires Petitioner to turn/bend his neck. The Arbitrator gives this factor moderate weight.

Petitioner was 52 years old when he sustained the accident and 54 years old when the case was tried. Petitioner will have to live with the effects of the injury for the remainder of his natural and working life. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained an injury to his cervical spine which ultimately required disc replacement surgery at C6-C7. Petitioner credibly testified he has tightness in his neck and persistent numbness in his left index finger. The Arbitrator finds these symptoms to be consistent with the injury Petitioner sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS	)
	) SS.
COUNTY OF COOK	)

☐ Affirm and adopt (no changes)	☒ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Madan Lonial,

Petitioner,

vs. NO: 10 WC 21911

Uniglobe Courier Services, Inc., and the
Illinois State Treasurer as Ex-Officio Custodian
of the Injured Workers' Benefit Fund,

20 I W C C 0 5 5 4

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes made below, which is attached hereto and made a part hereof.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of accident due to the unusual situation presented where, as here, the Petitioner suffered a syncopal episode while working for Respondent in a moving vehicle.

In order to obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of his employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 194 (2002). An injury "arises out of" one's employment if it originated from a risk connected with, or incidental to, the employment and involved a causal connection between the employment and the accidental injury. *Id.* "In the course of" refers to the time, place, and circumstances of the accident.

Illinois Bell Telephone Co. v. Industrial Comm'n, 131 Ill. 2d 478, 483 (1989). Both elements must be present at the time of the claimant's injury to justify compensation under the Act. *Id.*

Illinois courts have determined that "[t]here are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31. "Injuries resulting from personal risks generally do not arise out of employment." *Rodin v. Industrial Comm'n*, 316 Ill. App. 3d 1224, 1229 (2000).

However, as the Arbitrator wrote:

> "Larson discusses a well-established rule that injuries resulting from a non-occupational cause, such as an idiopathic fainting spell, are compensable 'if the employment places the employee in a position increasing the dangerous effect *** such as on a height, near machinery or sharp corners, or in a moving vehicle.' Larson's Workers' Compensation Law, § 9.01."

Illinois courts have long adhered to this general rule. See, *e.g.*, *Prince v. Indus. Comm'n*, 15 Ill. 2d 607, 611-12 (1959); *Ervin v. Indus. Comm'n*, 364 Ill. 56, 63 (1936); *Elliot v. Industrial Comm'n*, 153 Ill. App. 3d 238, 244 (1987); *Oldham v. Industrial Comm'n*, 139 Ill. App. 3d 594, 597 (1985).

In this case, the central issue on review is the existence of an accident. The Arbitrator discounted Petitioner's testimony about skidding on "black ice" and found that Petitioner suffered an idiopathic syncopal episode but concluded that Petitioner sustained a compensable accident because his job placed him in a position increasing the dangerous effect, *i.e.*, in a moving vehicle. Following the law established in *Prince*, *Ervin*, *Elliot*, and *Oldham*, the Commission agrees and concludes that Petitioner proved he suffered a compensable accident by a preponderance of the evidence.

Respondent cites two prior Commission decisions, neither of which is persuasive. First, Respondent cites *Kremitzki v. State of Illinois Department of Revenue*, 06 IWCC 2063, which is distinguishable because it predates *Shedd* and involved a claimant with a history of seizures. Second, Respondent cites *Williams v. Glass Specialty System*, 6 IWCC 567, in which the Commission determined that the claimant was a traveling employee who did not need to prove the underlying cause of his injury, *i.e.*, whether he blacked out while driving or could not recall what happened prior to a motor vehicle collision. The Commission also determined that even if the claimant had experienced a narcoleptic episode, rather than mere fatigue, the claimant was at an elevated risk given that the claimant had been driving for nine hours at the time of the collision. While Petitioner in this case had not been driving for nine hours, Illinois case law relies on the elevated risk created by a moving vehicle, not the time spent behind the wheel.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved that he suffered a disabling injury that arose out of and in the course of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills, if previously unpaid and not written off, pursuant to the fee schedule and §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to *Tower Automotive v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 427 (2011), Respondent shall pay Petitioner an amount equal to the medical benefits paid by Principal Life Insurance Company, Humana, and AIG/Chartis (The National Union Fire Insurance Company), which total $213,881.00, for the reasonable, necessary and related medical services rendered to him.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $533.33 per week for the period of April 3, 2008 through January 29, 2013, a period of 251 and 6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner permanent and total disability benefits of $533.33 per week for life, commencing January 30, 2013, as provided in §8(f) of the Act, because the injury sustained caused the complete disability of the Petitioner rendering him wholly and permanently incapable of work.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for the cost of living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020
o: 9/3/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LONIAL, MADAN
Employee/Petitioner

Case# **10WC021911**

UNIGLOBE COURIER SERVICES INC AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

20IWCC0554

On 7/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0147 CULLEN HASKINS NICHOLSON ET AL
MICHAEL A ROM
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0000 UNIGLOBE COURIER SERVICES INC
C/O NAVROZ SAYANI
7890 SAINT MARLO FAIRWAY DR
DULTH, GA 30097

6212 ASSISTANT ATTORNEY GENERAL
DREW DIERKES
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [x] 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

Madan Lonial
Employee/Petitioner

v.

Case # **10 WC 21911**
Consolidated cases: **N/A**

Uniglobe Courier Services, Inc. and the Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

20 IWCC0554

An *Application for Adjustment 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 **3/21/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] 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 **Was notice proper? Is the IWBF liable?**

FINDINGS

On **3/22/08**, 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 an average weekly wage of $**800.00**.

On the date of accident, Petitioner was **68** years of age, ***married*** with **0** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner an amount equal to the unpaid charges for the reasonable, necessary and related medical services rendered to him that total $**16,639.41**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Pursuant to *Tower Automotive v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 427 (1st Dist. 2011), Respondent shall pay Petitioner an amount equal to the medical benefits paid by Principal Life Insurance Company, Humana, and AIG/Chartis (The National Union Fire Insurance Company), which total $**213,881.00**, for the reasonable, necessary and related medical services rendered to him.

Respondent shall pay Petitioner temporary total disability benefits of $**533.33**/week for **251-6/7** weeks, commencing **4/3/08** through **1/29/13**, because Petitioner was temporarily totally disabled during this period, in accordance with Section 8(b) of the Act.

Respondent shall pay Petitioner permanent total disability benefits of $**533.33**/week from **1/30/13 and continuing for life,** because the injuries sustained caused the permanent and total disability of the Petitioner, pursuant to Section 8(f) of the Act.

The Illinois State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund was named as 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.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

7/25/19
Date

20 I W CC0554

JUL 25 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ATTACHMENT TO ARBITRATION DECISION

Madan Lonial
Employee/Petitioner

v. **Case No. 10 WC 21911**

Uniglobe Courier Services, Inc., and the Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Findings of Fact:

Petitioner, Madan Lonial, is a 79-year-old truck driver originally from India where he completed the equivalent of high school and two additional years of school during which he studied marketing and sales. Petitioner came to the United States of America in 1986. Petitioner has been married for 45 years and has two adult children. He is 5' 7" tall and weighs 180 pounds. Petitioner testified he has never injured his low back or knees and has never had medical treatment to his low back or knees prior to this claim.

On May 28, 2007, after answering a newspaper advertisement, Petitioner interviewed with Respondent for a truck driving position. (Tr. 10). The interview took place at the Ramada Inn in Bolingbrook, Illinois. Petitioner testified that he interviewed with a manager from Uniglobe named Steve and another individual named Manny. Respondent, Uniglobe, had a tractor (truck cab) on site and Petitioner was asked to drive it after which he was hired onsite at the Ramada Inn, Bolingbrook, Illinois on the same day. Petitioner testified that the truck cab had large Uniglobe signs on each side and the ICC number assigned to the truck was prominently displayed.

Petitioner was hired to drive loads from two locations in Illinois, Bolingbrook and Elk Grove Village, to various locations outside of Illinois. (Tr. 18) Petitioner was required to pass a physical examination and vision test every year to work as a truck driver. (Tr. 60) Petitioner was directed by the manager, Steve, and the dispatch staff (which was based in the State of Georgia), to the destinations of the loads. Petitioner testified that the Bolingbrook location had a "table office" in a warehouse and about 25 trucks with 25 different drivers (Tr. 37). Petitioner estimated that Respondent employed between 30-40 employees in Illinois. (Tr. 37) A Uniglobe manager named Mike sat at the table where Petitioner would check in before attaching a trailer and heading out with his load. The trucks were owned by Uniglobe and were clearly identified with signage stating Uniglobe on each side with a phone number for Uniglobe. Petitioner did not bring any equipment of his own other than a CB radio. (Tr. 22).

Petitioner was hired to work exclusively for Uniglobe and worked 28-30 hours per week. This consisted of two trips per week for which he would be paid $400.00 per trip or $800.00 per week. Petitioner was paid by check issued by Respondent and his rate of pay was set by the manager, Steve. (Tr. 26) Petitioner testified that he had met the owners of the company Navroz Sayani and Ali Sayani (Tr. 26, 27, PX 2, p. UW46) Petitioner testified that he never did anything for Uniglobe other than drive a truck at their direction. Respondent directed their drivers to use Pilot gas stations for refueling (Tr. 30) In addition, Uniglobe paid for a mandatory drug test every year and then deducted the amount from Petitioner's check. (Tr. 33-34) Petitioner would buy incidentals for the truck and be reimbursed by Respondent for items such as windshield washer fluid or antifreeze. (Tr. 34) Petitioner was not required to perform maintenance on the vehicles and would be told where to go for repairs or would be reimbursed for any repairs made on the road. (Tr. 35)

Petitioner drove for Respondent for ten months without incident. On March 22, 2008, Petitioner was driving a load from Elk Grove Village to Columbus, Ohio. Petitioner testified that he hit a patch of ice and skidded into a 6-7-foot ditch. (Tr. 39) The accident occurred at Mile Marker 123 on Highway 70 East in Indiana. (Tr. 64) As the truck went into the ditch, Petitioner's seat was moving up and down and he hit his left knee on the doorknob and his shoulder hit the left door. Petitioner felt pain in his low back and both knees (Tr. 40) After the accident, Petitioner called dispatch to report the accident and the police arrived on the scene. Officer Gary Wilson completed a report. PX 2, Exhibit 16. Petitioner

testified that three cranes were called to pull the tractor trailer from the ditch. Petitioner completed the delivery to Ohio. During this drive, Petitioner noticed increasing pain in his low back and both knees.

When Petitioner returned to Chicago, he sought treatment with Dr. Mohammad A. Saudye who referred Petitioner to Dr. Mohamed K. Ghumra at Access Neurocare. PX 13, PX 14. Petitioner underwent an MRI of the brain and an EEG on May 7, 2008, both of which were interpreted as normal. PX 14.

On May 12, 2008, Petitioner saw Dr. Henry A. Finn at the University of Chicago Bone and Joint Replacement Center @ Weiss. His notes indicate that on March 22, 2008, Petitioner "passed out + ran truck into ditch." PX 15.

An MRI of the lumbar spine dated May 16, 2008 revealed disc bulging at L4-L5, L5-S1 with exiting neural foramen. A lower extremity EMG of May 28, 2008 was read as abnormal with evidence of acute left SI radiculopathy. PX 14.

In the Attending Physician's Supplementary Statement, which is dated July 31, 2008, Dr. Saudye refers to a "syncopal episode," and totally restricts Petitioner from driving a truck. PX 13.

Thoracic MR images were taken on August 19, 2008 and showed mild spondylosis. Petitioner was referred to Dr. JoAnna Barclay at Sherman Hospital. She performed numerous Synvisc injections to Petitioner's left knee as well as epidural injections to the low back throughout 2008. A second lumbar MRI was done on February 3, 2009, which revealed disc bulging at L4-L5 and degenerative disc disease throughout the spine. PX 16.

In December 2008, Petitioner came under the care of a new primary care physician, Dr. Asad Shah, who administered Petitioner's medications. PX 17. Dr. Shah referred Petitioner to Dr. Scott Mox, an orthopedic surgeon, for complaints of left knee pain. PX 20. On March 17, 2009, Petitioner underwent a left knee replacement under the direction of Dr. Mox at Sherman Hospital. Petitioner participated in an extensive course of physical therapy and was referred to Dr. Rajeev Jain for pain management. PX 19. Dr. Mox released Petitioner back to the care of Dr. Ghumra on August 14, 2009. PX 20.

In 2011, Petitioner received another round of injections from Dr. N. Ravishankar at Fox Valley Pain Center. PX 18. Petitioner continued to treat with Dr. Ghumra and Dr. Ravishankar until he moved to Arizona in 2013 where he came under the care of Dr. Mandeep Powar at Midwest Internal Medicine in Lake

Havasu City. PX. 22. Petitioner testified that his treatment in Arizona has been limited to pain management that includes medication and injections to his back. Dr. Powar's records show treatment through March 8, 2019. Dr. Powar's assessment includes low back pain, chronic pain syndrome and spinal stenosis.

Petitioner allowed his CDL to expire and has never been released to return to any type of employment. Tr. 56, 60, 64-65. Petitioner continues to suffer back pain, which necessitates a frequent change of position. This disturbs his sleep. With regard to his left knee, Petitioner testified that he has difficulty walking, has a limp, and uses a cane. Petitioner has never been released to return to work by any doctor and Dr. Ghumra declared him to be permanently and totally disabled. PX 14, report dated January 30, 2013.

Dr. Ghumra indicated in his January 30, 2013 report that the motor vehicle accident from March 22, 2008 "caused and aggravated his low back pain and chronic pain syndrome." Id.

Conclusions of Law:

In support of his decision with regard to issue (A) "Was Respondent operating under and subject to the Illinois Workers' Compensation Act or Occupational Diseases Act?", the Arbitrator finds the following:

Section 3 paragraph 3 of the Illinois Workers' Compensation Act provides that the Act automatically applies to an enterprise or business conducting carriage by land, water or aerial services and loading or unloading in connection therewith, including the distribution of any commodity by horse drawn or motor vehicle where employer employs more than two employees in the enterprise or business. Petitioner testified that by virtue of his employment with Respondent, he was engaged in carriage by land, specifically driving a truck for a company that clearly employed more than two people as evidenced by Petitioner's testimony and documents from Respondent. (PX 6, PX 10, PX 11)

In addition, Section 3 paragraph 15 of the Illinois Workers' Compensation Act also provides that the Act automatically applies to an enterprise in which electric, gasoline or other power-driven equipment is used in the operation thereof. Petitioner testified that he drove a truck for Respondent.

The Arbitrator concludes that on March 22, 2008, Respondent was operating under and subject to the Illinois Workers' Compensation Act.

In support of his decision with regard to issue (B) "Was there is an employee-employer relationship?", the Arbitrator finds the following:

Respondent had a workers' compensation policy which covered their employees in the State of Georgia. (PX 2). Respondent treated its drivers in Georgia as employees. Respondent's website clearly refers to its drivers as employees (PX 2, Exhibit 15) and refers to company getaways with employees and their families. That material also refers to "owner-operators," which Petitioner clearly was not since Respondent admitted that they owned the truck Petitioner operated. (PX 2, PX 3)

In a declaratory action in the Circuit Court of Cook County, Illinois (Case No. 2014 CH 13318), Respondent was represented by attorney Richard Valentino. In that proceeding Respondent stipulated to a number of facts. That Petitioner began working for Uniglobe in 2007. (PX 2, pp. 3, 13). That Respondent owned the truck that Petitioner was driving at the time of the accident and that Petitioner had no interest in the truck as a lessee or otherwise. (Id. p. 4, 28, 29 and PX3)

Petitioner's unrebutted testimony shows that he was hired by Respondent to drive Respondent's truck. Petitioner was directed at all times by Respondent. (Tr. 28) Petitioner was instructed where to purchase gas. (Tr. 30). All maintenance and work on the truck was paid for by Respondent. (Tr. 35). Petitioner brought no tools that would be required for his job. Petitioner was not allowed to work other jobs. His rate of pay was set by Respondent. His pay stubs indicate he is being paid by Uniglobe Courier Service, Inc. (PX 8)

Respondent's Memorandum filed in the Circuit Court of Cook County, Illinois, on February 9, 2016 (PX 1) states the following:

"Lonial was employed by Uniglobe from May 17, 2007 to March 25, 2008. During this period, he 'drove a tractor/trailer from terminals in Bolingbrook, IL and Elk Grove Village, IL to various locations in other states.' One 'leg' of a typical trip would take ten hours, two of which would be spent driving through Illinois. In a normal week, Lonial would make two 'round trips,' departing from, and returning to Illinois twice. He thus spent eight hours a week driving in Illinois for approximately ten months." (PX 1)

The Arbitrator concludes that on March 22, 2008, an employee-employer relationship existed between Petitioner and Respondent.

In support of his decisions with regard to issues (C) "Did and accident occur that arose out of and in the course of Petitioner's employment by Respondent?", (D) "What was the date of the accident?", and (E) "Was timely notice of the accident given to Respondent?", the Arbitrator finds the following:

Petitioner testified that on March 22, 2008, he took a load from Respondent's location in Elk Grove Village, Illinois to Columbus, Ohio. Petitioner testified that outside of Greenfield, Indiana, there was a car in front of him with flashers on, so he moved to the left lane. Because trucks are not supposed to stay in the left lane, he moved back to the right lane, and when he did, he hit a patch of black ice, his truck skidded, and he and his truck went into a 6 - 7-foot ditch. Petitioner further testified that he notified dispatch and was assisted by other truck drivers who called the police. The police contacted the proper parties to remove the truck from the ditch with the use of cranes. Respondent was notified of the accident and paid for the cost of towing. (Tr. 59).

In the "Indiana Officer's Standard Crash Report," Officer Gary Wilson indicated that it at 7:18 a.m., it was dark, rainy, and that the road surface was wet. The Officer took the following statement: "Driver 1 stated he was driving eastbound on I-70 when he started sliding off the road. Driver 1 stated that when he hit the grass the semi continued into the ditch." PX 2, Exhibit 16.

Dr. Muhammad Saudye's subpoenaed records show that on March 26, 2008, Petitioner had blood work done. PX 13. On July 31, 2008, he saw Petitioner for a "syncopal episode," and diagnosed him with left knee pain with significant osteoarthritis and probable tear of the posterior horn of the medial meniscus, trochanteric bursitis causing left hip pain, and left shoulder pain. Dr. Saudye's also noted that two left knee arthroscopies were done in 2000 and 2004. PX 13.

On April 24, 2008, Petitioner presented to Dr. Mohamed Ghumra of Access Neurocare who detailed the visit in a letter to Dr. Saudye. *Id.* Petitioner reported having an episode of syncope where the last thing he remembered was approaching a slow-moving vehicle that had its lights flashing. *Id.* Petitioner felt a dry sensation in his mouth, dry throat, felt like choking, and had a mild headache and in an instant, he passed out and found himself in a ditch. *Id.* Petitioner complained of injuries to his low back, left knee, and left hip. *Id.* Dr. Ghumra ordered an EEG and Carotid Doppler study. *Id.* The EEG taken on May 7, 2008 was within normal limits in the awake stage only. (PX 14).

Petitioner presented to Dr. Henry Finn of the University of Chicago Bone and Joint Replacement Center on May 12, 2008 with complaints of left knee and hip pain. (PX 15). Dr. Finn noted that Petitioner passed out and ran his truck into a ditch. *Id.* Dr. Finn also noted left knee surgeries in 2000 and 2004. *Id.*

At trial, eleven years post-incident, Petitioner denied that he suffered a syncopal episode prior to driving his truck into a ditch that day. Petitioner further testified that he was able to complete his route that day without further incident and used over-the-counter pain medication.

It is true that the police report makes no mention of Petitioner fainting, or experiencing a syncopal episode, before the truck went in the ditch. However, it is also true that the report makes no mention of icy conditions.

Petitioner also testified that prior to the March 22, 2008 incident, he never injured his left knee and he never received treatment by a doctor for his left knee.

The Arbitrator questions Petitioner's credibility.

Based on the foregoing, the Arbitrator finds that on March 22, 2008, Petitioner did suffer a syncopal episode, which was an idiopathic, non-occupational cause, before landing the truck in a ditch.

However, Larson discusses a well-established rule that injuries resulting from a non-occupational cause, such as an idiopathic fainting spell, are compensable "if the employment places the employee in a position increasing the dangerous effect *** such as on a height, near machinery or sharp corners, or in a moving vehicle." Larson's Workers' Compensation Law, §9.01. Illinois courts have long followed this general rule. Please see *Ervin v. Indus. Comm'n*, 364 Ill. 56 (1936) and *Prince v. Indus. Comm'n*, 15 Ill.2d 607 (1959).

Therefore, based on the foregoing, the Arbitrator concludes that on March 22, 2008, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

The Arbitrator further finds that Petitioner provided notice of this accident to Respondent on March 22, 2008.

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds the following:

Prior to March 22, 2008, Petitioner was capable of performing all aspects of his job driving a truck and had done so for the Respondent for ten months. In addition, he had passed all required physical and vision testing and had maintained his CDL license. Dr. Mohamed Ghumra rendered a causal connection opinion in his January 30, 2013 narrative report as follows: "I believe the motor vehicle accident from March 22, 2008 caused and aggravated his low back pain and chronic pain syndrome." PX 14.

In his February 9, 2009 chart notes, Dr. Asad Shah, Petitioner's primary care physician, assessed him with severe left knee arthritis, and opined: "He denies any major problems or pain in terms of that left knee prior to the incident, although he did have left knee arthroscopy back in 2004 in Oakbrook and stated he recovered well since that time **** In terms of causality, he states that he had very few symptoms prior to this incident in March of '08 and in my opinion, the knee arthritis was exacerbated by this on-the-job incident, thus this would be considered an on-the-job work injury. Having that on the job injury has caused him to have the left knee replacement sooner than it normally would have been required." PX 20.

Petitioner testified that prior to the March 22, 2008 incident, he never injured his low back and never received treatment for his low back. Tr. 40-41. He testified as to what he presently notices about his low back and left knee. Tr. 60-64.

The Arbitrator relies on the opinions of Dr. Ghumra and Dr. Shah and considers Petitioner's testimony in concluding that the current conditions of ill-being of his low back and left leg are causally related to the accident of 3/22/08.

In support of his decision with regard to issue (G) "What were Petitioner's earnings?", the Arbitrator finds the following:

As shown above, Respondent's Memorandum, filed in the Circuit Court of Cook County, Illinois, on February 9, 2016, states:

"Lonial was employed by Uniglobe from May 17, 2007 to March 25, 2008. During this period, he 'drove a tractor/trailer from terminals in Bolingbrook, IL and Elk Grove Village, IL to various locations in other states.' One 'leg' of a typical

trip would take ten hours, two of which would be spent driving through Illinois. In a normal week, Lonial would make two 'round trips,' departing from, and returning to Illinois twice. He thus spent eight hours a week driving in Illinois for approximately ten months." (PX 1)

Petitioner testified that he earned $800.00 per week in salary as set by the Respondent. Petitioner's testimony was unrebutted on this issue. In support of his testimony, Petitioner supplied check stubs issued by Uniglobe Courier Service, Inc., for most of the ten-month period he worked at Respondent, as well as Form 1099s for 2007 and 2008. (PX 8, PX 7) Petitioner testified that he made two round trips per week and was paid $400.00 each round trip.

In the absence of evidence to the contrary, the Arbitrator concludes that Petitioner's average weekly wage on March 22, 2008 was $800.00 per week.

In support of his decisions with regard to issues (H) "What was Petitioner's age at the time of the accident?", and (I) "What was Petitioner's marital status at the time of the accident?", the Arbitrator finds the following:

After reviewing various medical records in evidence, the Arbitrator finds that Petitioner's date of birth was November 12, 1939, which would make him 68 years old on the March 22, 2008. Moreover, the Request for Hearing (AX 1) indicates that at the time of injury, Petitioner was married and had no dependent children. Therefore, the Arbitrator further finds that on March 22, 2008, Petitioner was married and had no dependent children.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds the following:

The Arbitrator concludes that as a result of injuries sustained on March 22, 2008, Petitioner incurred $16,639.41 in unpaid medical bills, as well as $213,881.00 in medical expenses, which Principal Life Insurance Company, Humana, and AIG/Chartis (The National Union Fire Insurance Company) paid. The Arbitrator finds that the treatment rendered to Petitioner was reasonable and necessary to cure or alleviate his condition of ill-being, which resulted from the accident of March 22, 2008.

Causation opinions from Dr. Shah and Dr. Ghumra were offered as to Petitioner's left knee and low back, respectively. Petitioner testified to the present conditions of ill-being of his low back and left knee.

Following the March 22, 2008 accident, however, Petitioner also treated for conditions of ill-being of his right shoulder, right hip, and right knee, and underwent an EEG and an MRI of the brain for his head. The Arbitrator finds such treatment to be necessary, reasonable, and causally related to the March 22, 2008 accident, based on Petitioner's testimony and the chain of events.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982)

The above bills remain unpaid or were paid by Equian/Principle Life Insurance Company or Humana, which were Petitioner's wife's health insurance companies, at various times throughout his treatment, or by AIG/Chartis (The National Union Fire Insurance Company) under Occupational Accident Policy #009100951.

Petitioner submitted into evidence PX 24 – PX 37.

PX 24 has a $0.00 balance as payments were made to Midwest Orthopaedic Institute by WC AIG/Chartis. DOS 9/29/09 - 10/6/09

PX 25 has a $0.00 balance as payments were made to Fox Valley Pain Center by Principal Life Insurance Company. DOS 1/6/11 - 2/11/11

PX 26 has a $0.00 balance as payments were made to Access Neurocare by AIG Claim Services and Principal Life Insurance Company. DOS 11/9/08 – 1/30/13

PX 27 has a balance from Athletico of $299.74. PHCS and AIG paid the rest of the bills. DOS 1/18/14 – 1/27/14

PX 28 has a balance from Associated Imaging Specialists of $1,561.47. "Insurance" paid the rest of the bills. DOS 3/30/08 – 11/1/11

PX 29 has a balance from Pres Physical Therapy of $7,496.14. AIG/Chartis and Principal Life Insurance Company paid the rest of the bills. DOS 12/9/09 – 9/13/11

PX 30 was rejected as it was not certified.

PX 31 has a balance of from Elgin Barrington Neurosurgery of $361.91. AIG/Chartis paid the rest of the bills. DOS 2/23/09 – 3/25/15

PX 32 was rejected as it was not certified.

PX 33 has a balance from Advocate Sherman Hospital $6,920.45. "Insurance" and Medicare paid the rest of the bills. DOS 10/10/08 – 2/28/14, less unrelated ophthalmic charges.

PX 34 is a statement by Equian, which is the subrogation vendor for Principal Life Insurance Company. For dates of service 6/4/08 through 7/29/11, Principal Life Insurance Company paid Petitioner's medical benefits to 11 providers and is seeking reimbursement for such payments in the amount of $44,114.02.

PX 35 is a statement by Humana, which, for dates of service 1/11/14 through 1/26/19, paid Petitioner's medical bills to numerous providers and is seeking reimbursement for such payments in the amount of $9,654.32.

PX 36 is a statement from AIG/Chartis (The National Union Fire Insurance Company) for dates of service 7/10/08 through 10/6/10 in which they have paid Petitioner's medical bills to numerous providers and are seeking a reimbursement of such payments in the amount of $160,113.00 for medical benefits, pursuant to the Occupational Accident Policy.

PX 37 was rejected as it was not certified.

The Arbitrator finds that Respondent shall pay Petitioner an amount equal to the unpaid charges for the reasonable, necessary and related medical services rendered to him that total $16,639.41, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

The Arbitrator further finds, pursuant to *Tower Automotive v. Illinois Workers' Compensation Commission*, 407 Ill. App. 3d 427 (1st Dist. 2011), that Respondent shall pay Petitioner an amount equal to the medical benefits paid by Principal Life Insurance Company, Humana, and AIG/Chartis (The National Union Fire Insurance Company), which total $213,881.00, for the reasonable, necessary and related medical services rendered to him.

Neither party offered the Occupational Accident Policy into evidence.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD", the Arbitrator finds the following:

On March 22, 2008, after the truck was pulled out of the ditch, Petitioner completed his route, which at that point was from Greenfield, Indiana, to Columbus, Ohio. During the trip, Petitioner testified, he noticed increasing pain in his low back and both knees. He took over-the-counter pain medication.

When he returned to Chicago, Petitioner testified, he sought treatment from Dr. Mohammad A. Saudye, who then referred him to Dr. Ghumra. Following the accident, other than the blood work, the first treating record in the subpoenaed records of Dr. Saudye is the Attending Physician's Supplementary Statement, which is dated July 31, 2008. However, there is a letter from Dr. Mohamed K. Ghumra to Dr. Saudye dated April 24, 2008. PX 13.

On April 3, 2008, Dr. Ghumra authored a prescription slip that included the following: "Be considered disabled until further evaluation." PX 14.

On May 16, 2008, Dr. Ghumra authored a prescription slip that stated the following: "Mr. Madan Lonial is under my care for an episode of syncope. He is under my care and currently disabled from work, until his workup/testing is completed. Please call if you have any questions." PX 14.

On July 31, 2008, Dr. Saudye referred to a "syncopal episode," and totally restricted Petitioner from driving a truck. PX 13.

Thoracic MR images were taken on August 19, 2008 that showed mild spondylosis. Petitioner was referred to Dr. JoAnna Barclay at Sherman Hospital. She performed numerous Synvisc injections to Petitioner's left knee as well as epidural injections to his low back throughout 2008. A second lumbar MRI was done on February 3, 2009, which revealed disc bulging at L4-L5 and degenerative disc disease throughout the spine. PX 16.

In December 2008, Petitioner came under the care of a new primary care physician, Dr. Asad Shah, who administered Petitioner's medications. PX 17. Dr. Shah referred Petitioner to Dr. Scott Mox, an orthopedic surgeon, for complaints of left knee pain. On March 17, 2009, Petitioner underwent left knee replacement surgery under the direction of Dr. Mox at Sherman Hospital. Petitioner participated in an extensive course of physical therapy and was referred to Dr. Rajeev Jain for pain management. Dr. Mox released Petitioner back to the care of Dr. Ghumra on August 14, 2009. PX 20.

In 2011, Petitioner received another round of injections from Dr. N. Ravishankar at Fox Valley Pain Center. Petitioner continued to treat with Dr. Ghumra and Dr. Ravishankar until he moved to Arizona in 2013 where he came under the care of Dr. Mandeep Powar at Midwest Internal Medicine in Lake Havasu City. (PX. 22). Petitioner testified that his treatment in Arizona has been limited to pain management that includes medication and injections to his back. Dr. Powar's records show treatment through March 8, 2019. Dr. Powar's assessment includes low back pain, chronic pain syndrome and spinal stenosis.

In his narrative report dated January 30, 2013, Dr. Ghumra wrote that beginning on September 25, 2008, he regularly treated Petitioner. From November 9, 2008 to January 30, 2013, Dr. Ghumra kept Petitioner off work and frequently updated his disability papers. PX 14.

The evidence shows that since the accident, no doctor has released Petitioner to return to work. No Section 12 examination was ever conducted.

As of January 30, 2013, Dr. Mohamed Ghumra found Petitioner to be permanently and totally disabled from any gainful employment. On that date, he examined Petitioner, recorded Progress Notes, and authored a narrative report. PX 14.

The Arbitrator finds that Petitioner is entitled to receive from the Respondent 251-6/7 of temporary total disability benefits, because he was temporarily disabled from April 3, 2008 through January 29, 2013 at a rate of $533.33/week in accordance with Section 8(b) of the Act.

AIG/Chartis (The National Union Fire Insurance Company) has paid $38,857.00 in indemnity benefits through the Occupational Accident Policy and is seeking a reimbursement in that amount. PX 36.

Neither party offered the Occupational Accident Policy into evidence.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds the following:

As a result of injuries sustained on March 22, 2008, Petitioner continues to have pain in his back and left leg. Petitioner testified that he suffers pain when he sleeps and frequently has to change positions. Petitioner testified that he has pain in his left knee when he stands for long periods of time and has a limp, which necessitates the use a cane.

On January 30, 2013, Dr. Mohamed Ghumra examined Petitioner. In his History of Present Illness, Dr. Ghumra wrote:

"Here for follow up after a long interim. No change at all in his chronic pain issues. Still ambulating with a significant amount of pain and using a walker. His low back pain and radicular symptoms are not any different. Left side is worse. Hard time standing or sitting in one position is hard time (sic). Wakes up at night in pain. Sits in a recliner but does not help." PX 14.

Upon examining Petitioner, Dr. Ghumra found, *inter alia*, that his gait and station were antalgic with pain in the knees and low back, that he uses a cane, and that overall, he is unchanged. Furthermore, he found Petitioner has a persistent lumbar spasm. He assessed Petitioner with low back syndrome, radicular syndrome of lower limbs, degenerative disc disease, and chronic pain syndrome. Dr. Ghumra recommended continued use of prescription pain medication that included Hydrocodone-Acetaminophen and Oxycontin tablets. PX 14, Progress Notes.

Dr. Ghumra opined: "He will need long-term medication therapy for the rest of his life. He is also a poor surgical candidate poor high/risk surgical candidate (sic) for any back procedure and may not only provide him (sic) any or even temporary relief. I feel that Mr. Lonial is permanently and totally disabled from any gainful employment." PX 14, Narrative Report.

No opinion to the contrary was offered.

As a result, the Arbitrator concludes that as a result of injuries he sustained on March 22, 2008, Petitioner is permanently and totally disabled and is entitled to $533.33/week from August 1, 2012 for life.

In support of his decision with regard to issue (O) "Was notice proper? Is the IWBF liable?", the Arbitrator finds the following:

The Arbitrator notes that PX 12 indicates that Petitioner sent, via certified mail, notice of the March 21, 2019 trial to the last known address of the Respondent's owner, business, and attorney in the declaratory action. Petitioner also sent notices of prior hearing dates to Respondent Employer. Respondent IWBF did not object to these notices. The trial date on March 21, 2019 was agreed upon by the parties and notice was provided.

Petitioner's PX 5 is a letter dated May 28, 2010 from Richard Allender of the Illinois Department of Insurance to Petitioner. Mr. Allender states that Chartis provided coverage under Petitioner's occupational accident insurance policy but that "[a]ccording to the Illinois Supreme Court, all trucking activities must be covered by workers' compensation, not occupational accident insurance." He further stated: "Therefore, it appears your employer may have violated Illinois law and could be responsible for workers' compensation for your injuries."

In a notice dated February 11, 2013, Shelton Wilson, Senior Investigator, Insurance Compliance, Illinois Workers' Compensation Commission, affirms and states, in pertinent part, the following:

"I have conducted a search of the NCCI Proof of Coverage (POC) online database. Based upon the information reported to and maintained by NCCI in its electronic database there appears to be no policy information showing proof of workers' compensation insurance on **3/22/08 for Uni Globe Courier 3694 Union Ave. Hapeville, Georgia 30354**. The NCCI records are not official records of the Illinois Workers' Compensation Commission and this search is provided as a courtesy and upon request of the parties in the above-indicated cause." Mr. Wilson attached such POC records. PX 2.

Jennifer A. Chamagua of National Council on Compensation Insurance ("NCCI") sent a letter dated August 13, 2013 to Petitioner's attorney. She enclosed certified records from their database for the period 1/1/08 through 12/31/08 with regard to the following matter: "Madan Lonial v. Uniglobe Courier Services, Inc., Illinois Workers' Compensation Commission Case # 10 WC 021911, Records Subpoena to NCCI dated July 15, 2013." Such records show, *inter alia*, that Respondent had a workers' compensation policy in effect that covered their employees in the State of Georgia. PX 2, Exhibit 14.

As discussed in issue (B) above, in a declaratory action in the Circuit Court of Cook County, Illinois styled HARTFORD UNDERWRITERS INSUANCE COMPANY, a Connecticut Corporation, Plaintiff, v. UNIGLOBE COURIER SERVICES, INC., and MADAN LONIAL, individually, Defendants, Case No. 2014 CH 13318, Respondent stipulated to a number of facts and documents. (PX 2)

With regard to the same action, Plaintiff filed, on February 9, 2016, their MEMORANDUM OF FACT AND LAW IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT. PX 1.

In a document filed March 29, 2016, with regard to the same action, Defendant Madan Lonial provided his RESPONSE TO HARTFORD'S MEMORANDUM OF FACT AND LAW IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT." PX 4.

In an ORDER entered on December 8, 2016, in the Circuit Court of Cook County, Illinois, Judge Sanjay Tailor, wrote, in pertinent part, the following:

"Hartford's Motion for Summary Judgment is granted. The Court finds and declares that Hartford owes no duty to defend or indemnify Uniglobe with respect to Lonial's claim in the Illinois Workers' Compensation Commission or Lonial's injuries alleged therein and that Lonial is entitled to no rights, title, or interest in the Hartford policy for recovery, if any, he makes in the Workers' Compensation Commission for [?]." PX 9, Exhibit A.

On March 29, 2017, the undersigned Arbitrator granted Respondent Employer's motion to dismiss Hartford and Travelers as Respondents from these proceedings. PX 9.

On March 21, 2019, Respondent Injured Workers' Benefit Fund ("IWBF") raised no objection to this case proceeding to trial.

Based on the foregoing, the Arbitrator finds that proper notice was provided to all parties and further finds that as there was no worker's compensation insurance coverage by Respondent Employer for Petitioner on March 22, 2008, Respondent IWBF is liable for this claim.

Brian T. Cronin — 7-25-19

Arbitrator — Date

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF LAKE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIKEAL ASHPOLE,

Petitioner,

vs. NO: 18 WC 37279

TRANSPORT SERVICE, LLC,

20 IWCC0555

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed under Section 19(b) of the Act by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical benefits, and temporary total disability (TTD) benefits, 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. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed August 30, 2019, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

20IWCC0555

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 $30,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: SEP 2 1 2020

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/pm
O: 8/5/2020
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

ASHPOLE, MIKEAL
Employee/Petitioner

Case# **18WC037279**

TRANSPORT SERVICE LLC
Employer/Respondent

20IWCC0555

On 8/30/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0529 TUITE LAW
KYLEE D MILLER
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

2337 INMAN & FITZGIBBONS LTD
STEPHEN M McCLARY
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g))
☐	Second Injury Fund (§8(e)18)
☒	None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mikeal Ashpole
Employee/Petitioner

v.

Transport Services, LLC.
Employer/Respondent

Case # **18** WC **37279**

Consolidated cases: ______

20IWCC0555

An *Application for Adjustment 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 **Waukegan**, on **7/2519**. 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. xx Were 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. xx Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **November 15, 2018**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**62,284.04**; the average weekly wage was $**1,197.77**.

On the date of accident, Petitioner was **56** 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 $**9,539.12** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**3,178.04** for other benefits, for a total credit of $**12,717.16**.

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 **$798.51**/week for **36 weeks**, commencing 11/16/18 through 7/25/19, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $ $**9,539.12** for TTD, **$0.00** for TPD, $**0.00** for maintenance, and $**3,178.04** (ppd advance) for other benefits, for a total credit of $**12,717.16**.

Respondent shall pay reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's causally related injuries pursuant to Sections 8 and 8.2 of the Act.

Petitioner's request for penalties and fees under 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.

Carolyn M. Doherty
Signature of Arbitrator

8/28/19
Date

AUG 30 2019

FINDINGS OF FACT

Petitioner testified that he has worked for Respondent, Transport Services, LLC., as a HAZMAT truck driver transporting chemicals for eight years. Accident is not in dispute. ARB EX 1. On November 15, 2018 Petitioner was making a delivery to EPS in Marengo Illinois when he slipped and fell on ice. T.8-9. He testified that he struck his back, head, and upper shoulders very hard. T.10. He testified that after lying on the ground for a time he was able to get back into his truck and contact his dispatch to inform them of the injury. T.11. They instructed him to call two injury hotlines, which he did. Petitioner testified that he was asked to give recorded statements. T. 11. However, Petitioner testified that he was slurring while talking to the nurse on the hotline so the calls were discontinued and he was told to contact dispatch again for further instruction. T. 12. Petitioner again contacted dispatch and asked them to contact 911 but they did not. Petitioner did not feel able to drive and called 911 for himself. T. 12.

Marengo Fire Department responded to Petitioner's 911 call on November 15, 2018. (PX4). They took a history of injury and noted Petitioner's chief complaint was head and back pain due to a fall. PX 4. EMS transported Petitioner to Centegra Hospital – Huntley ("Centegra"). The McHenry-Western Lake County EMS System Radio Report on November 15, 2018 under chief complaint and Paramedic observation showed Petitioner's mechanism of injury was a slip and fall from standing and that he complained of back and right shoulder pain and had not lost consciousness. (PX2/83). The McHenry Western Lake County EMS Run Form also states Petitioner fell and was complaining of headache, back pain, and shoulder pain. (PX2/84). The initial triage note from November 15, 2018 at Centegra shows Petitioner complained of pain in his head, neck, back, and bilateral shoulders. (PX2/85). He reported a history of a slip on fall due to ice that had occurred just prior to his arrival at the ER. (Id.). He was evaluated and instructed to follow up with his primary care provider. (T.14). Petitioner was given an off work note for the one day and prescribed Norco. PX 2, p. 89.

Petitioner testified that he followed up with the "employee doctor who does our DOT exams." T. 14, 26-27. On 11/19/18, Petitioner reported to Advocate Sherman Occupational Health ("Advocate Sherman") for further treatment. T.14-15. PX 6. The appointment was made by Petitioner's manager. T. 14. PX6/33-34. He testified that he had given a history of injury of slipping and falling on ice at work. T.15. The records reflect a history of slipping and falling on snow while loading a truck at work. His complaints were noted as headache, feeling foggy and upper back pain. PX 6p. 33. Petitioner testified that his personal concern initially had been for the pain in his head. T.14-15, T.49. In another portion of the note under chief complaint the physician listed: "WCI: pt slipped on ice at work, fell backwards injured head and upper back." (PX6/32). Petitioner was diagnosed with a fall, closed head injury, and cervical sprain. (PX6/31). He was discharged with a head injury, taken off work, and told to follow up on November 23, 2018. (PX6/34). Of note, the initial evaluation did not diagram Petitioner's upper back or shoulder. Instead the primary focus at the November 19, 2018 visit was on Petitioner's head injury.

On November 23, 2018 Petitioner followed up with Advocate Sherman as instructed. (PX6/26). In hand written notes, Petitioner was diagnosed on November 23, 2018 with "recheck head injury, *right shoulder,* and upper back pain." (PX6/26). He remained off work. (Id.). Petitioner's chief complaint at that time was pain in his neck and upper back due to a slip and fall. Petitioner continued to feel foggy. (PX6/28). He was instructed to follow up on November 26, 2018. (Id.). The pain diagram of November 23, 2018 indicated pain in the upper right shoulder and neck area. PX 6, P. 29.

On November 26, 2018 Petitioner followed up with Advocate Sherman. (PX6/25). In handwritten notes, it was reported that at that time his closed head injury was diagnosed as essentially resolved but his right shoulder

strain continued. (Id.). He was instructed not to drive the company vehicle or to use his right arm. (PX6/21). He was placed on a five pound lifting restriction. (Id.). His chief complaint was: "WCI: CHI, right shoulder pain." (PX6/22). He was instructed to undergo physical therapy for two weeks and to return for a follow up on December 10, 2018. (PX6/21). Petitioner testified that Respondent was unable to accommodate his work restrictions at that time. Petitioner testified he has remained off work since the date of his injury. (T.26).

Petitioner treated with Doctor of Physical Therapy, Amie Inamdar, at Marengo Physical Therapy from November 28, 2018 until December 7, 2018. On November 28, 2018, 13 days post accident, Dr. Inamdar recorded an onset of injury of November 15, 2018 due to a slip and fall backwards on the ice. (PX5/4). She reported Petitioner informed her that when he landed he felt immediate pain in his head and back. He lay there for a few minutes due to the severity of the pain. He was taken by ambulance to the ER and a CT was performed on his upper back and neck. She stated: "The patient's head and back pain was severe at the time, so he did not notice the presence of increased right shoulder pain until over the weekend as he had the weekend off." (emphasis added), (Id.). He noticed a general ache in the right shoulder along with significant difficulty in lifting and raising the arm, sleeping, and using the bathroom. Dr. Inamdar noted that the pain in the right shoulder still felt quite severe, especially when Petitioner tried to move it. (Id.). Dr. Inamdar noted "Onset due to: At home injury. Onset Speed: Sudden. Recent Symptom Trend: Condition worsening. Mechanism of Shoulder injury: Posterior blunt trauma." PX 5, p. 4.

Petitioner's pain was located in the neck, shoulder, and shoulder girdle. He reported feeling pain in the joint itself. (Id.). On assessment, Dr. Inamdar determined Petitioner presented with severe right arm pain along with limitations in right shoulder AROM, strength, and PROM. On exam he exhibited positive drop arm tests along with scapular compression with AROM indicating potential involvement of the right rotator cuff. (underline added). (PX5/6). His initial diagnosis was right shoulder tendinitis. (Id.).

At his second PT appointment on November 30, 2018 Petitioner reported feeling like something was torn or wrong with his shoulder joint. (PX5/9). Dr. Inamdar's report of onset remained the same as the November 28, 2018 note. (Id.). The diagnoses remained the same as the November 28, 2018 note. On daily assessment Dr. Inamdar noted that Petitioner was gaining range of motion but had visible tears in his eyes throughout treatment. (PX5/11).

On December 3, 2018 Petitioner returned to Dr. Inamdar reported feeling like something was wrong with his shoulder, like someone had shoved a piece of cardboard into it. (PX5/13). Attempts to raise the arm felt like something was tearing in his shoulder. (Id.). Petitioner's onset of injury and diagnosis remained unchanged from the original assessment. The daily assessment reported Petitioner was willing to try all exercises but that he experienced significant pain with certain activities. (PX5/16). Dr. Inamdar noted she had to tell the patient to stop performing exercises due to visible pain signs such as wincing, tears, and limited motion and scapular compensation. (Id).

On December 5, 2018 Petitioner reported to Dr. Inamdar that he continued to suffer from intense pain when trying to reach with his right shoulder. (PX5/18). The pain in his shoulder was so great at the end of the session that it made him feel nauseous. (Id.). The onset and diagnosis remained unchanged from the initial assessment.

Petitioner underwent his final visit at Marengo Physical Therapy on December 7, 2018. He reported his shoulder felt about the same as previous visits. (PX5/23). He experienced some pain at rest but the pain became stabbing and severe with certain movements, particularly with reaching. He continued to feel as if the pain was directly within the shoulder joint. (Id.). As with all previous visits, he continued to show positive O'Brien's, Hawkins-Kennedy, and Neer's testing, as well as positive Drop Arm Tests. (PX5/25). His onset and diagnoses remained

the same. Dr. Inamdar reported that Petitioner had undergone a total of 5 sessions and was willing and motivated to attempt all exercises. (PX5/26). However, his active range of motion, "AROM," tolerance had not progressed at all. Dr. Inamdar believed conservative treatment should be put on hold until further medical screening could be performed to address Petitioner's ongoing right shoulder pain and activities of daily living, "ADL," limitations. (Id.).

On December 8, 2018 Petitioner returned to Centegra ER with chief complaints of neck and back pain which "started yesterday (doing physical therapy.)" (PX2/56). Petitioner testified that he had been having headaches, was nauseated, was in pain, and had been having trouble sleeping. (T.17). The Order Sheet indicated the chief complaint of "right shoulder" and a diagnosis of "fall, contusion." PX 2, p. 59. The ER intake sheet indicated an admitting complaint of "back and shoulder pain W11/15/18." PX 2, p. 81. A second document entitled "Emergency Department" indicated Petitioner's reason for visit to the ER was "Back & Shoulder pain (upper back/neck)." Later, the ER physician, Dr. Hemant Patel, recorded a present history of illness as:

> "injury to right shoulder. The injury happened last night. Fell. Occurred at home. Patient is experiencing moderate pain. No injury to the head or neck or other injury. (3 weeks ago fell at work seen here had ct head and neck-neg except ddd c/s-then shoulder pain right has been getting pt and tense rx by OT workman's compensation and seen cardiologist stankovich-chronic afib on dig and carvidaol-had neg nuclear stress test-tonight had right shoulder pain going up to right neck on xarelto lives alone and he got worried truck driver.)" [sic.] (PX3/24).

Dr. Patel's discharge note from December 8, 2018 indicated that he assessed the following conditions : Single contusion to the right shoulder; fall (h/o shoulder injury), AFib. PX 2, p. 72, PX 3, p. 27..

At trial, Petitioner denied telling the ER physician that he fell at home. T. 19. On physical exam Dr. Patel noted Petitioner had mild tenderness located at the anterior aspect of the shoulder and that the shoulder exam was otherwise negative. Petitioner underwent a right shoulder x-ray and chest x-ray at the Centegra ER; both were negative. (PX3/25). The shoulder x-ray showed no fracture, normal alignment, and no bony lesion. (Id.). The radiologist, Dr. Christopher Wickman, noted in his x-ray report under Indications that Petitioner had had a "fall two weeks ago, with right shoulder pain, worse overnight." (PX3/26). Under indications for the chest x-ray Dr. Wickman reported symptoms of "light headedness and weakness." He recommended Petitioner undergo a nonemergent chest CT but no acute process was detected. (PX3/27). Upon discharge, Petitioner was instructed to "take one extra 'dig' [sic.] as today his rate was high, level was low in blood, follow up with 'PMD' [sic.]"

On December 10, 2018 Petitioner attended his regular follow up appointment previously scheduled with Advocate Sherman. (PX6/17). In handwritten notes, his chief complaint was: "WCI right shoulder follow up." (Id.). It was also noted that he had been seen on Saturday night at the Centegra ER. (Id.). He was diagnosed with a possible tear. (Id.). His diagnoses on discharge was right shoulder tendinitis. PX6/17). An MRI was ordered. Petitioner was restricted to no use of the right arm. (Id.). He was to follow up on December 19, 2019.

On December 18, 2018 Petitioner underwent an MRI at Advocate Sherman. (PX6/10). Under indications Dr. Phillip McDonald reported: Rotator cuff tear." (Id.). Under history it was noted that on November 15 patient fell backwards landed on his back. Under impression, he diagnosed mild tendinosis of the supraspinatus, mild tendinosis of the infraspinatus, moderate tendinosis of the superior distal fibers of the subscaplaris, and moderate degenerative changes of the acromioclavicular joint. (PX6/11).

Petitioner followed up with Advocate Sherman on December 19, 2019. (PX6/16). In hand written notes, Petitioner's chief complaint was right shoulder pain. (PX6/14). Under HIP Petitioner's onset was reported as

November 15, 2018 in the context of a fall. (Id.). Under progress notes it was reported the MRI report had been reviewed, Petitioner's arm was not much better since physical therapy and meds, and he was to be referred to an orthopedic." (PX6/16). In another portion of the notes from December 19, 2018, his chief complaint was: "WCI: head injury, right arm injury, injury date 11/15/18, work related." (PX6/13). He was given the restrictions of no use of the right upper extremity. (PX6/12). Petitioner testified that he was referred by Advocate Sherman to Dr. Gross. T. 20.

On December 28, 2018 Petitioner began treating with orthopedic surgeon Dr. Steven Gross at Lake Cook Orthopedics. (PX8). Dr. Gross recorded a history of injury to the right shoulder that had occurred about six weeks ago when Petitioner slipped and fell on ice while walking back to his truck at work. (PX8/8). Petitioner reported landing hard on his back and also the posterior part of his right shoulder. (Id.) He reported ongoing shoulder pain since that time with a pain at 6 out of 10. (Id). He had no history of any previous shoulder problems and reported that his shoulder was normal prior to his workplace injury. (Id). Dr. Gross noted the date of Petitioner's injury was 11/15/18. (Id). On examination Petitioner had "significantly positive" Hawkins and Neer impingement tests. (Id). Dr. Gross stated Petitioner was experiencing signs and symptoms consistent with traumatic bursitis to the area. (PX8/9). Dr. Gross stated he had reviewed the MRI and did not see any major structural damage at that time. (Id.). Dr. Gross performed a cortisone injection and referred Petitioner to additional physical therapy. (Id.). He placed Petitioner on no use of the right arm restrictions and instructed him to follow up in four weeks. (PX8/9-10).

Petitioner underwent PT with Illinois Bone and Joint Institute from January 16, 2019 to February 8, 2019. (PX9/19). T. 21. April Flood, PT, DPT noted at his first evaluation that Petitioner had been suffering from right shoulder pain for approximately 2 months beginning with an incident on November 15, 2018 when he slipped and fell on ice while at work. (PX9/23). Petitioner was discharged from PT having not met any of his PT goals. (PX9/19). He was to follow up with his doctor and was to undergo further medical imaging to address his remaining symptoms. (Id).

On January 25, 2019 Petitioner followed up with Dr. Gross. (PX9/12). Petitioner reported that the injection had not helped much at all. (Id).T. 21. He had started to attend PT, which was helping with range of motion, but he was still in pain. (Id.). Petitioner reported there was no light duty available for him at work and that he needed to wait until he had a full release to return back to work. (Id.). Dr. Gross's impression and plan stated that he had had the opportunity to review Petitioner's previous MRI exam and agreed with the radiologist's interpretation. (Id.). At that time the MRI showed evidence of rotator cuff tendinitis/ tendinosis and his physical exam was suggestive of the same diagnosis. (Id.). However, the equivocal O'Brien's test raised the possibility of superior labral pathology. Dr. Gross noted that Petitioner seemed to be struggling with his right shoulder, more so than what would be expected based on the results of the MRI. (PX9/13). Dr. Gross opined this raised the possibility of some additional pathology that might have been missed on the original MRI, such as a superior labral tear. (Id.). Dr. Gross instructed Petitioner to continue physical therapy and to see how he responded to it. If he did not improve, Dr. Gross believed it would be reasonable to order an MR arthrogram of the right shoulder in order to evaluate for superior labral pathology in better detail. (Id.).

Petitioner followed up with Dr. Gross on February 8, 2019. (PX9/10). Petitioner stated he was going to therapy, but he was not having any improvement. Dr. Gross stated he had received a note from the therapist a few days ago stating that Petitioner was not making progress and continued to "struggle mightily with discomfort and pain." (Id.). Petitioner reported that he had begun to notice more of a popping sensation in his right shoulder. On examination Dr. Gross noted the O'Brien's test was "overtly positive today and is much more notably positive than even at his last visit." (Id.). Dr. Gross reported that based upon Petitioner's physical examination, there may be a superior labral tear. Dr. Gross ordered an MR arthrogram of the shoulder to evaluate the possibility of

a superior labral tear. (Id.). PT was discontinued as Petitioner was not making any further progress. (Id.). A follow up visit was to be scheduled after the MR arthrogram was performed.

Petitioner testified that his MR arthrogram initially was not approved by workers compensation. (T.22). He testified that both his medical and TTD benefits were cut off on February 8, 2019. (T.23).

Petitioner testified he was sent to see Dr. Craig Phillips at Respondent's request for a Section 12 examination on March 5, 2019. (T.23). Dr. Phillips is an orthopedic specialist affiliated with Illinois Bone and Joint Institute. Following the Section 12 exam, the MR arthrogram was authorized by Respondent. Respondent also advanced four weeks of PPD to Petitioner in the amount of $3,178.04. ARB EX 1.

An MR arthrogram of the Petitioner's right shoulder was taken on April 3, 2019 at Illinois Bone and Joint Institute. (PX 9/14). The clinical indication was due to right shoulder pain, fall November 2018, no prior surgery. (Id.). The impression was: Nondisplaced tearing involving the posterosuperior, anterosuperior portions of the labrum, mild rotator cuff tendinopathy without discrete tear, and moderate to severe acromioclavicular, mild glenohumeral degenerative changes. Communication of these tears, as can be seen with a SLAP tear, was not ruled out. (Id.).

On April 5, 2019 Petitioner followed up with Dr. Gross to review the MR arthrogram. Dr. Gross reported that Petitioner had undergone an independent medical evaluation and the arthrogram had been approved. (PX9/8). Petitioner was reportedly still having pain in his right shoulder and was very frustrated with the pain and dysfunction in terms of the use of his shoulder. (Id.). On exam, O'Brien's and Speeds tests were positive. Dr. Gross sated he had independently reviewed the MR arthrogram and determined a superior labral tear was present. (Id.). There was some inflammation of the rotator cuff, but no full-thickness rotator cuff tear. He opined there was likely some bursal surface fraying present. There was also some downsloping of the acromion process, indicative of some likely impingement in the area. Some patchy chondromalacia was also present in the glenohumeral joint. (Id.). For his assessment and plan, Dr. Gross noted that Petitioner was suffering from a "sizable" superior labrum tear. (PX9/9). He believed this to be the primary source of Petitioner's pain. (Id.). He determined that conservative treatment had failed and that Petitioner was a good surgical candidate. (Id.).

Dr. Gross proposed Petitioner undergo a right shoulder arthroscopy, debridement, subacromial decompression and open biceps tenodesis. (PX 9/9). Dr. Gross discussed with Petitioner the likelihood of a more favorable outcome for this proposal rather than a labral repair. (Id.). However, Petitioner was advised that if there was more extensive tearing of the labral than was seen on the MR arthrogram; it may be beneficial to repair a portion of the labrum, in addition to the biceps tenodesis. (Id.). Petitioner expressed his desire for the procedure and Dr. Gross noted they would move forward with scheduling the procedure. (Id.). Respondent did not authorize the required procedure.

On May 13, 2019, Dr. William Heller at Midland Orthopedics saw Petitioner for a second Section 12 examination. RX 1. Dr. Heller stated in his report that he had reviewed the treatment notes from Centegra Huntley emergency department dated 11/15/18 and 12/8/18, treatment notes from Advocate Sherman commencing 11/19/18, physical therapy notes (he does not enumerate which facility), treatment notes of Dr. Steven Gross from 12/28/18 to 4/5/19, films and report from right shoulder MRI performed without contrast on 12/18/18, films and report from right shoulder MRI arthrogram performed 4/3/19, work status reports, and history forms completed by Petitioner. (RX1). Dr. Heller makes no specific mention of the EMS reports from November 15, 2018, the nurses or triage notes from November 15, 2018 at Centegra ER, or the nurses notes, radiology notes, or triage notes from December 8, 2018 at Centegra ER in his report.

Dr. Heller stated that he had reviewed both MRI's. He agreed the first MRI showed mild rotator cuff tendinosis and degenerative changes at the AC joint and no evidence of a contusion. He opined that the second MRI performed on April 3, 2019 did not show a superior labrum tear as described by the radiologist. He found no evidence of a definitive labral tear or SLAP lesion. (RX1). Instead, Dr. Heller opined that it was more likely that some of the intra-articular contrast dye had been injected into the anterior subcoracoid recess during placement of the injection needle. (Id.). He found the signal abnormality in the superior labrum described by the radiologist to be equivocal. RX 1.

Dr. Heller opined that Petitioner had suffered a head and neck contusion from his fall on November 15, 2018. He stated he found no definitive evidence on physical examination, medical records, or the MRI studies to indicate the Petitioner had suffered a significant right shoulder injury on 11/15/18. He stated that he did not see "...any evidence on the MRI evaluations to suggest the claimant has a significant abnormality of his right shoulder other than preexisting AC joint arthritis." (Id.). Dr. Heller supported this by saying all of Petitioner's initial complaints on 11/15/18 were related to his head and neck and that he had made no mention of any right shoulder complaints during his November 19, 2018 initial follow up. Dr. Heller went on to state that he believed the emergency room records of December 8, 2018 clearly indicated that the Petitioner had fallen at home the previous night and injured himself. Dr. Heller noted Petitioner denied this history of injury on December 8, 2018.

Dr. Heller opined that "for all of these reasons, I do not believe there is any evidence that the claimant suffered a right shoulder injury on 11/15/18. Based upon available records, I find it most likely that he may have injured his right shoulder in a fall at home on 12/7/18 but that is difficult to verify and the claimant, himself, denies that incident. In any case, I see no evidence to causally link right shoulder symptoms to the incident of 11/15/18. Furthermore, my interpretation of his MRI and MRI arthrogram is that he does not have significant intrinsic right shoulder musculoskeletal pathology. (Id.). Dr. Heller indicated that he did not believe Petitioner needed any additional treatment that related to the accident of 11/15/18. Dr. Heller's report is dated May 13, 2019, prior to Petitioner's right shoulder surgery.

On June 3, 2019 Petitioner underwent a right shoulder arthroscopy, debridement of labral tear, subacromial decompression, and open biceps tenodesis. (PX12/6). Dr. Gross's surgical report from June 3, 2019 states: "a tear of the superior labrum was identified. A full-thickness separation of the anterior superior aspect of the labrum was identified, indicating the anterior superior labral tear, as was predicted based on the results of the MR arthrogram." (PX12/10). Dr. Gross also identified biceps tendinitis, grade 2 chondromalacia in the central glenoid area, inflamed subacromial bursal tissue, and mild bursal surface fraying of the supraspinatus tendon. (Id.).

Petitioner began post-operative physical therapy with Illinois Bone and Joint Institute on June 17, 2019. (PX12/36). The date of injury was listed as November 15, 2018. The reason for referral was post surgical physical therapy. Petitioner reported to the therapist that he had a long history of shoulder pain over seven months and had been off work. Petitioner reported that since the shoulder had started hurting he could not do any lifting, pushing, or pulling due to how painful the shoulder had been. (Id.). Petitioner was evaluated and given a PT protocol. (Id.).

On June 18, 2019 Petitioner followed up with Dr. Gross. Dr. Gross reported that Petitioner was no longer feeling the "tugging pain" in his shoulder that he had experienced prior to surgery. (PX12/6). Petitioner continued to have some soreness in the shoulder for which he was taking Tylenol. (Id.). Dr. Gross noted in his impression and plan that Petitioner was doing very well and was compliant with treatment. He was to wear the sling for another two weeks, continue PT, and to follow his rehabilitation protocol. He was to follow up in six

weeks. (PX12/7). Petitioner was to remain off work if Respondent could not accommodate his restrictions of no over the head use of the right arm, no lifting with the right arm, and no repetitive use. (PX12/21).

Petitioner was still undergoing physical therapy at the time of trial on 7/25/19. T. 25-26. Petitioner testified that prior to his November 15, 2018 slip and fall he had no prior problems with his right shoulder, neck or back. (T.27). Petitioner testified that he attended annual DOT physicals at Advocate Sherman. (Id.) Petitioner had undergone and passed a DOT physical on September 21, 2018, a month and a half prior to his accident. (PX7/299). His exam related to his extremities on September 21, 2018 was normal. (Id). Petitioner testified that he currently notices soreness in his arm but that he is "getting better." T. 27-28.

On cross-exam, Petitioner testified that he reported head and upper back and shoulder pain to the paramedics and to the ER. T. 30-31. He testified that he experienced right shoulder pain immediately after the fall but was more concerned initially about his head injury which was more urgently painful at the time. T. 33. He did not recall making complaints specific to his right shoulder at the ER on the date of injury. T. 35. However, he testified that any record reflecting only head and cervical complaints would be incorrect. T. 38-43.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

(F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELEATED TO THE INJURY?

The Arbitrator initially notes that accident is not in dispute. ARB EX 1. Respondent disputes the causal connection between Petitioner's undisputed accident of 11/15/18 and the diagnosed right shoulder condition for which Petitioner underwent surgical repair. The Arbitrator finds that based upon the unbroken chain of events as credibly testified to by Petitioner and supported by the medical records, Petitioner's right shoulder condition is causally related to the accident of 11/15/18. In so finding, the Arbitrator notes that Petitioner slipped and fell on ice on November 15, 2018 striking his head, neck, and upper back. The EMS radio report and run report from November 15, 2018 reflect that Petitioner complained of shoulder pain immediately after his fall. PX 2. The initial triage note at Centegra also reflects that Petitioner was complaining of shoulder pain. PX 2.

Petitioner testified that he followed up with Advocate Sherman clinic for his post-injury evaluation on November 19, 2018. He stated that his employer set the appointment for him. Advocate Sherman evaluated his head and neck injury. Petitioner acknowledged that he considered the injury to his head initially to be the most severe of his conditions and that he was most concerned about treatment for his head. The 11/19/18 records do not specifically reference right shoulder pain but repeatedly reference upper back pain. Four days later – only eight days after the initial injury - on November 23, 2018, Petitioner followed up again with Advocate Sherman. They evaluated him for his head, neck, and right shoulder pain. On November 26, 2018, Petitioner was again evaluated for right shoulder pain and sent to PT. PX 6.

Thereafter, on November 28, 2018, Petitioner's physical therapist recorded an onset of injury of November 15, 2018 due to a slip and fall backwards on the ice. (PX5/4). She reported Petitioner informed her that when he landed he felt immediate pain in his head and back. He lay there for a few minutes due to the severity of the pain. He was taken by ambulance to the ER and a CT was performed on his upper back and neck. She stated initially his head injury had been more severe and he did not focus on the increase in shoulder pain until a few days later. The physical therapy records indicate "The patient's head and back pain was severe at the time, so he did not notice the presence of <u>increased</u> right shoulder pain until over the weekend as he had the weekend off."

(emphasis added), (Id.). He noticed a general ache in the right shoulder along with significant difficulty in lifting and raising the arm, sleeping, and using the bathroom. Dr. Inamdar noted that the pain in the right shoulder still felt quite severe, especially when Petitioner tried to move it. (Id.). The Arbitrator does not find that Petitioner reported an injury occurring at home but rather an increase and worsening of the right shoulder pain over the weekend at home.

Petitioner underwent physical therapy for his right shoulder from November 28, 2018 to December 7, 2018. He was released from PT on December 7, 2018 when it was determined he was not making significant progress and should be re-evaluated to determine an alternative course of treatment. During PT Petitioner consistently complained from the onset that he felt something was torn in his shoulder. Throughout PT he had positive O'Brien's, Hawkins, Speed, and Drop Arm tests. The Arbitrator finds that the initial medical records from 11/15/18 through 12/7/18 clearly reference injury and complaints involving Petitioner's head, neck, upper back and right shoulder and so buttress a finding of causal connection for all of those injuries under a chain of events analysis. The Arbitrator is not dissuaded by Dr. Inamdar's reference to an onset of injury "at home."

The Arbitrator also notes the December 8, 2018 Centegra ER record noting that Petitioner fell at home. The Arbitrator further notes Dr. Heller's opinion that this single entry supports a finding of an intervening accident on December 8, 2018 sufficient to sever any causal connection for the right shoulder injury. The Arbitrator finds this argument and opinion to be without merit based on the overwhelming majority of treating records supporting a right shoulder injury stemming from the fall at work on 11/15/18. Petitioner credibly testified that he did not have a fall at home on December 7 or 8, 2018. Instead he stated he was having significant pain, headaches and trouble sleeping that prompted him to visit the ER. The records from December 8, 2018 in their entirety show that Petitioner had been seen at the ER a few weeks earlier for a fall. This is in reference to his November 15, 2018 injury where he was evaluated at the same ER. The note goes on to explain that Petitioner was undergoing intense PT/ OT for workers compensation, had chronic a-fib, and was taking "dig." Ultimately the ER modified his heart medications for the day, instructing him to take additional "dig", an abbreviation for digoxin. The x-ray of the shoulder taken on December 8, 2018, was negative and did not reflect any new injury. The majority of records from the December 8, 2018 visit as noted above reference the fall a few weeks earlier and consistent right shoulder pain complaints thereafter.

Petitioner followed up with Advocate Sherman on December 10, 2018 for a previously scheduled visit to evaluate his head, neck, and shoulder injury from the November 15, 2018 fall. Although they noted he had been at the Centegra ER over the weekend, the primary reason for his visit remained a workers' compensation follow up visit. Subsequent visits at Advocate Sherman from December 10, 2018 through December 19, 2018 continue to list the workers' compensation injury of November 15, 2018 as the need for treatment.

The medical record does not support the theory that Petitioner had an intervening accident at home on December 8, 2018. Petitioner's treaters at Advocate Sherman were aware of the December 8, 2018 ER visit but continued to treat his right shoulder as a part of his workers compensation injury. On December 19, 2018 at his last visit with Advocate Sherman, the treating physician specifically stated: "WCI: head injury, right arm injury, injury date 11/15/18, <u>*work related*</u>." (*emphasis added.*). Petitioner's treating physicians clearly stated that Petitioner's shoulder condition continued to remain causally related to his work place accident on November 15, 2018.

Only Dr. Heller's opinion concludes Petitioner suffered an intervening accident on December 8, 2018. The Arbitrator finds Dr. Heller's opinion to be unpersuasive as it is not supported by the medical evidence in its entirety. Dr. Heller makes no mention of the triage notes, nurses' notes, or EMS run report of November 15, 2018 in which Petitioner complains of shoulder pain. He makes no mention of the triage notes, nursing notes, or

radiology notes from the December 8, 2018 Centegra ER visit. He makes no mention of the fact that Petitioner's treaters continued to state Petitioner's injury was work related even after December 8, 2018. Finally, Dr. Heller opined that nothing was substantially wrong with Petitioner's shoulder. Instead, Dr. Heller assumes, without evidence, that the contrast dye was improperly inserted during the MR Arthrogram. Dr. Steven Gross' surgical report provides ample basis in support of the finding that Petitioner had suffered a substantial right shoulder labral tear in addition to other significant shoulder pathology at the time of his 11/15/18 work fall.

Petitioner continues to treat with Dr. Steven Gross from December 28, 2019 through present. Petitioner testified that he underwent surgical repair of his shoulder on June 3, 2019. He continues to treat with Illinois Bone and Joint for physical therapy. Petitioner testified that he did not have a prior injury to his right shoulder.

Based on the chain of events, the Arbitrator finds causal connection for Petitioner's right shoulder injury and treatment, including the surgery. The Arbitrator further finds that Petitioner did not have an intervening accident on December 8, 2018 sufficient to sever causal connection for any of the denoted conditions. The Arbitrator is not deterred in making these findings by any perceived delay in symptom reporting or by any discrepancies in the ER history which are clearly outweighed by the majority of treatment records documenting right shoulder complaints from the date of accident. Again, causal connection for Petitioner's closed head injury and cervical sprain is not in dispute. To the extent those conditions are disputed, the Arbitrator finds causal connection for those conditions as well based on the medical treatment records. In sum, the Arbitrator finds that Petitioner suffered work related injuries to his right shoulder, back, head, and neck on November 15, 2018. Petitioner timely reported these injuries to his treating providers and Respondent.

(J) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with the care and treatment of Petitioner's causally related injuries pursuant to Sections 8 and 8.2 of the Act. PX 1. Respondent shall receive credit for amounts paid, if any. Respondent shall hold Petitioner harmless from any reimbursement claim made by an employer provided group insurance medical plan, if applicable.

(K) WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner alleges he is entitled to TTD from November 16, 2018 to present. Respondent disputes stating Petitioner is only entitled to TTD from November 16, 2018 to November 26, 2018. Respondent also asserts a credit for $9,539.12 for previous payment of TTD. ARB EX 1.

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner TTD for 36 weeks commencing November 16, 2018 through July 25, 2019. The record shows, and Petitioner testified, that he has remained off work, either from a full restriction or due to Respondent's inability to accommodate Petitioner's light duty restrictions, from November 15, 2018 through present. Petitioner's current condition of ill being and therefore his current off work status remains causally related to his workplace injury of November 15, 2018. Respondent is entitled to a credit for previously paid TTD in the amount of $9,539.12. ARB EX 1.

(N) Is Respondent due any credit?

Respondent asserts a $9,539.12 credit for payment of TTD. Respondent also asserts a $3,178.04 PPD advance payment credit. Petitioner agrees to these credits. ARB EX 1. Therefore, the Arbitrator finds that Respondent is entitled to a credit for previously paid TTD as noted above and PPD advance payment credit totaling $12,717.16.

(M) Should Penalties or fees be imposed upon Respondent?

Having considered the arguments regarding Petitioner's request for penalties and fees under the Act presented by both parties, the Arbitrator finds that Respondent's conduct was not so unjustified, unreasonable or vexatious so as to justify the imposition of penalties and fees under the Act. Petitioner's request for penalties and fees under the Act 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	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
ROCK ISLAND	)		☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Martinez,

Petitioner,

vs. NO: 15 WC 42090

Jim Giese Commercial Roofing,

Respondent.

20 I W C C 0 5 5 6

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 expenses and the chain of referral, temporary total disability, and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator with the changes made below, which is attached hereto and made a part hereof.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of Petitioner's medical expenses, particularly the chain of referral, which was not expressly addressed in the Decision of the Arbitrator.

Respondent maintains that the Arbitrator erred in awarding the expenses incurred treating with Dr. Waqas Hussain, arguing that Petitioner violated the "two-physician rule" and did not establish a proper chain of referral. See 820 ILCS 305/8(a)(2), (a)(3) (West 2014). The determination as to whether a medical provider is the choice of the claimant or within a chain of referral from a chosen provider is a question of fact for the Commission to determine. *Bassgar, Inc. v. Illinois Workers' Compensation Comm'n*, 394 Ill. App. 3d 1079, 1085 (2009).

In particular, Respondent claims that Petitioner should not be awarded the expenses incurred while treating with Dr. Hussain, arguing that Petitioner's initial choice of physician was Dr. David Birdsell and his second choice was his primary care physician, Dr. David Ade. Respondent submitted an exhibit (RX2) indicating that one of the claims it paid was for

Petitioner to see Dr. Ade on November 4, 2015. Respondent asserts in the Statement of Exceptions that Petitioner complained to Dr. Ade of left shoulder pain and indicated that he was treating with a chiropractor, but neither Petitioner nor Respondent submitted a medical record for this date. Moreover, other than asking whether Petitioner received treatment between September 25 and November 17, 2015, no testimony was elicited about Petitioner's visits or treatment with Dr. Ade for his left shoulder or any other treatment. Accordingly, there is no evidence before the Commission that Petitioner complained to Dr. Ade of left shoulder pain, let alone that Dr. Ade treated Petitioner's left shoulder. Indeed, Petitioner testified that he initially treated with Dr. Birdsell in June 2015, as opposed to with his primary care physician, because the "regular" doctor does not take away that kind of pain.

Given the lack of evidence that Dr. Ade treated Petitioner's left shoulder, the Commission rejects Respondent's argument that Petitioner violated the "two-physician rule" and did not establish a proper chain of referral.

In all other respects, the Commission affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved his current condition of ill-being is causally connected to the accident in this case.

IT IS FURTHER FOUND BY THE COMMISION that Petitioner failed to prove that he is entitled to any further temporary total disability compensation benefits from Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's medical expenses in the amount of $36,900.18 pursuant to the fee schedule and §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for any amounts already paid by Respondent on the awarded bills. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receives a credit, pursuant to § 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $530.16 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 a 15% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

20IWCC0556

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 1 2020
o: 9/3/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, JOSE Case# **15WC042090**
Employee/Petitioner

JIM GIESE COMMERCIAL ROOFING **20IWCC0556**
Employer/Respondent

On 1/8/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1,52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1367 HOPKINS & HUEBNER PC
PAUL SALABERT
100 E KIMBERLY RD SUITE 400
DAVENPORT, IA 52806

4866 KNELL O'CONNOR & DANIELEWICZ
TORRIE POPLIN
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

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

Jose Martinez
Employee/Petitioner

v.

Jim Giese Commercial Roofing
Employer/Respondent

Case # **15** WC **42090**

Consolidated cases: ____

20 I W CC0556

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission in the city of **Rock Island, Illinois**, on **November 6, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] 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 **August 26, 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 $**45,947.20**; the average weekly wage was $**883.60.**

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**555.32** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he is entitled to any further temporary total disability compensation benefits from Respondent.

Respondent shall pay reasonable and necessary medical services of $**36,900.18**, as provided in Section 8(a) and 8.2 of the Act. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**530.16/week** for **75 weeks** because the injuries sustained caused **15%** loss of use of the person as a whole as provided in Section **8(d) (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

January 6, 2020
Date

JAN 8 - 2020

FINDINGS OF FACTS

Petitioner testified via a Spanish interpreter/translator that he began working for Respondent from 1993 to 1996 and from 1998 until October 27, 2015. (Tr. pp. 18-19) Petitioner's job consisted of roofing, insulation, and removing old insulation. Petitioner further testified that on August 26, 2015, his supervisor was Bob.

On August 26, 2015, Petitioner said that he was working at 12:30 at night at John Deere in East Moline. (Tr. p. 20) At that time, there were generators that were being used to run the lights. One generator was running low on diesel and Bob told Petitioner to get a container, which contained about five gallons of diesel, to put into the generator. (Tr. p. 20) Petitioner testified that he was being rushed to bring the diesel because the generator was running low and was going to shut off. (Tr. p. 20) Petitioner further testified that as he was running with the container in his left hand he tripped over the handle of a cart. (Tr. p. 20) Petitioner was unable to see the cart handle because of a bundle of insulation blocking it. Petitioner's accident was witnessed by other people working. Petitioner's supervisor, "Doc," helped to get Petitioner up off the floor of the roof. (Tr. p. 21)

At the time of the fall, Petitioner had a lot of pain in his left shoulder and was screaming in pain. (Tr. p. 22) After the fall, Doc asked him if he was ok. Petitioner testified that he continued to have strong pain in his shoulder. Petitioner continued to work that evening until six in the morning. However, he wasn't doing anything heavy and was told to go inside the plant to make sure there was nothing falling from the ceiling.

Petitioner presented to Birdsell Chiropractic on August 28 2015. (Tr. p. 23 & Px. 1) At that time, Petitioner indicated that he had a pain rating of 7 out of 10 for motion in his left shoulder. (Px. 1) Petitioner testified that after the August 26, 2015, accident, he was unable to lift his left arm above shoulder height. (Tr. pp. 25-26) If he tried to lift it any higher, it would drop on its own. (Tr. p. 26) On August 28, 2015, Petitioner told Dr. Birdsell about his work accident. (Tr. p. 26) Dr. Birdsell gave him a massage and put some wires on his arm to shock the nerves. (Tr. pp. 26-27) The treatment did not provide Petitioner with any relief. (Tr. p. 27) Petitioner again was treated by Dr. Birdsell on September 11, 2015. Dr. Birdsell noted that on palpation of the left supraspinatus there was a moderate measure of tenderness as well as to the left shoulder. (Px. 1) Petitioner last was treated by Dr. Birdsell on September 25, 2015. (Px. 1)

On October 27, 2015, Petitioner was evaluated by Delos D. Carrier, MD at the request of his employer. (Px. 3) Dr. Carrier took a history from Petitioner. (Px. 3) He noted that Petitioner reported that on August 19, 2015, he tripped and fell while working on a job site. Additionally, Petitioner had seen a chiropractor several times for his left shoulder. Petitioner presented with pain located in the left shoulder which he described as sharp and moderate. Petitioner told Dr. Carrier that he noticed that it was made worse by certain movements and raising the arm upward.

Petitioner further told Dr. Carrier that at the time of the accident he needed to get diesel fuel from a cart and was caring a 5-gallon container while walking between two carts on top of the roof of a building. (Px. 3) Petitioner was walking between these two carts and his right leg struck a handle that was part of one of these carts. He fell while holding the diesel fuel container in his right hand and fell to his left side. He stated he struck his left side, face, and neck against something and felt immediate left shoulder pain. (*Id.*) His foreman, "Doc," helped him get up. Petitioner told Dr. Carrier that he went to see a chiropractor in June 2015 because he slept on his shoulder wrong. (*Id.*)

Dr. Carrier noted that he called "Doc" Dan Sendt and asked him about what he saw with respect to Mr. Martinez's injury. He stated he couldn't remember the exact date of the injury, but that he saw Mr. Martinez trip over a handle of a four wheel the wagon. He fell to the roof surface, but doesn't remember much more with respect to how he fell. (Px. 3)

Dr. Carrier performed an examination of Mr. Martinez's left shoulder. Dr. Carrier noted that there was tenderness to palpation over the deltoid. Movement of the shoulder caused significant pain. A painful arc existed during abduction. Yergason's test was positive. Neer's test was positive. Speed's test was positive. O'Brian's test was positive. Drop arm test was positive. Petitioner used shoulder shrug to try to bring the arm down slowly. Finally, Hawkin's test was positive. (Px. 3)

It was noted that Dr. Carrier reviewed the records of David Birdsell, DC from June 15, 2015, through September 25, 2015.

With regard to medical causation, Dr. Carrier noted that "Mr. Martinez had a witnessed fall apparently on August 19, 2015, or possibly on August 26, 2015. This injury was witnessed by Mr. Dan "Doc" Sendt. My clinical examination was suggestive of a left shoulder rotator cuff injury. At the very least, he appears to have a rotator cuff strain, but there is a high probability that he has a rotator cuff tear." (Px. 3) Dr. Carrier opined that he cannot within a reasonable degree of medical certainty conclude that the reported August 19th or August 26, 2015, work injury was because of Mr. Martinez's current complaints. (*Id.*) He based his conclusion solely on the examination note of Dr. Birdsell from June 15, 2015. Moreover, Dr. Carrier made it a point to note "[i]nterstingly, Dr. Birdsell's August 28, 2015, chiropractic note states, "His improvement is affected by an acute exacerbation of symptoms." I am not sure as to why Dr. Birdsell made this comment, because there is no documentation of worsening of Mr. Martinez's medical condition from Mr. Martinez's physical findings and complaints on August 28, 2015, in comparison to his complaints and findings documented and the last appointment in June 2015 with Dr. Birdsell." (*Id.*)

On November 17, 2015, Petitioner presented and was evaluated by Waqas Hussain, MD. (Px 2) Dr. Hussain had previously treated and operated on Petitioner's right shoulder. (Tr. p. 28) Petitioner testified that at that time he gave Dr. Hussain a history of his August 26, 2015 accident. (*Id.*) Dr. Hussain noted that Petitioner had a history of left shoulder pain that began August 26, 2015 and the problem had been getting worse. In fact, Petitioner had difficulty with work, recreational, and every day activities. Dr. Hussain further noted that it was worsening with exercise, lifting, and direct pressure, but better with rest.

Dr. Hussain's examination of Petitioner's left shoulder demonstrated mild tenderness to palpation with slightly decreased range of motion. (Px. 2) Dr. Hussain's preliminary diagnosis was that left shoulder pain concerning for rotator cuff tear, bicipital labral pathology, impingement, and symptomatic acromioclavicular joint osteoarthritis. (*Id.*)

Dr. Hussain administered a corticosteroid injection and scheduled Petitioner for a repeat evaluation. Finally, Petitioner was returned to work with desk duties only. (Px. 2) Petitioner testified he did not return to work with Respondent after October 28, 2015. (Tr. p. 29)

On December 15, 2015, Petitioner was again seen by Dr. Hussain. (Px. 2) Petitioner continued to have pain and limited range of motion. At that time, Dr. Hussain recommended an MRI arthrogram of the left shoulder and kept Petitioner on restricted work of left arm desk duties, light duties. (*Id.*) Petitioner underwent an MR arthrogram on March 3, 2016. (Px. 4) The MR arthrogram revealed that Petitioner had:

- Massive rotator cuff tear involving the supraspinatus infraspinatus and subscapularis tendons with atrophy of the muscle bodies of these tendons;
- Ruptured biceps tendon; and
- Diffuse degeneration and tearing of the glenoid labrum.

On March 16, 2016, Dr. Birdsell authored a report wherein he opined that "[a]fter consulting with Mr. Martinez in reviewing my patient records and the findings from a recent MRI of his left shoulder on March 3, 2016, my opinion is that Mr. Martinez injured his left shoulder in the work-related injury of August 2015 and either caused and/or aggravated the condition found on the MRI." (Px. 5) Dr. Birdsell further stated that "[i]nitially, I was treating Mr. Martinez for supraspinatus sprain/strain. After the August 2015 work related injury, it was apparent that a new injury had occurred to the left shoulder from the fall he sustained at work and an acute exacerbation presented by the patient on August 28 2015." (*Id.*)

Petitioner returned to Dr. Hussain on August 5, 2016 with worsening problems in the left shoulder. (Px. 2) Dr. Hussain noted the injury occurred after a fall while working where he landed on his left shoulder. Prior to his fall Petitioner had not had any pain or problems related to his shoulder. It was also noted Petitioner tried a course of conservative treatment including injections, physical therapy, chiropractic care, and activity modification without sustained relief. (*Id.*) Dr. Hussain reviewed the March 3, 2016 MRI of the left shoulder with Petitioner. Dr. Hussain further reviewed the results with Petitioner and advised him that he may need a left total shoulder arthroplasty in the future. For now, Dr. Hussain recommended Petitioner undergo a left shoulder arthroscopy, rotator cuff repair versus debridement, labral debridement, and subacromial decompression. (*Id.*)

Petitioner was again seen on August 16, 2016. It was noted he has not had any betterment of his symptoms. Dr. Hussain also had a discussion with Petitioner in regard to the timeline for his symptomatology and injury. This was done through a medical Spanish translator. Dr. Hussain noted that "patient did affirm that he has had symptoms and problems in his left shoulder in the past, which have not limited him from doing many of his normal activities and exercises. He did admit that he saw symptomatic relief with a chiropractor in the past. He qualified his pain as mild prior to the injury but more moderate to severe after the injury in 08/2015. In summary, he noted that although he had mild symptoms prior to his injury, they did not limit him significantly in terms of what he could or could not do, particularly from a work standpoint, and after his injury, his symptoms increased in severity and continue to cause him problems and issues to this date." (Px 2)

Petitioner testified that he wanted to go ahead with surgery at that time. (Tr. p. 30) However, Petitioner did not have health insurance to cover the cost of surgery. (*Id.*)

On August 22, 2016, Dr. Hussain authored a report wherein he stated he reviewed complete medical records from Dr. Birdsell from June 15, 2015 through August 28, 2015. (Px. 6) Dr. Hussain also noted that he had an opportunity to discuss the clinical history contained in those records with Mr. Martinez on August 16, 2016. The history included the fact that Petitioner's shoulder symptoms prior to his work injury of August 26, 2015 were mild in nature and had improved after treating with Dr. Birdsell June 15, 24, and 29, 2015. In stark contrast to when he saw Dr. Birdsell August 28, 2015, two days after the acute injury to his left shoulder at work, with an acute exacerbation of pain and worsening symptoms to the point to which he was unable to effectively perform his work activities. (*Id.*) Dr. Hussain opined within a reasonable degree of medical certainty that there was an acute exacerbation of the symptoms due to the work injury on August 26, 2015, to which the patient reports continued symptoms and problems. He further opined that Petitioner's ongoing symptoms and complaints of pain and limitations are at the very least the result of an aggravation of an underlying condition and have continued to cause the patient ongoing problems. Finally, he opined that Petitioner perform activities that would minimize exacerbation of his underlying problem including limited repetitive exercise with the effect of extremity and only rear overhead activities. (*Id.*)

On April 27, 2017, Petitioner underwent a Section 12 examination at the request of Respondent with Dr. Guido Marra. (Px. 7) The history noted that on August 26, 2015, Petitioner was at work, tripped over a handle, and hit and struck the lateral aspect of his shoulder. (*Id.*) It was also noted Petitioner noticed immediate pain and difficulty with using his arm. Dr. Marra further noted that he reviewed records provided to him by Respondent. (*Id.*) Dr. Marra summarized the records he reviewed as follows: "I had the opportunity to review his MRI scan, which documents are very large retracted rotator cuff tear. There is evidence of muscle atrophy. There is medial subluxation of his biceps tendon and a tear of the supra, infra, and subcapularis. There are no signs of any substantial glenohumeral arthrosis. I did have the opportunity to review Dr. Hussein's office notes and the chiropractic physician David Birdsell's, which are consistent with the above history." (*Id.*) Dr. Marra was asked several questions and provided answers to the same as follows:

Question: "Please summarize the history provided by the petitioner regarding the mechanism of injury for his alleged 8/26/2015 work incident. Is the history regarding a mechanism of injury for his alleged 8/26/2015 incident consistent with complaints and/or objective findings in the medical records during your exam? Please explain."

Response: "They are consistent with a rotator cuff tear. This is based on a traumatic event with complaints of pain."

Question: "Summarize the history provided by the petitioner, if any regarding prior injuries or complaints to his left shoulder work incident. Please explain what if any pre-existing or degenerative condition the petitioner suffered prior to the 8/26/2015 incident."

Response: "Review of the MRI scan does demonstrate some evidence of chronicity of this tear, which can be an acute extension of a chronic rotator cuff tear. The subcapularis tear does appear to be more acute in nature, while the supraspinatus appears to be a chronic injury."

Question: "Did the petitioner exhibit signs of symptom magnification?"

Response: "No."

Question: "Is the petitioner's current diagnosis causally related to the work accident? Is the petitioner's current state of ill-being a normal result of a degenerative process of a preexisting condition? Was there an acceleration of a preexisting degenerative condition? Alternatively, did he suffer a temporary exacerbation of the alleged 8/26/2015 work incident? Please explain and provide any objective findings and the basis thereof."

Response: "It appears to me that Mr. Martinez had an acute extension of a chronic tear of his rotator cuff. I do feel that this is causally related to the work accident."

Question: "Are there any work restrictions for petitioner's current condition necessary as a result of the 8/26/2015 incident? If so, please provide restrictions and duration."

Response: "Yes, I currently would provide the restriction of no lifting more than 10 pounds and no overhead work."

The Arbitrator notes that in addition to the above questions, Dr. Marra was specifically asked "[i]f your opinion as to the petitioner's current diagnosis and objective findings differentiate from the previous IME." To which Dr. Marra responded: "Please see above regarding my opinions." Therefore, it is clear that Dr. Marra also reviewed the IME report of Dr. Carrier in preparing his report. (Px. 7)

At hearing, Respondent introduced a letter authored by Dr. Marra and dated January 11, 2018. (Rx. 1) The letter indicates that it is an addendum of his IME and based on additional records sent to him. Dr. Marra summarized the same records he claimed to have reviewed in his April 27, 2017 report and the records summarized in Dr. Carrier's IME report. However, this addendum report notes that Dr. Marra does not believe the injury is work related and clearly a preexisting condition. Dr. Marra does not opine whether or not the condition was aggravated by the August 26, 2015, accident.

Petitioner testified that after the April 27, 2017, Section 12 examination his arm was still hurting and he couldn't lift it above his shoulder or head. (Tr. p. 31) He also testified that he was able to lift his arm above his head and shoulder prior to August 26, 2015. (Tr. p. 32).

The deposition of Dr. Hussain was taken on May 10, 2018. (Px. 13) Dr. Hussain testified as to his examination and treatment of the Petitioner for his August 26, 2015 accident. Dr. Hussain testified that Petitioner did affirm that he had symptoms and problems in his left shoulder in the past, which had not limited him from doing many of his normal activities and exercises. He did admit that he saw symptomatic relief with the chiropractor in the past. He qualified his pain as mild prior to the injury, but more moderate to severe after the injury in August 2015. (Px. 13, p. 12) Dr. Hussain also testified that although Petitioner had mild symptoms prior to his injury, they did not limit him significantly in terms of what he could or could not do, particularly from a work standpoint point and after his injury, his symptoms increased in severity and caused him problems and issues to date. (*Id.*) Dr. Hussain further testified that typically with this type of tear pattern, where it's a massive tear involving the near entirety of the rotator cuff, he often sees this in the context of a traumatic injury. (Px. 13, p, 24) Dr. Hussain explained that systemic problems or other medical issues typically do not cause these types of problems, not to this severity. (*Id.*) Finally, Dr. Hussain testified within a reasonable degree of medical certainty that Petitioner's condition of ill-being was due to the work-related injury that had occurred. (Px. 13, p. 13)

On June 19, 2018, Petitioner returned to Dr. Hussain, since he had obtained insurance at that time. (Tr. 32) Dr. Hussain noted that his pain increased with abduction and that there were no new accidents or injuries that would contribute to his onset of pain. (Px 2) Dr. Hussain recommended another MRI of the left shoulder for further investigation.

Petitioner had another MRI on June 26, 2018. The MRI arthrogram revealed the following:

- Massive tears of the supraspinatus and infraspinatus tendons with marked retraction and muscle atrophy;
- Tear of the subscapularis tendon with dislocation of the biceps tendon medially; and
- Degenerative changes at the AC joint. (Px. 2)

The deposition of Dr. Birdsell was taken on June 20, 2018. (Px. 14) Dr. Birdsell testified as to the treatment he rendered to Petitioner from June 15, 2015 to June 29, 2015. According to Dr. Birdsell, Petitioner had some pain in his left shoulder but was able to lift his arm above his shoulder. (Px. 14, p. 9) Dr. Birdsell also testified as to his examinations and treatment of the Petitioner for his August 26, 2015 accident. Dr. Birdsell testified that on August 28, 2015, Petitioner presented with a history of his August 26, 2015 work accident where he fell on his left shoulder. (Px. 14, p. 18) Dr. Birdsell testified within a reasonable degree of chiropractic certainty that Petitioner's August 26, 2015 fall injured supportive tissue, particularly the tendons and the supraspinatus, infraspinatus, and subscapularis and biceps tendon of his shoulder. (Px. 14, p. 25-26) During the deposition, Respondent repeatedly asked Dr. Birdsell to explain subtle changes in the wording of his record. Dr. Birdsell credibly explained that he may have changed some notes after speaking with Petitioner's children as Petitioner was mainly Spanish speaking. (Px. 14, pp. 37, 45)

On July 10, 2018, Petitioner was again seen by Dr. Hussain. Dr. Hussain noted that he reviewed his history and physical examination findings with Petitioner. Dr. Hussain recommended left shoulder arthroscopy, rotator cuff repair versus debridement, biceps tendon tenolysis versus tenodesis, and subacromial decompression. (Px. 2) On August 14, 2018, Petitioner presented for a pre-operative consult with Dr. Hussain. (*Id.*)

Petitioner underwent surgery on August 29, 2018. (Px. 9) Dr. Hussain performed a left shoulder arthroscopy, rotator cuff repair, a biceps tenotomy with tenolysis, superior labrum anterior and posterior (SLAP) tear debridement, anterior labral debridement and glenoid chondroplasty, removal of loose body, and subacromial bursectomy. (*Id.*) Dr. Hussain noted that there was obvious evidence of full-thickness retracted tears of both the supraspinatus and infraspinatus.

Post surgically, Petitioner underwent physical therapy at Genesis Physical Therapy from September 4, 2018 to February 18, 2019. (Px. 10 & 11)

On September 13, 2018, Petitioner was seen by Dr. Hussain. (Px. 2) It was noted Petitioner was overall doing well and happy with his progress. Petitioner's sutures were removed. Dr. Hussain recommended continuing with formal physical therapy.

On October 11, 2018, Petitioner returned to Dr. Hussain for reevaluation of his left shoulder. (Px. 2) Dr. Hussain noted that he was wearing his sling as previously instructed. His incisions were well healing. It was recommended he continue physical therapy and was provided with the script for Naproxen.

On December 11, 2018, Petitioner was again seen by Dr. Hussain. (Px. 2) Petitioner was advised he could discontinue his sling and was recommended that he continue physical therapy.

Petitioner was last seen by Daniel Nichols, PA-C on March 11, 2019. (Px. 2) He reported he still had some occasional clicking and popping particularly when raising his arm above shoulder level. It was noted, Petitioner continued to do his home therapy exercises. Petitioner was discharged from care at that time. On June 18, 2019, Petitioner was given a return to work slip with no restrictions. (Px. 2)

Petitioner testified that since his surgery he has not had any other accidents or injuries to his left shoulder. (Tr. p. 33)

Arbitrator's Credibility Assessment

The Arbitrator notes that the petitioner does have some issues regarding his credibility. It is troubling that the petitioner denied any prior issues or symptoms until confronted on cross-examination when his prior medical treatment was reviewed. Then, he still downplayed this.

In spite of this, the petitioner's testimony still established a witnessed work accident, immediate medical treatment, and evidence regarding causation.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to Disputed Issue C - Did an accident occur that arose out of and in the course of petitioner's employment by the respondent, and Disputed Issue F - Is the petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

Having considered the totality of the evidence adduced at hearing, the Arbitrator finds that on August 26, 2015, Petitioner sustained an accidental injury arising out of and in the course of his employment with respondent.

The Arbitrator notes that the findings and opinions of Dr. Birdsell and Dr. Hussain are more persuasive than those of Dr. Carrier and Dr. Marra. The Arbitrator further notes that Dr. Marra initially agreed with both Dr. Birdsell and Dr. Hussain as to the causal relationship between Petitioner's accident of August 26, 2015, and his massive left shoulder rotator cuff tear. It was not until Respondent contacted Dr. Marra, after the unfavorable first IME report, that he changed his opinion. Even with the petitioner's prior medical treatment, the Arbitrator still finds that he proved an accident and aggravation. The Arbitrator finds that Dr. Marra's belated report and opinions are not credible. Moreover, the Arbitrator finds that opinions of Dr. Birdsell and Dr. Hussain, the Petitioner's treating physicians, to be sufficiently reliable, credible, and persuasive so as to satisfy the Petitioner's burden of proof in the instant matter.

Petitioner need not prove that his work accident was the sole or even primary cause of his current condition. At a minimum, the petitioner proved by the preponderance or greater weight of the evidence that he suffered an aggravation of any prior condition.

Based on the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that on August 26, 2015, Petitioner sustained an accidental injury arising out of and in the course of his employment with Respondent. The Arbitrator further finds that Petitioner's condition of ill-being to his left shoulder is causally related to the August 26, 2015, accident.

In support of the Arbitrator's decision relating to Disputed Issue J - Were the medical services that were provided to petitioner reasonable and necessary, the Arbitrator finds the following facts:

The findings and conclusions of the Arbitrator relating to the issues of accident, and causal relationship are adopted and incorporated herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner has proved by a preponderance of the evidence that the medical services provided to Petitioner were reasonable and necessary and that Respondent has not yet paid all appropriate charges for same. At trial, Petitioner submitted Px. 12 alleging the following gross medical bills:

1. Birdsell Chiropractic - $135.00
2. ORA Orthopedics - $13,964.70
3. Metro MRI Center - $612.84
4. Advanced Radiology - $239.82
5. Genesis / Illini - $21,947.82

The Arbitrator finds that the aforementioned medical bills relate to dates of service 08/28/2015 through 06/18/2019 and are causally related to Petitioner's work accident as they correspond to dates of service as ordered by Petitioner's treating doctors and correspond to treatment rendered in connection with Petitioner's injuries. The respondent is ordered to pay the petitioner's reasonable, necessary, related medical bills per the fee schedule.

In support of the Arbitrator's decision relating to Disputed Issue K - What amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

The findings and conclusions of the Arbitrator relating to the issues of accident and causal relationship are adopted and incorporated herein. Having resolved the issues of accident and causal relationship in favor of Petitioner, the Arbitrator finds that Petitioner was temporarily and totally disabled as a result of the work accident as evidenced by the medical records and Petitioner's testimony, which noted Petitioner's inability to work. However, the evidence of record shows that the respondent accommodated the petitioner until October 2015, when his seasonal employment ended. There is no evidence that the petitioner attempted to find any work after that time until March 2019. The Arbitrator finds that the petitioner failed to prove that he is owed any further temporary total disability compensation benefits from Respondent.

In support of the Arbitrator's decision relating to Issue L – What is the nature and extent of the injury, the Arbitrator finds the following facts:

The findings and conclusions of the Arbitrator relating to the issues of accident and causal relationship are adopted and incorporated herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator further finds and concludes that Petitioner has proven by a preponderance of the evidence that his left shoulder condition has reached maximum medical improvement and that as a result of his accidental injuries he has suffered permanent partial disability for same. Specifically, records demonstrate that Petitioner sustained a left shoulder full thickness retracted tears of the rotator cuff, partial tear of the rotator cuff, dislocated biceps tendon with biceps tendon tendinopathy and tenosinovitis, superior labrum anterior and posterior (SLAP) tear, glenohumeral primary osteoarthritis, loose body, and subacromial bursitus requiring surgical intervention by way of arthroscopy, rotator cuff repair, a biceps tenotomy with tenolysis, superior labrum anterior and posterior (SLAP) tear debridement, anterior labral debridement and glenoid chondroplasty, removal of loose body, and subacromial bursectomy. Therefore, consistent with the following factors, the Arbitrator finds:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a roofer at the time of the accident and that he *is* not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes Petitioner testified that he continues to experience popping in his left shoulder when he lifts his arm. Also, he testified he does not lift heavy things and does not do overhead activities. Because of the aforementioned, the Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 62 years old at the time of the accident. Because of the fact that his age suggests he may have a shorter work life expectancy thereby experiencing any such disability to a lesser extent than someone with a longer work life expectancy. Also, his age suggests he may feel the effects of his injury to a greater degree than a younger person, the Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no evidence was introduced affecting Petitioner's future earnings capacity. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner testified that he continues to experience popping in his left shoulder when he lifts his arm. Also, he testified he does not lift heavy things and does not do overhead activities. Petitioner's final visit with his doctor noted that still has some occasional clicking and popping particularly when raising his arm above shoulder level. It was also noted that he will continue to have occasional stiffness and soreness. Petitioner's final physical therapy visit noted he still experienced a bit of grinding when reaching overhead and his left arm is slightly weaker in abduction than his right. The Arbitrator finds that Petitioner's complaints are corroborated generally and broadly by his treatment records and accordingly, the Arbitrator places *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the person as a whole pursuant to §8(d) (2) of the Act.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF MADISON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Milton Perry,

Petitioner,

vs. No. 19 WC 13852

Peabody Gateway North Mine,

Respondent.

20IWCC0557

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 sole issue of the nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 2020 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.

20IWCC0557

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 24 2020
o-09/17/2020
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PERRY, MILTON
Employee/Petitioner

Case# **19WC013852**

PEABODY GATEWAY NORTH MINE
Employer/Respondent

20IWCC0557

On 3/4/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0384 NELSON & NELSON ATTYS AT LAW
ROBERT C NELSON
420 N HIGH PO BOX Y
BELLEVILLE, IL 62220

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MILTON PERRY
Employee/Petitioner

v.

PEABODY GATEWAY NORTH MINE
Employer/Respondent

Case # **19** WC **13852**

Consolidated cases: _____

20IWCC0557

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 **Linda Cantrell**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 30, 2020**. By stipulation, the parties agree:

On the date of accident, **January 10, 2019**, 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 **$84,855.68**, and the average weekly wage was **$1,631.84**.

At the time of injury, Petitioner was **51** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits ***have*** been provided by Respondent.

Respondent shall be given a credit of **$29,062.19** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$29,062.19**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$813.87** (Max rate)/week for a further total period of 122.55 weeks. Specifically, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 17.5% loss of use of the body as a whole; as provided in Section 8(e)11 of the Act, because the injuries sustained caused 15% loss of use of the right foot; and as provided in Section 8(c) of the Act, because the injuries sustained caused 10 weeks of disfigurement to the left ear.

Respondent shall pay Petitioner compensation that has accrued from **August 7, 2019** through **January 30, 2020**, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall have a **$1,087.89** credit for overpayment of TTD applied to the PPD award listed above.

As stipulated by Respondent, they will pay the reasonable, necessary, causally related medical bills as identified in Petitioner's Exhibit #5 pursuant to the Medical Fee Schedule as set forth in the Act or by private agreement.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Linda J. Cantrell
Signature of Arbitrator

2/28/20
Date

MAR 4 - 2020

STATE OF ILLINOIS)
) **SS**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MILTON PERRY,)
)
Employee/Petitioner,)
)
v.) Case No.: 19 WC 13852
)
PEABODY GATEWAY NORTH MINE,)
)
Employer/Respondent.)

20 IWCC0557

FINDINGS OF FACT

This claim came before Arbitrator Linda J. Cantrell for trial in Collinsville on January 30, 2020. The parties agree that on January 10, 2019, Petitioner was employed as a coalminer for Respondent, that he sustained accidental injuries that arose out of and in the course of his employment, and that his current condition of ill-being is causally related to his injury. The only issue in dispute is nature and extent of Petitioner's injuries. All other issues have been stipulated.

MEDICAL HISTORY

Petitioner was transported to the emergency room at Sparta Community Hospital by a co-worker immediately following the accident. Petitioner reported a rock measuring approximately 3 feet wide by 1 foot thick fell on him causing a laceration to his left ear, right arm and right foot. Petitioner complained of moderate pain and mild distress. X-rays revealed an oblique fracture at the base of the second metatarsal of the right foot, with minimal displacement laterally of the distal fracture fragment. Petitioner's right foot sustained multiple abrasions and contusions. A CT of the brain without contrast was normal. Petitioner sustained multiple abrasions and contusions to his right shoulder. Petitioner sustained a 4.0 cm laceration to his left ear that required a complex surgical repair consisting of alignment of multiple flaps involving cartilage, removal of foreign bodies, and 16 sutures. Petitioner was instructed to use crutches, remain off work until released by orthopedic doctor Donald Bassman, and to take Cipro and Acetaminophen.

On 1/14/19, Dr. Tony Chien with Community Orthopedic & Sports Medicine ordered physical therapy and an MRI for Petitioner's right shoulder, prescribed a cam-walker for his right foot and Norco, and ordered Petitioner to remain off work. Dr. Chien noted shooting pains in Petitioner's right shoulder and neck.

Petitioner underwent the right shoulder MRI on 1/17/19 that confirmed a full-thickness rotator cuff tear through the supraspinatus tendon and extending into the infraspinatus. Petitioner began physical therapy at Sparta Physical Therapy and Sports Medicine on 1/21/19 for his right shoulder. He was ordered to undergo therapy 3 times per week for 4 weeks. Petitioner complained of increased pain with raising his arm and was noted to be left-handed.

On 1/28/19, Dr. Chien noted Petitioner was using crutches for mobility. The intensity of his pain listed as 8 out of 10 with noticeable swelling and bruising in his foot. He recommended Petitioner bear weight as tolerated using the cam-walker and prescribed Norco for pain. Shooting pain from Petitioner's right shoulder down his arm and into his neck was noted. Dr. Chien recommended acromioplasty, distal clavicle resection, and open rotator cuff repair. Petitioner underwent six therapy sessions and did not return after his 2/4/19 visit due to Respondent's suggestion that he begin treating with Dr. Nathan Mall.

On 2/06/19, Dr. Mall confirmed the causal relationship between the trauma and Petitioner's shoulder condition. Petitioner underwent a right rotator cuff repair and biceps tenodesis on 2/14/19. Dr. Mall's operative report notes the diagnoses are (1) Right shoulder rotator cuff tear of the subscapularis, (2) Rotator cuff tear of the supraspinatus and infraspinatus and into the teres minor, (3) Subacromial spur and bursitis, (4) Superior labral tear, and (5) Biceps instability through the superior labral tear and upper border of the subscapularis tear. Dr. Mall described the surgery in five parts: (1) Arthroscopic rotator cuff repair of the supraspinatus, infraspinatus, and teres minor from a subacromial approach, (2) Arthroscopic rotator cuff repair of the subscapularis from an intraarticular approach, (3) Extensive debridement of the superior labrum, biceps stump and a small area of chondral damage to the glenoid, (4) Subacromial decompression and acromioplasty, and (5) Open biceps tenodesis (suture of the end of the tendon to a bone). Dr. Mall described the rotator cuff tear as extremely large and extended into the teres minor. Hardware included three medial row anchors and three lateral row anchors.

On 2/27/19, Dr. Mall ordered physical therapy which Petitioner underwent at Sparta Physical Therapy and Sports Medicine. Dr. Mall limited Petitioner to no pushing and pulling for the first three months following surgery. On 5/22/19, Dr. Mall noted Petitioner was doing very well. At that time he recommended another four weeks of strengthening therapy. Dr. Mall continued his restrictions to 0 lbs. lifting overhead, no more than 2 lbs. pushing or pulling, and no more than 2 lbs. lifting from floor to waist.

On 06/19/19, Dr. Mall reported that Petitioner was not ready to return full-duty work. Dr. Mall ordered another four weeks of therapy and restrictions of lifting no more than 2 pounds above chest and 10 pounds from floor to waist, and primarily one-handed work. Dr. Mall ordered Petitioner to return to full duty work effective 7/10/19. On 8/7/19, Dr. Mall noted Petitioner was doing well with full-duty work with no significant increase in his symptoms. Dr. Mall released Petitioner at MMI on 8/7/19, with no restrictions.

TESTIMONY

Petitioner is 52 years old at the time of arbitration. Petitioner testified he worked for Respondent for eight years as an underground coal miner prior to his accident. He is classified as a ram car driver. His job duties include operating equipment and reaching overhead to hang heavy cables, water lines and curtains. He walks approximately 2½ miles daily often over uneven surfaces underground.

The oblique fracture at the base of the second metatarsal of Petitioner's right foot continues to cause him discomfort and swelling intermittently after activity. Petitioner testified he has pain if he attempts to walk a mile at one time for exercise. He experiences pain walking on uneven terrain which his job requires him to do on a daily basis. He testified he has to go on his tip toes to hang utilities which increases his pain. He experiences swelling approximately once per month. He takes Ibuprofen to address difficulties with his foot.

Petitioner testified he can barely lift more than one-half of the weight he could lift before the accident as a result of his shoulder injury. He experiences the greatest pain when lifting electrical cable, water lines and curtains overhead while at work. His job requires him to lift 40 to 70 pounds overhead multiple times at each "cross-cut", which occurs approximately 10 to 15 times per work shift. Petitioner testified he uses his dominate

left arm to lift and hold the weight of cables, lines, and curtains. He only uses his right arm to guide, assist and tie the cables into place. Petitioner's job duties also involve shoveling the "tail piece" on the belt moving coal through the mine. He testified he can no longer shovel without stopping every 10 minutes or so.

Petitioner demonstrated his overhead range of motion at arbitration. He is able to move his right hand above his head, however, he testified he can only hold it there approximately two minutes before he has to rest his shoulder. He testified he can no longer work under a lift as a car mechanic which he did for approximately 20 years before becoming employed by Respondent.

Petitioner described difficulties with sleeping and ordinary daily activities. He cannot sleep on his left side and his right shoulder aches while lying in bed. He has trouble reaching far behind his back or tucking in his shirt. He takes Tylenol approximately once a week for his shoulder. Petitioner offered into evidence photographs of his shoulder depicting the front and rear view of his upper extremities. The photographs depict a notable difference in the bulk of Petitioner's musculature.

Petitioner offered into evidence photographs of the scaring over his left ear. The photographs are consistent with the Arbitrator's observation of same at arbitration. The scarring is primarily visible from the side and back of Petitioner's head. Petitioner testified he experiences a burning sensation over the scar with contact.

ISSUE (L): What is the nature and extent of the injury?

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work full duty as an underground coalminer. He has been employed by Respondent for approximately nine years. Prior to becoming employed by Respondent, Petitioner worked as a Chevy Tech Mechanic for twenty years. He testified his current job duties require a lot of walking on uneven terrain and overhead work. Petitioner testified he has significant difficulties performing his job duties and had to alter the manner in which he performs his job. As Petitioner's current condition significantly interferes with the performance of his job, the Arbitrator gives greater 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. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016), the Commission concluded that greater weight should be given to a Petitioner who was younger in age because they would have to work with a disability for an extended period of time. While Petitioner is 51 and not immediately retirement age, he does have over ten years before retirement age working underground, with ongoing symptoms and limitations for the remainder of his work life. Petitioner is older than the Petitioner in *Jones* and the Arbitrator therefore places some weight on this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no evidence of reduced earning capacity contained in the record. Petitioner testified he has returned to full-duty work for Respondent in the same position we was working prior to the accident. The Arbitrator therefore gives less weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner's shoulder injury significantly interferes with his current employment and activities. His job duties include operating equipment and reaching overhead to hang heavy cables, water lines and curtains. He is required to lift 40 to 70 pounds overhead multiple times at each "cross-cut", which occurs approximately 10 to 15 times per work shift. This activity causes him the greatest pain. Petitioner testified he can barely life more than one-half the weight he could lift before the accident. Petitioner uses his dominate left arm to lift and hold the weight of cables, lines, and curtains. He only uses his right arm to guide, assist and tie the cable into place. Petitioner's job duties also involve shoveling coal which he is no longer able to do without stopping every 10 minutes or so.

Petitioner demonstrates he is not able to raise his arm above ear level. He is able to raise his right hand above his head, but can only hold it there approximately two minutes before he has to rest his shoulder. He testified he can no longer work under a lift as a car mechanic which he did for approximately 20 years before becoming employed by Respondent.

Petitioner described difficulties with sleeping and ordinary daily activities due to his shoulder injury. He cannot sleep on his left side and his right shoulder aches while lying in bed. He has trouble reaching far behind his back or tucking in his shirt. He takes Tylenol approximately once a week for his shoulder. Petitioner offered into evidence photographs of his shoulder depicting the front and rear view of his upper extremities. The photographs depict a notable difference in the bulk of Petitioner's musculature.

The oblique fracture at the base of the second metatarsal of Petitioner's right foot continues to cause him discomfort and swelling intermittently after activity. He walks approximately 2½ miles daily often over uneven surfaces underground at work that causes pain. Petitioner testified he has pain if he attempts to walk a mile at one time for exercise. He has difficulty hanging utilities underground as he has to get on his tip toes which increases his pain. He experiences swelling approximately once per month. He takes Ibuprofen to address difficulties with his foot.

Petitioner offered into evidence photographs of the scaring over his left ear. The photographs are consistent with the Arbitrator's observation of same at arbitration. Petitioner's left ear does have a horizontal scar approximately in the middle crescent of his ear which is noted as being seen both from the front and the back. This is less noticeable from the back because of the physiological positioning of his ear but is evident. Petitioner testified he experiences a burning sensation over the scar with contact.

Taking into consideration Petitioner's continued postoperative symptoms and restrictions with respect to his right shoulder, and his continued symptoms and restrictions with respect to his right foot, which he did not experience prior to the accident of January 10, 2019, and the physical demands of his job duties as they relate to his injuries, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% of the body as a whole related to his right shoulder under 8(d)2 of the act, 10 weeks disfigurement related to his left ear under 8(c) of the Act, and 15% loss of use of a right foot, pursuant to §8(e)11 of the Act.

20 I W C C 0 5 5 7

Linda J. Cantrell

Linda Cantrell, Arbitrator

2/28/20

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Krystle Hite,

Petitioner,

vs. No. 11 WC 36263

State of Illinois – Dept. of Human Services,

Respondent.

20IWCC0558

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 causal connection, prospective medical care, temporary total disability and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2019, 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.

20IWCC0558

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: SEP 24 2020
o-09/17/2020
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HITE, KRYSTLE
Employee/Petitioner

Case# **11WC036263**

ST OF IL-DEPT OF HUMAN SERVICS
Employer/Respondent

20IWCC0558

On 1/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0000 BRISKMAN BRISKMAN & GREENBERG
SUSAN FRANSEN
175 N CHICAGO ST
JOLIET, IL 60432

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

JAN 17 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

Krystle Hite
Employee/Petitioner

Case # **11** WC **36263**

v.

State of Illinois – Department of Human Services
Employer/Respondent

20 IWCC0558

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **December 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **July 22, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner's average weekly wage was $**426.95**.

On the date of accident, Petitioner was **21** 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 $**6,242.63** 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 $**5,369.87** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**284.63**/week for **51 4/7** weeks, commencing **July 23, 2011** through **July 18, 2012**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**6,242.63** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $**33,299.16**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid,

Respondent shall pay Petitioner permanent partial disability benefits of $**256.17**/week for **50** weeks, because the injuries sustained caused the **10**% 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.

Arbitrator Anthony C. Erbacci

January 15, 2019
Date

JAN 17 2019

FACTS:

Petitioner, Krystle Hite, testified in this matter. She was 28 years of age when this case went to hearing and was 21 years old on the date of accident or on July 22, 2011. Her date of birth is July 12, 1990. She was not married and had one dependent on the date of the accident. Her daughter is now 11 years old. Before this work accident happened, Petitioner had no difficulties with her first pregnancy, nor did she ever have pain or problems while having sexual intercourse. She had also never been told she had a cervix that was retroverted.

On July 22, 2011, Petitioner was working for the Department of Human Services as a personal assistant and had been for two years. Her duties were to help her clients with their food, medications, showers, cleaning of their homes, taking them to doctor appointments and finally helping them with grocery shopping. She worked full time for the state and had the same client during this time. While she had left this client in June, 2011 as she was uncomfortable with him, she did return to work for him when he called and asked her to do so.

Petitioner became pregnant with twins in March, 2011. She was having no problems with her pregnancy and was 17 weeks along on the date of the accident. Petitioner worked 7 days a week for this client, from about 8:45 a.m. to 1:30 p.m.-2:00 p.m. On July 22, 2011, Petitioner had reported in to work, washed the client's dishes, cleaned up and even made him breakfast. He seemed a little upset on this date and ended up punching her in the stomach. She identified PE 9, the incident report, which stated exactly as Petitioner testified to. After being assaulted by her client, Petitioner left his apartment and found police who assisted her.

Petitioner presented to Provena St. Joseph Medical Center (now Presence) after this incident, to get examined as she was feeling pain in her lower abdomen. After testing was done, she was told she had lost one of her twins, likely due to brain trauma from the impact of her client punching her. The doctors believed her second child would survive at this time. The next day Petitioner went to Silver Cross Hospital to get another opinion and was told the same thing.

Approximately three weeks to one month later, Petitioner felt something in her abdomen again, and went back to Provena. She had another ultrasound and was told that her second baby had passed away. She then went through 14 hours of labor and had to deliver both of her babies naturally. She had her mother to help her after this, as both children had to be buried.

Petitioner testified that she suffered greatly after this incident. She testified that she was angry and mad all the time and would even yell at her daughter for bringing up the twins. Petitioner testified that after two months, she saw Dr. Choudry, her internal medicine doctor. Dr. Choudry referred Petitioner to a psychiatrist, as the depression Petitioner was feeling was not getting better. Petitioner testified that she never saw the psychiatrist as she did not want someone telling her it would be ok. Petitioner testified that she did not believe it would be ok and still does not think or feel it is ok. Petitioner testified that the emotional pain from losing her twins has never gone away and she still visits their graves and even has ceremonies there. She mourns their loss every single day.

Petitioner testified that she also had physical problems as a result of the accident. When she saw Dr. Choudry as stated, she was diagnosed with dyspareunia, a recurrent physical pain she had and still has, during intercourse. Petitioner testified that the pain is much worse when she has her menstrual cycle. Petitioner testified that she never had this pain or problem prior to this work

accident. Petitioner went to a specialist at Loyola Hospital about this and was told that this was due to the miscarriages. This is when she also found out that her cervix was retroverted.

Petitioner testified that she tried to go back to work as a personal assistant for the state, but was told she had to completely reapply. She then decided to work for another company and when she got pregnant with her son, she stopped working all together. This was approximately March, 2012. She gave birth to her son on January 31, 2013, while having a very difficult pregnancy throughout. She had multiple pains, was considered high risk, had to see three doctors every week, and was spotting. She has tried having more children after having her son, but has been unable to conceive.

Petitioner now works for Grand Prairie Transit in Lockport. While originally being hired as a bus driver, she was promoted to a supervisor and has now worked full-time there for four years.

On Cross Examination, Petitioner admitted her work hours prior to the accident did fluctuate weekly, but she got her forty hours in, if not more than that. She is a supervisor at Grand Prairie Transit, a safety compliance officer. She was told by doctors after the work accident involved herein, that she needed to be cleared from her depression before she could go back to work. She never followed up with a psychological professional.

On Redirect Examination, Petitioner admitted she made $11.85 an hour. She also identified Petitioner's Exhibit 8 as being her W-2 form from the State of Illinois for 2011.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

Per the Petitioner's testimony and Petitioner's Exhibit 9, there is no doubt that Petitioner sustained an accident that arose out of and in the course of her employment with the Respondent. She was a personal assistant, helping one particular client. While working with this individual, he became very agitated and punched Petitioner in the stomach. She lost the twin babies she was carrying as a result. The Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment with the State of Illinois.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

Based upon the totality of the credible evidence adduced at hearing and the temporal sequence of events following the Petitioner's accident, the Arbitrator concludes that Petitioner unfortunately lost her fetus twins as a result of the work accident sustained on July 22, 2011.

On July 22, 2011, the Petitioner was punched in the stomach by a client and sought treatment at Provena (now Presence) Saint Joseph Medical Center. Upon presentation, Petitioner was

complaining of abdominal pain after being hit in the stomach. An ultrasound examination was performed and the diagnosis of left fetus demise was made. Petitioner was discharged home.

Petitioner followed up at Silver Cross Hospital on July 23, 2011 for a second opinion and the same diagnosis was made. Petitioner had lost one of her twins due to the trauma from her client while working.

Petitioner returned to Provena Saint Joseph Medical Center on August 16, 2011 with complaints of pain in her abdomen again and she was admitted. She was diagnosed with the demise of the second fetus, and had to deliver both fetuses vaginally. After this, said babies were sent to a funeral home for proper burial. Petitioner was discharged from the hospital on August 18, 2011.

Petitioner also treated with Dr. Samiullah Choudry of Internal Medicine and Family Physicians after this accident. On December 27, 2011 Petitioner saw Dr. Choudry for odorless vaginal discharge and itching. She was referred for treatment of this and for counseling as related to the work accident. This directly correlated with the Petitioner's testimony. On March 5, 2012, Petitioner was diagnosed with a yeast infection and was again given a referral for psychiatric counseling. Petitioner admittedly never went for counseling.

On March 29, 2012, Petitioner returned to the clinic and saw Dr. Joudeh Yazen instead of Dr. Choudry. The medicine for the yeast infection was not helping Petitioner and she was making complaints of pain during intercourse. Petitioner was then diagnosed with dyspareunia. Again, this is consistent with the testimony of the Petitioner regarding her permanent problems after this work accident. The Petitioner's final visit with Dr. Choudry as a result of the work accident was June 25, 2012. At that time, Petitioner complained of migraines and it was determined she was pregnant. Petitioner testified that she did deliver this baby at the end of January, 2013 and that it was a healthy baby boy.

The Respondent submitted no evidence as to the Petitioner's medical condition either before the accident or after.

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

Petitioner alleges an AWW of $568.75 and Respondent alleges an AWW of $370.31. The Arbitrator finds neither to be correct. Respondent's Exhibit 3 indicates a collective pay of $19,256.30 from 8/1/10 to 7/31/2011. In making its calculation, it appears that the Respondent divided the entire amount by 52. This is this is not the correct divisor as the dates themselves suggest less than 52 weeks as reported. The time period for a valid wage statement should have been from 7/22/10 to 7/22/11. The amount shown in Respondent's Exhibit 3 should be divided by at most 46 weeks, yielding an AWW of $418.61. The Arbitrator however, finds Petitioner's Exhibit 8 to be more persuasive. This is Petitioner's 2011 W-2 form showing income from the State of $12,424.30. This would have been for 29 1/7 weeks yielding an AWW of $426.95. Therefore, the Arbitrator finds that Petitioner's AWW is $426.95.

In Support of the Arbitrator's Decision relating to (H.), What was Petitioner's age at the time of the accident, and (I.) What was Petitioner's marital status at the time of the accident, the Arbitrator finds and concludes as follows:

Petitioner testified that her date of birth is July 12, 1990. She had one daughter, who was 11 on the date of Petitioner's testimony, thereby making her 4 when the incident occurred. She was not married when the work accident happened. The Arbitrator finds this credible and finds as a matter of law that Petitioner was 21 years old, was single and had one dependent when the work accident of July 22, 2011 happened.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Accident and causal connection has been found by the Arbitrator. Based on this, the following medical bills are awarded to Petitioner per the fee schedule:

Petitioner's Exhibit 2 – Medical bill from Joliet Radiological, Associates in the amount of $1,023.00. Respondent made no attempt to pay this bill.

Petitioner's Exhibit 3 – Medical bill from Silver Cross Hospital in the amount of $3,638.45. Respondent shall be given credit for any payments actually made;

Petitioner's Exhibit 5 – Medical bill from Presence Saint Joseph Medical Center in the amount of $28,637.71. There were payments made, and Respondent shall be given credit for any payments actually made.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner was off of work as a result of this work accident from July 23, 2011 through July 18, 2012, a period of 51 4/7 weeks. In support of this award, the Arbitrator finds the following:

Initially after the accident, the hospitals kept Petitioner off of work. Petitioner then saw Dr. Samiullah Choudry through July 18, 2012 as related to this incident. He had referred Petitioner to a psychiatrist on several occasions and while Petitioner admittedly did not go for this care, the Arbitrator finds these authorizations off of work credible. Throughout the records, it appears that Dr. Choudry kept Petitioner off of work until cleared by psychiatry. He specifically wrote this on 12/27/11, 3/5/12, and lastly on 7/18/12. Petitioner attempted to go back to work in early 2012 but was unable to continue as she was pregnant and did not want to lose another baby. The Arbitrator again finds this credible, but can only award Temporary Total Disability benefits through the last medical note, that being July 18, 2012. Therefore, Temporary Total Disability benefits are only awarded through July 18, 2012, for a total of 51 4/7 weeks.

Respondent's Exhibit 2 indicates that the Petitioner was paid Temporary Total Disability benefits for some period of time. The Respondent is, therefore, entitled to credit for all of the Temporary Total Disability benefits it did, in fact, pay to the Petitioner.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

As this accident occurred prior to September 1, 2011, consideration of the factors enumerated in Section 8.1(b) of the Act is not required in determining the nature and extent of the Petitioner's injuries.

As a result of being punched in the stomach by a client, the Petitioner suffered the loss of both of her twin unborn children. Prior to the injury, the Petitioner was having a normal pregnancy without any complications or difficulties. When she was punched in the stomach, Petitioner's unborn twins sustained head trauma that was fatal. Over the course of the 3-4 weeks following the injury, Petitioner lost both of her unborn babies. She not only sustained this physical loss, but she was also diagnosed with depression as a result. The Petitioner did not seek treatment for her depression, but she testified that she currently continues to experience the symptoms that led to her being diagnosed with depression. Additionally, Petitioner testified, and the records support, that she started having problems with her vaginal region after this work accident. She testified that since her injury, she has pain with sexual intercourse, especially while menstruating, and now has a retroverted cervix.

Having considered the totality of the credible evidence adduced at hearing, as well as having considered prior Commission decisions regarded as precedent, the Arbitrator finds that, as a result of the injury of July 22, 2011, the Petitioner sustained the 10% loss of use of her whole person. Respondent shall pay the Petitioner the sum of $256.17/week for 50 weeks, because the permanent injuries sustained caused 10% loss of use of man as a whole as provided in Section 8 of the Act.

In Support of the Arbitrator's Decision relating to (M.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

Based upon the record as a whole, the Arbitrator declines to award penalties or attorney's fees in the instant matter. In so doing, the Arbitrator notes the unusual nature of the Petitioner's injuries and the lack of a specific causation report or testimony relating those injuries directly to the Petitioner's work accident. Additionally, the Arbitrator notes that the Petitioner was paid some Temporary Total Disability benefits for a period of time.

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BEVERLY HAWLEY,

Petitioner,

vs.

NO: 13 WC 5532

STATE OF ILLINOIS,
ILLINOIS DEPARTMENT OF TRANSPORTATION,

Respondent.

20 I W CC 0559

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: SEP 24 2020

D. Douglas McCarthy

DDM/tdm
O: 8/5/20
052

Stephen Mathis

DISSENT

A claimant who suffers from a pre-existing condition may recover benefits under the Act where an accident aggravates or accelerates her condition. *International Vermiculite Company v. The Industrial Commission*, 77 Ill. 2d 1 (1979). Further the accident must be a factor which contributes to the disability. *Caterpillar Tractor Co. v. The Industrial Commission*, 92 Ill. 2d 30 (1982). Mere correlation of symptoms is not enough as causation between the accident and the resulting disability must exist. *Long v. The Industrial Commission*, 76 Ill. 2d 561 (1979). Further, as the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." Petitioner failed to prove her condition is work-related. Therefore, I respectfully dissent.

The Majority in affirming and adopting the Decision of the Arbitrator affords greater weight to the opinions of Drs. Fister and Coe over those of Dr. Fernandez. I find the opinions of Dr. Fernandez to be more persuasive; therefore, I afford greater weight to his opinions over those of Dr. Coe.

On March 1, 2019, Dr. Fernandez provided his opinions via evidence deposition. RX1. Dr. Fernandez testified he obtained a history from Petitioner as to her work duties specifically her repetitive typing over 32 years. RX1, p.15. In formulating his opinions, Dr. Fernandez accepted Petitioner's description of her work duties "which included significant exposure to typing on a fairly constant or repetitive basis." RX1, p. 22. Dr. Fernandez opined Petitioner's work activities did not cause nor aggravate her carpal tunnel syndrome. *Id.* Dr. Fernandez explained that no reasonable scientific evidence establishes a link between carpal tunnel syndrome and typing. RX1, p. 22, 46. Moreover, Dr. Fernandez confirmed Petitioner demonstrated her workstation to him from which he took measurements as to the extension/flexion and testified such activities did not cause nor aggravate her condition. RX1, p. 31-32; 35.

On December 11, 2017, Dr. Coe provided his opinions via evidence deposition. PX1. In contrast to Dr. Fernandez, Dr. Coe testified to a causal relationship between Petitioner's work activities and her carpal tunnel syndrome. PX1, p. 31-32. What Dr. Coe failed to provide is the basis of his opinion. When questioned as to the basis of his opinion, Dr. Coe merely restated his summary conclusion as to a causal link between Petitioner's work activities and her carpal tunnel syndrome. *Id.* See *Miller v. Illinois Workers' Compensation Commission*-affirmed in Rule 23 Order, 2020 IL App (2d) 218577WC-U ("Affirmance is justified in this case because the current

causation opinion by Dr. Coe appears to be nothing more than a bald assertion."); *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶ 24 ("An expert opinion is only as valid as the reasons for the opinion." (Internal quotation marks omitted.)).

On review, Petitioner advanced the argument that Petitioner's carpal tunnel syndrome developed due to a non-ergonomic workstation. The evidence simply does not support this theory. Again, Dr. Fernandez specifically obtained measurements of Petitioner's workstation and opined no causal relationship. RX1, p. 13-32; 35. Unlike Dr. Fernandez, Dr. Coe failed to take measurements or confirm the set-up of Petitioner's workstation. Dr. Coe provided no testimony as to Petitioner's workstation, instead, merely noting the various work activities Petitioner performed involving her hands- typing, answering phones, stapling, and shuffling paper. PX1, p. 44.

As for the Majority's reliance on Dr. Fister's "opinion," I disagree. Dr. Fister evaluated Petitioner on one occasion- December 5, 2012. Petitioner provided the following history: "49 y/o female with c/o RT hand pain. She believes this injury occurred from repetitive typing and using the mouse." PX2. Dr. Fister's records note the following: "This is actually a workcomp situation and certainly these conditions can be aggravated by repetitive typing on the keyboard." *Id.* From this, it appears Dr. Fister's "opinion" is predicated on Petitioner's belief that her development of carpal tunnel syndrome is due to typing. Moreover, this "opinion" provides no basis as to what Dr. Fister believed were Petitioner's work duties. As such, I would afford little weight to this record.

For the above stated reasons, I, respectfully, dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAWLEY, BEVERLY Case# **13WC005532**

Employee/Petitioner

IL DEPT OF TRANSPORTATION

Employer/Respondent

20IWCC0559

On 10/28/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5122 PORRO NIERMANN LAW GROUP
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

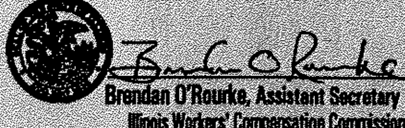
5031 ASSISTANT ATTORNEY GENERAL
KRISTIN A LEASIA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

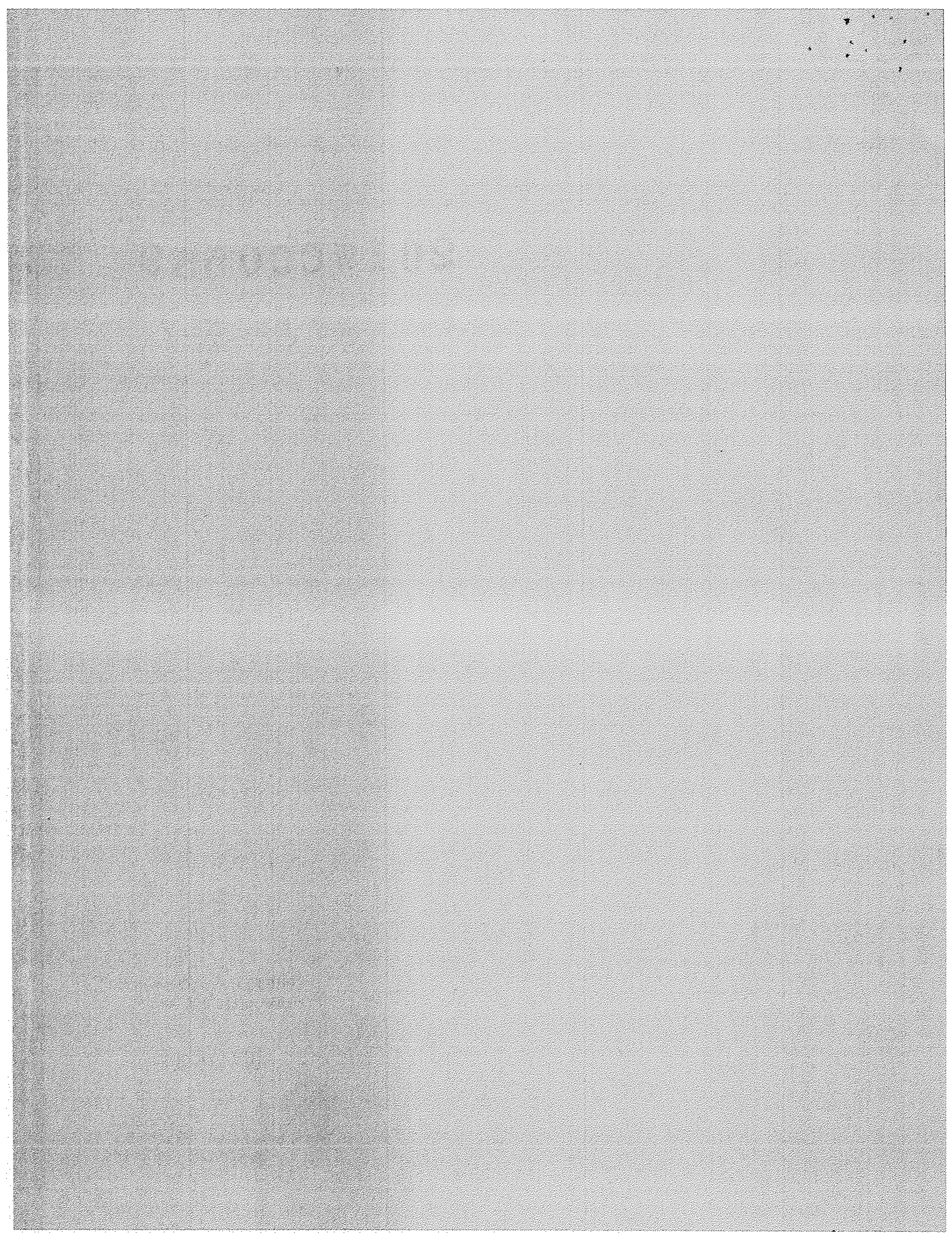
0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

OCT 28 2019



Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission



STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§ 8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BEVERLY HAWLEY,
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION,
Employer/Respondent

Case # **13** WC **5532**

Consolidated cases: ______

20 IWCC0559

An *Application for Adjustment 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 **9/26/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **10/26/12**, 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 as related to her right hand/wrist ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**49,270**; the average weekly wage was $**947.50**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner has proven by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in them course of her employment with Respondent on October 26, 2012.

The Arbitrator finds that Petitioner has proven by a preponderance of the credible evidence that a causal connection exists between the accident sustained on October 26, 2012 and her current condition of ill-being regarding her right hand/wrist.

Respondent shall pay reasonable and necessary medical services of $375.00, as provided in Section 8(a) and 8.2 of the Act.

The Arbitrator finds that Petitioner has proven by a preponderance of the credible evidence that as a result of said accidental injuries she has sustained permanent partial disability to the extent of 12.5% loss of use of the right hand/wrist (23.75 weeks of compensation) pursuant to §8(e)9 of the Act, as set forth in the attached Decision.

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.

20IWCC0559

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert M. Harris

Signature of Arbitrator Robert M. Harris

October 24, 2019
Date

OCT 28 2019

MEMORANDUM OF DECISION OF ARBITRATOR
STATEMENT OF FACTS

Petitioner worked for three decades as an office coordinator for the Illinois Department of Transportation. Her shifts were 7.5 hours long and she spent 5 to 6 hours a day typing for her work. Her workstation had a keyboard set up in front of her and she rested the palmer surface of her wrists on the desk surface while she extended her wrist to do the typing. She had no ergonomic devices for the keyboard, the mouse or mousepad. Her chair also did not adjust to permit use of the keyboard from different angles. In her 7.5 hour shift, she had two 15 minute breaks and a 45 minute lunch period.

Petitioner gradually developed tingling, numbness and pain in her dominant right hand. She noted the complaints initially when she would stop the duties and go home to rest after work. The symptoms gradually worsened to the point she was experiencing the symptoms during work, and particularly with the typing activities. She did not have the symptom with activities other than typing. She explained that her symptoms would improve when away from work over the weekend but would return when she started typing again the following week. The symptoms became severe enough that she sought treatment and underwent an EMG/NCV on 11/6/12 by Dr. Gavino at Sherman Hospital. (PX2 p.13-14) This test revealed right carpal tunnel syndrome and ulnar entrapment syndrome. (PX2 p.13-14) Dr. Gavino noted that he discussed the test findings with her on 11/9/12. (PX2 p.13) That is the date when petitioner informed her supervisor, Tom Ballenbach, of the work injury. (PX5) She also completed a formal written notice of her injury, identifying repetitive typing and mouse usage as the reason she sustained the injury. (PX5) She further identified her accident date as 10/26/12. (PX5)

The people handling IDOT's workers compensation matter referred her to a hand specialist at Midwest Bone & Joint, Dr. James Fister, MD. Petitioner's visit with Dr. Fister came on 12/5/12. (PX2 p.8) Dr. Fister reviewed the electrical tests and recommended releases for the carpal tunnel syndrome as well as the ulnar nerve condition. (PX2 p.7) Petitioner testified that she described her work duties in detail to Dr Fister. Dr. Fister also documented her injury date as 10/26/12, further explaining that he was dealing with a workers' compensation situation and offering a causation opinion as her conditions could be aggravated by repetitive typing on the keyboard. (PX2 p.8-9) Dr. Fister requested approval from workers' compensation for the surgeries. (PX2 p.9) Workers' compensation did not approve the surgeries and Petitioner continued working.

Petitioner eventually came under the care of Dr. Berkson at OrthoIllinois Rockford on 9/5/13. (PX3 p.24) She reported pain and numbness in the third and fourth fingers of the right hand variably. (PX3 p.24) The diagnosis included generalized arthropathy and carpal tunnel syndrome. (PX3 p.26) Dr. Berkson gave her a splint to use at night and sent her for updated electrical tests. (PX3 p.26) Dr. Gavino also performed the updated EMG/NCV on 9/12/13, revealing the same findings as the first study. (PX3 p.22, 28-29) Dr. Berkson

thought the median nerve was causing most of the symptoms and recommended a carpal tunnel release. (PX3 p.23) That surgery was done on 12/3/13 and petitioner was reporting an improvement in her symptoms at the visit three days after the surgery. (PX3 p.20, 64-65) Dr. Berkson told her to resume her activities but avoid heavy lifting, pushing and pulling. (PX3 p.20) Petitioner testified that she returned to her typing duties a week after the surgery. Petitioner's next visit with Dr. Berkson came two weeks after the surgery and she was reporting no more tingling or numbness. (PX3 p.18) Petitioner reported tenderness at the incision location. (PX3 p.18) Petitioner was back to work at that point. (PX3 p.18)

Petitioner next returned to Dr. Berkson on 1/16/14 reporting some pain and discomfort in the wrist and third, fourth and fifth fingers, along with vague discomfort proximal to the surgical scar. (PX3 p.16) Petitioner reported that her present complaints were worse that her preoperative symptoms. (PX3 p.16) Dr. Berkson recommended that she return for a follow up 3 months post-op. (PX3 p.16) That visit came on 2/27/12 and she reported mild hypersensitivity by the incision and distal to it. (PX3 p.13) Petitioner's numbness had resolved. (PX3 p.13) She also reported slight discomfort at the insertion of the right flexor carpi ulnaris tendon. (PX3 p.13) Dr. Berkson predicted that she would have additional resolution of the residual complaints over time and he discharge her from care. (PX3 p.14) Petitioner returned to Dr. Berkson on 2/13/17 reporting right third finger pain dating back to 1/29/17. (PX3 p.3) Dr. Berkson diagnosed the condition as trigger finger of the middle finger of the right hand and he injected the tendon sheath with and anesthetic/cortisone mix. (PX3 p.4)

At trial, Petitioner explained how the right-hand injury affected her ability to perform activities. She continued typing at the same 5 to 6 hours per shift. She had now performed the work for 38 years. She noticed tingling and numbness into the right hand with her typing. She also noticed difficulty using the hand outside work, explaining that she had trouble opening containers and even the little plastic top of a ketchup bottle. Her right hand was significantly weaker than her left even though she was right handed. She had difficulty lifting and gripping things with the hand. She thought she might have to return to the doctor for additional treatment.

Dr. Jeffrey Coe. M.D., Ph.D., examined Petitioner at her request pursuant to Section 12 on 2/20/17. (PX1 p.7) Dr. Coe is a board-certified specialist in occupational medicine which is the area of medicine which deals with the health of people at work. (PX1 p.5) Dr. Coe's areas of expertise and training of an occupational medicine specialist include injuries or illnesses arising from the workplace, their causation, their diagnosis, and treatment, issues related to rehabilitation returned to work after workplace injuries. (PX1 p.5-6) As part of his practice, Dr. Coe saw patients, carried out evaluations for various purposes, worked as an advisor or consultant to various organizations and taught occupational medicine at the University of Illinois. (PX1 p.6) In the Department of Medicine, he taught occupational medicine about workplace injuries and supervise the work of some of the doctors and training to become specialists in occupational medicine. (PX1 p.7)

Petitioner explained to Dr. Coe that she was a coordinator at the Department of Transportation and that she used her arms and hands repetitively throughout her day. (PX1 p.9) She performed continuous keyboarding and handling of blueprint plans 5 to 6 hours per day. (PX1 p.9) No ergonomic study had ever been performed of her workplace, but she described her workstation is essentially a desk upon which a computer had been placed. (PX1 p.10) No specific ergonomic modification of the keyboard and mouse pad had been made, although she had attempted from time to time to adjust her keyboard to make it more comfortable. (PX1 p.10-11) Petitioner found she was unable to raise or lower the keyboard height and noted that the keyboard and mouse pad had no hand or wrist support. (PX1 p.11) Petitioner explained she developed symptoms with these work activities that the symptoms first manifested his tingling in her right hand, becoming increasingly severe over time. (PX1 p.11) She eventually had those conditions worked up, with the diagnosis of carpal tunnel syndrome. (PX1 p.12-13) She was also found to have cubital tunnel syndrome involving the ulnar nerve. (PX1 p.14-15) She ultimately came under the care of Dr. Berkson who prescribed anti-inflammatory medication and right wrist splinting. (PX1 p.17) The purpose of the splinting was to prevent forced flexion of the wrist or a lot of repetitive motion of the wrist in an effort to get the median nerve to calm down. (PX1 p.17)

Dr. Berkson performed the carpal tunnel release on 12-3-13. (PX1 p.18) At surgery, he found the median nerve to be pinched in hyperemic. (PX1 p.19) The procedure involved cutting through the carpal ligaments on top of the carpal tunnel to afford more room and release pressure from the nerve. (PX1 p.19) By the postoperative visit three days later, her right-hand numbness and tingling had resolved and another month later she just had residual hand discomfort in the scar area and flexor surface of the wrist. (PX1 p.20) Dr. Berkson discharged her from care on 1-16-14 telling to come back as needed. (PX1 p.20)

Dr. Coe examined Petitioner three years after the surgery and she was continuing to complain of residual postoperative hand symptoms. (PX1 p.21) She still had residual discomfort and tingling of her right palm in the area of the scar line but she no longer had any the tingling going down into her fingers. (PX1 p.24) She felt that there was some continued weakness in her right hand with difficulty trying to open jars, gripping and twisting activities. (PX1 p.24) Dr. Coe described the various risk factors associated with the development of carpal tunnel syndrome, noting that only her age and gender were relevant factors for her condition. (PX1 p.21-23) Dr. Coe's examination revealed pillar tenderness involving the two prominences of the palm, including the base of the thumb and base of the little finger (thenar and hypothenar eminence). (PX1 p.26) During the surgery, Dr. Berkson cut through the transverse carpal ligament linking the two areas in there was a slight butter flying in the palm because the ligament was opened up. (PX1 p.27) This caused discomfort at the point with the ligament used to be attached and the pain was partly mechanical as the palm was not quite as stable after the surgery. (PX1 p.27) She also had decreased sensation a light touch around the scar. (PX1 p.27) She also

reported some right palm pain at the extremes of right wrist range of motion. (PX1 p.28) Dr. Coe thought that was most likely due to the scar tissue form from the surgery. (PX1 p.28) There was also light decrease in light touch sensation on the flexor surface of the right first through third fingers. (PX1 p.29) Pinched grip testing revealed a 10-pound pension grip on the right side compared to an 18-pound grip on her left. (PX1 p.30) Dr. Coe noted that you would normally expect the grip in the dominant right side to equal or exceed the nondominant left side. (PX1 p.34)

Regarding causation, Dr. Coe opined there was a causal relationship between Petitioner's work activities and/or condition of right carpal tunnel syndrome. (PX1 p.32) Dr. Coe opined Petitioner could continue working her regular job. (PX1 p.33) Dr. Coe also opined the deficits he detected during the examination were permanent at this point and not likely to change. (PX1 p.34) On cross-examination, Dr. Coe admitted that Petitioner's job involved several activities, but they all required and exertion in a continuous manner. (PX1 p.45) When asked about risk factors, he recognized that age and gender were her only risk factors. (PX1 p.52) When asked about research involving development of the condition, Coe explained that the condition was caused by a change within the nerve itself in the epinurium, which are the parts of the nerve on the outside were tiny little blood vessels went into the nerve to nourish the nerves. (PX1 p.56-57) Dr. Coe noted that standard medical teaching identified repetitive strain has a factor causing the carpal tunnel syndrome on account of people engaging the muscles of their hand, increasing tension in the muscles in performing flexion or extension on a repeated basis. (PX1 p.57) This resulted in repetitive micro trauma which appears to limit the flow of nutrients within the nerve resulting in the damage. (PX1 p.57) Dr. Coe explained that he performed research studying people developing carpal tunnel syndrome with the same task. (PX1 p.58) Dr. Coe indicated the research was not conclusive as to who would and would not develop carpal tunnel syndrome. (PX1 p.58)

Dr. John Fernandez examined Petitioner at Respondent's request pursuant to Section 12 on 5/23/18. (RX1 p.11) He is a board-certified orthopedic surgeon focusing on upper extremity surgery, including nerve reconstruction. (RX1 p.7) Dr. Fernandez and his group sees 1,400 to 1,500 new patients a year and 20% of those patients involved carpal tunnel syndrome. (RX1 p.8) 75% of his work was done for respondents and he performed 6 to 8 IMEs per week. (RX1 p.9) Respondent had provided him with a report of injury from 11/12/12 and an EMG from 11/6/12. (RX1 p.10) He took his own x-rays. (RX1 p.10) Dr. Fernandez had Petitioner complete a form evaluating a person's perceived disability from disabilities to the arm, shoulder and hand (DASH score). (RX1 p.14) Petitioner scored 34.47 at his 2018 visit, also indicating an increase in her symptoms with heavier activities. (RX1 p.14) Petitioner reported that she developed pain, numbness and tingling over the course of 32 years of repetitive typing at work. (RX1 p.15) She ultimately had a carpal tunnel release which improved her symptoms but her symptoms had started to return by 2015. (RX1 p.16) She again

was experiencing numbness and tingling in the hand with grip weakness and burning in the palm. (RX1 p.16) She also now had pain in the middle finger with a local mass. (RX1 p.16) Dr. Fernandez diagnosed the presentation as possible recurrent carpal tunnel syndrome, middle finger stenosing tenosynovitis and retinacular cyst of the right middle finger. (RX1 p.19) He noted that carpal tunnel is a syndrome with many relevant risk factors. (RX1 p.20) Dr. Fernandez agreed the only risk factors Petitioner had were her age and gender. (RX1 p.21) Dr. Fernandez did not think there was a causal relationship between the repetitive typing and carpal tunnel syndrome, explaining he did not believe there was reasonable scientific evidence supporting causation. (RX1 p.22) He thought she should have her recurrent symptoms worked up and addressed, including possible treatments of splinting, cortisone injections and possibly surgery. (RX1 p.23-24) Treatment for the trigger finger could include a cortisone injection and possible surgery and the cyst could be surgically excised. (RX1 p.24) Dr. Fernandez thought she could continue working in a full duty capacity. (RX1 p.24) He thought she would have an excellent prognosis. (RX1 p.25)

On cross, Dr. Fernandez noted he had recommended splinting to keep the wrist relatively straight because hyperextension and hyperflexion added pressure to the median nerve. (RX1 p.26) Splinting could alleviate symptoms and even reduce swelling. (RX1 p.26) He agreed that increased pressure in the carpal canal was related to onset and progression of carpal tunnel syndrome. (RX1 p.26) So the added pressure in the canal is ultimately what leads to the pressure on the nerve which leads to carpal tunnel syndrome. (RX1 p.26) Mechanically, adding pressure leads to ischemia, which is compromise of the blood supply of the nerve. (RX1 p.27) The blood vessels supplied nutrition and took away waste and when you cut off the blood supply to the nerve, the nerve becomes symptomatic, progressing from numbness, tingling and eventual numbness, weakness and pain. (RX1 p.27) He noted that once the pressure reaches a certain threshold in the canal, the supply become compromised and symptoms appear. (RX1 p.27) If you increase the pressure in the canal and do it repeatedly, that leads to a reaction of edema, which is weeping of fluid around the nerve and the tendons in the canal. (RX1 p.28) This leads to thickening and fibrosis of the tissues. (RX1 p.28) The fibrosing compromises the canal even more which increases the pressure in the canal. (RX1 p.28) It is like a self-feeding cycle where pressure keeps building which makes it easier to elicit symptoms. (RX1 p.28-29) The longer period of time that a person is exposed to an increase in pressure in the canal, the more likely it is that ischemia will result in fibrosing which allows symptoms to manifest with less pressure on the canal. (RX1 p.29) Splinting was meant to reduce pressure in the canal. (RX1 p.30) The cortisone injection was also meant to reduce swelling. (RX1 p.31)

Dr. Fernandez asked Petitioner to demonstrate her work set-up for him. (RX1 p.31) Petitioner pronated the forearm at 60 degrees and extended her wrist by 20 degrees. (RX1 p.32) Dr. Fernandez agreed he had not

performed any research involving what specific movements increased pressure in the canal. (RX1 p.34) He knew that researches had determined that canal pressure increased with flexion and extension movements beyond neutral. (RX1 p.34) Dr. Fernandez admitted there was a mass of research out there on carpal tunnel syndrome, much of which he did not consider of sufficient scientific validity. (RX1 p.35) He did rely on some of the epidemiological research, but noted that there is research out there supporting any position you want to take on carpal tunnel syndrome. (RX1 p.36) When pressed on which journals were reliable sources for medical information, he was not convinced by the studies which found a correlation between typing and development of carpal tunnel syndrome. (RX1 p.38) Dr. Fernandez knew that Petitioner correlated the appearance and worsening of her symptoms with typing and writing. (RX1 p.38) She reported a gradual onset and progression of the symptoms, which she correlated with typing. (RX1 p.38-39) Her surgery relieved the pressure and reduced the symptoms. (RX1 p.39) She then returned to the same activities and her symptoms recurred. (RX1 p.39) Dr. Fernandez did not believe that a person was more susceptible to redeveloping carpal tunnel syndrome if they had it at an earlier time. (RX1 p.39-40) Considering the risk factors for petitioner, 10 to 15% of the female population at her age developed carpal tunnel syndrome. (RX1 p.41) When pushed on what standard of probability he was applying to the case, he claimed there was zero percent of causation even though he knew there was research in peer reviewed journals showing the correlation he was denying. (RX1 p.46) Dr. Fernandez admitted that typing increases the canal pressure and he could not identify any other activities petitioner performed which required prolonged extension or flexion of the wrist other than typing. (RX1 p.49-50) Dr. Fernandez claimed it would take 40 to 50 degrees of extension to raise canal pressure sufficiently to result in ischemia. (RX1 p.53) But he could not identify any research which supported his idea as to how much extension was needed to raise the pressure to the threshold levels. (RX1 p.53)

CONCLUSIONS OF LAW

Regarding Issue C- Did Petitioner sustain an accident arising out of and in the course of her employment with Respondent? and Issue F- Is Petitioner's current condition of ill-being causally related to the accident?, the Arbitrator finds and concludes as follows:

The Arbitrator finds and concludes Petitioner has proven by a preponderance of the credible evidence that her condition of ill-being in her right hand and arm (carpal tunnel syndrome only) is causally related to her work duties with Respondent.

The Arbitrator finds and concludes the opinions of treating physician Dr. Fister and Petitioner's examining expert Dr. Coe should be accorded greater weight, credibility and reliance than the opinions of Dr.

Fernandez. The Arbitrator accordingly adopts then opinions of treating physician Dr. Fister and Petitioner's examining expert Dr. Coe over those of Respondent's expert Dr. Fernandez.

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). **Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.** *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). That is what the Arbitrator has determined the preponderance of the credible evidence supports in this Decision.

The Arbitrator notes Respondent disputes accident and causation. Respondent argues Petitioner bases her claim for compensation solely on the opinions of Dr. Coe. **This is inaccurate.**

Further, Respondent incorrectly asserts, "At no point during this treatment did Petitioner receive an opinion from her treating doctors that her condition was caused by her workplace activities. At most, her treaters noted in a few places that Petitioner herself attributed her condition to typing at her job with IDOT. The only opinion linking Petitioner's condition to her workplace activities came from Dr. Coe's 2017 IME." The Arbitrator finds and concludes Respondent's assertions and portrayal of the evidence here are incorrect. Treating physician Dr. Fister wrote in his records the following: "This is actually a workcomp situation and certainly these conditions can be aggravated by repetitive typing on the keyboard. We will hold on scheduling the surgery until we get workcomp insurance clearance…" (PX 2, pp. 8-9), **Dr. Fister here was clearly not merely parroting what Petitioner told him but was rather expressing his own expert medical opinion, an opinion which no expert has directly reviewed, discussed or criticized - let alone rebutted. Respondent has erroneously minimized – and misconstrued - the significance of Dr. Fister's record notes and opinion. The Arbitrator finds Dr. Fister's opinion are evidence-based, credible, reliable and accordingly adopts them.**

Respondent further argues, "Petitioner's workplace activities fail, as a matter of law, to establish a compensable repetitive workplace injury claim." **The Arbitrator does not agree.**

Respondent further argues that, "The Commission, however, per *Davis* and *Brooks*, has already rejected typing, without more, as creating a compensable claim under the Act." **This is not an accurate statement.** Respondent's assertion misconstrues the meaning of what these two Commission Panel Decisions have held.

First, in *Brooks*, while the Commission concluded Petitioner could not prove her claim of CTS, the Commission wrote, "The Commission is not persuaded that work activities comprised only of substantial

typing, using a computer mouse, and using a telephone with a headset **significantly contributes** to the development or aggravation of CTS." Long-established case law only requires that the work place conditions need only be **a contributing cause or factor - not a "significant" contributing factor**; therefore, **this Commission Decision does not change existing case law causation requirements.**

Further, in *Davis,* Respondent does ***not*** mention that the Commission stated, **"We do not believe that it is true that a claimant could never successfully prove causal connection between certain clerical activities and carpal tunnel syndrome,** as per the opinion of Dr. Pomerance, but we do believe that the Petitioner **in this case** did in fact fail to prove such a causal nexus." In *Davis,* the Commission found "Petitioner failed to offer persuasive evidence that her job duties caused repetitive trauma resulting in carpal tunnel syndrome." Therefore, contrary to Respondent's assertions, it cannot be argued that Petitioner, as a matter of law, **could never successfully prove causal connection between certain clerical activities and carpal tunnel syndrome.**

Here, the causation finding is supported by Petitioner's credible - and unrebutted - testimony regarding her work duties, the evidence in the record supporting a finding of the highly repetitive nature of the work she actually performed, the facts in evidence showing the onset and progression of relevant symptoms while Petitioner was performing her work duties **over a period of many continuous years**, the lack of other activities or etiologies (e.g., no intervening accident) to credibly explain the appearance of the symptoms and the condition, as well as the opinions of Respondent's initial doctor (Dr. Fister) and Petitioner's examining expert Dr. Coe opining that the work Petitioner performed was **a causative factor** in the development and progress of her symptoms and conditions.

Further, the Arbitrator finds particularly unpersuasive Dr. Fernandez's opinion that "...there's no causality from typing and writing. **Zero percent**." (RX 1, p. 46). That Dr. Fernandez would opine with such certainty that typing and writing has "zero percent" causality is engaging in an "absolute" that is unreasonable and unsubstantiated in the field of medicine, allowing the possibility of no chance whatsoever, no matter the facts, in any case. **The Arbitrator is unwilling to adopt that extreme position - and notes neither has the Commission (See *Davis*, as noted herein).**

Further, the Arbitrator finds also particularly unpersuasive Dr. Fernandez's opinion, which is really speculation, that Petitioner's gender (female) and age (49) are "intrinsic risk factors" to cause carpal tunnel syndrome **related to this claim**. But the reason why the discussion of these intrinsic risk factors" is speculative in this case is because **Dr. Fernandez never establishes with actual facts and evidence a foundation to support his opinion that gender and age are actually involved in this claim**; rather, he offers his testimony assuming such risk factors were relevant in this claim, but that was never proven.

The Arbitrator emphasizes Respondent did not dispute (let alone rebut) any of the details of Petitioner's work duties to which she credibly testified and which the record evidence corroborates. The evidence demonstrates Petitioner worked 7.5 hour shifts five days a week. Petitioner had 30 minutes of breaktime and a 45-minute lunch, leaving 6 ¼ hours of work per shift. Petitioner typed 5 to 6 hours per shift, representing 80% to 96% of her actual work period. Petitioner's workstation never had ergonomic accommodations and that detail is also undisputed and reflected in the analysis of both experts. She also performed the typing by resting the palmer surface of her wrists on the hard desk top and extending her hands upward to reach the keyboard. She had performed typing in this fashion for 31 years by the date of her accident and for 38 years by the time of trial. She experienced her CTS symptoms with the typing and could correlate it with no other activities. She performed no other repetitive activities in or outside of work. She also noted that the symptoms all abated over the weekends when she was away from typing duties and the symptoms would come right back when she resumed typing on Monday. The timeline (which clearly supports a "chain of events" theory) certainly supports a conclusion that the CTS is causally related to the work.

The medical evidence also supports a causal relationship. When the EMG/NCV detected CTS and ulnar nerve entrapment, Respondent sent Petitioner for Dr. Fister for treatment. Dr. Fister causally related the CTS and ulnar entrapment to her typing duties but Respondent would not authorize the surgery Fister was recommending. Petitioner continued working. Dr. Berkson never addressed causation one way or the other. Dr. Coe also related the injuries to the repetitive typing activities. Dr. Coe noted that the condition resulted from increased pressure in the carpal canal which resulted in microtrauma to the median nerve in the canal. Dr. Coe explained that standard medical teaching identified repetitive use of the muscles of the hand increased tension in the muscles in performing flexion or extension on a repeated basis. (PX1 p.57) This resulted in repetitive strain in the canal, resulting in repetitive micro trauma which limited the flow of nutrients within the nerve resulting in the damage. (PX1 p.57) Dr. Coe identified the repetitive typing duties to the CTS and noted that medical literature supported the causal link.

However, the Arbitrator emphasizes that Dr. Coe offered no comment and no opinion regarding any ulnar nerve entrapment condition, either in his deposition or in his report; rather, his opinions only relate to Petitioner's carpal tunnel syndrome condition. Accordingly, the Arbitrator finds that Petitioner has failed to prove any alleged condition of ill-being to her elbow (ulnar nerve entrapment) is causally related to this accident. Further supporting this conclusion is the fact that according to Dr. Coe, treating physician Dr. Berkson indicated there might be some cubital tunnel syndrome, he found no clinical evidence, no symptoms, no findings of cubital tunnel syndrome, and therefore his diagnosis as of October 24, 2013 was right carpal tunnel syndrome, at which time surgery was prescribed. (PX 1, p. 18).

Dr. Fernandez agreed that the condition developed over an extended period of time as increased pressure in the carpal canal results in ischemic changes to the nerve and thickening of the surrounding tissues. However, he did not believe there was a connection between typing and CTS. Dr. Fernandez knew that a body of medical literature existed in peer reviewed journals supporting a causal relationship between typing duties and CTS but he did not consider these to be "reasonable." He also relied on ergonomic studies for some of his own work. However, he downplayed the pro-causation literature as insufficiently scientific, claiming that better research showed no causal relationship. But Dr. Fernandez identified none of his preferred literature or even the authors. In fact, he refused to do so, telling Petitioner's counsel at his deposition, "No, I wouldn't do that. I'll let you figure that out for yourself." (RX 1, p. 53). That type of answer does not serve to strengthen the persuasiveness of his opinions. So we have a dispute over causation between Dr. Fernandez on the one side, opposed by respondent's first hand specialist (Dr Fister), Dr Coe and a known body of literature supporting causation.

Moreover, the nature of CTS development would also seem to support a causal relationship between Petitioner's long-term repetitive typing and her CTS. The experts both tell us that increased canal pressure leads to chronic nutritional nerve issues and scarring and thickening of the surrounding structures in the canal. Any movement of the wrist beyond a straight neutral position increases pressure in the canal. And as conditions in the wrist progress, it takes less pressure in the canal to elicit symptoms. That logically explains why petitioner was experiencing symptoms with her typing duties. Dr. Fernandez objected that Petitioner would need more extension or flexion to create enough pressure to cause the ischemic changes. However, he admitted he had not performed any of the research and he knew that no researcher had correlated what level of pressure was required in the canal to cause the changes which led to CTS. Dr. Fernandez also knew there was no literature defining how much flexion or extension was required to develop CTS, nor did he offer any opinions as to what quantity is required to develop CTS. Thus, Dr. Fernandez' arguments are simply arguments, and they are arguments which presently lack a scientific or factual foundation. The causation standard is based on a preponderance of evidence standard. The condition in her canal was obviously progressing, it correlated directly with typing activities (a fact never rebutted), it abated when she was away from typing (a fact never rebutted) and she had deviated her wrist over full shifts to perform the repetitive typing for three decades by the time the condition manifested (a fact never rebutted). Under these circumstances, the pro-causation opinions of Drs. Fister and Coe are more persuasive, credible, weight and reliable than Dr. Fernandez's opinion denying causation. The risk factors do not scientifically establish causation as they are nothing more than epidemiological correlation showing a higher incidence of CTS in women at Petitioner's age, and even then, at a low level of occurrence. Petitioner has proven by a preponderance of the credible evidence that her repetitive typing activities are causally related to the development of her CTS and ulnar nerve entrapment.

Lastly, the Arbitrator finds and concludes Dr. Coe's opinions and the foundation for those opinions is afforded greater weight based on his more impressive and relevant professional credentials – his clearly his superior expertise in the area of occupational medicine (beyond his medical degree) based on his experience (see dep, PX 1, pp. 5-7) and his education, namely, his board-certified specialty in occupational medicine and his Ph.D. in Occupational Medicine form the University of London, London School of Hygiene.

Issue D- What is the date of the accident?

Petitioner alleged an accident date of 10/26/12. (Arb.Ex1) That accident date is mentioned on the 11/12/12 formal notice of injury to Respondent (PX5), the 12-5-12 note from Dr. Fister (PX2) and is the time period within which she first sees Dr. Shah and has the 11/6/12 EMG/NCV. The preponderance of the credible evidence shows Petitioner has proven that 10/26/12 is a reasonable manifestation date for her injuries.

Manifestation dates are commonly characterized as the date when the fact of injury and causal relationship to work would have become plainly apparent to a reasonable person. See *Peoria County Belwood Nursing Home v. Indust. Com'n*, 115 Ill.2d 524, 531 (1987). "Fairness and flexibility are the common themes" when settling on manifestation dates for repetitive trauma injuries. *Durand v. Indust. Com'n*, 224 Ill.2d 53, 71 (2006) The dates should not be fixed so rigidly as to punish workers who choose to keep producing for their employers as their bodies break down. The Act was designed to protect injured employees rather than to grant windfalls for employers by setting dates and barriers which are little more than legal fictions (an artificial accident date to repetitive injuries). The *Durand* court recognized that repetitive trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. *Durand*, 224 Ill.2d at 68. The Court highlighted the need to protect workers who continue to produce for their employer as the injuries worsen. An employee who discovers the onset of symptoms and their relationship to employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. *Durand*, 224 Ill.2d 53, 68 (2006). Drs. Fister, Coe and Fernandez all understood that Petitioner's carpal tunnel syndrome had developed over an extended period of time. Thus, 10/26/12 is a reasonable manifestation date for the accident and is sufficiently supported by the credible evidence in the record.

Issue E- Was timely notice of the accident given to Respondent?

Petitioner completed a formal notice of accident for Respondent on 11/12/12. (PX5) The report documents that she provided notice of her injury to her supervisor on 11/9/12, the day she received the

EMG/NCV results. Given the accident date of 10/26/12, Petitioner gave timely notice, supported by a preponderance of the evidence in the record.

Issue J- Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Given the findings on accident and causation, Respondent shall pay the $375 charge from Midwest Bone & Joint, subject to Sections 8(a) and 8.2.

Issue L– What is the nature and extent of the injuries?

Petitioner testified as to how the CTS symptoms were still affecting her seven years after her manifestation date. The CTS was still present despite the initial relief obtained through Dr. Berkson's release. The CTS was affecting both her work and nonwork activities.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner returned to the same work she was doing when he injury developed. The Arbitrator also gives this factor no weight.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. She has decades ahead of her to experience the continuing consequences of the carpal tunnel syndrome. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that petitioner continued working in the same position. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, Petitioner outlined her continuing symptoms and explained their impact on her activities of daily living. Dr. Coe outlined the residual complaints he found during his 2017 evaluation. Dr. Fernandez outlined all the continuing limitations he discovered during his evaluation in 2018, and he recommended that she be worked up again for recurrent carpal tunnel syndrome. Dr. Coe did opine that Petitioner certainly reached MMI and he had no permanent limitations indicated for her. Dr. Coe noted Petitioner was able to return to work at full duty and he had no specific restrictions for her. Dr. Coe did note Petitioner had mechanical changes that occur after the surgery which include discomfort, mild sensory deficit, and mild weakness in her right hand and pinch grip. Dr. Coe opined these conditions are permanent. (PX 1, pp. 33-34). Because of continuing symptoms and limitations related to her injuries and post-surgical changes, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the right hand (23.75 weeks of compensation, 190 X .125%) for the residual effects of her carpal tunnel syndrome pursuant to §8(e)9 of the Act.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: October 24, 2019

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

ERIC BRYER,

Petitioner,

vs. NO: 14 WC 41588

VCO DEVELOPMENT and
ILLINOIS STATE TREASURER
as EX-OFFICIO CUSTODIAN of the
INJURED WORKERS' BENEFIT FUND,

20 I W C C 0 5 6 0

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 employment, notice, wage rate, accident, causal connection, medical expenses, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

VCO Development is a dissolved corporation and was represented at arbitration by Aaron O'Dell, the former owner of VCO Development. The Commission finds the participation and testimony of Mr. O'Dell improper and, therefore, strikes his testimony and questioning from the record.

In its Statement of Exceptions, the Petitioner argues that appropriate legal representation for a corporation is through an attorney. Therefore, Mr. O'Dell should not have been allowed to testify on his own behalf. In support, the Petitioner cites *Downtown Disposal Services, Inc. v. City of Chicago*, 2012 IL 112040 (2012) for stating that a corporation is an artificial entity and must always act through agents in the interest of the corporation.

In *Downtown Disposal Services, Inc.*, the court held that a corporation must be represented by counsel in the legal proceedings. The Court, however, held that there was no automatic nullity rule. Instead, the circuit court should consider the circumstances of the case and the facts before it in determining whether dismissal is proper. The circuit court should consider, *inter alia*, whether the non-attorney's conduct is done without knowledge that the action was improper, whether the corporation acted diligently in correcting the mistake by obtaining counsel, whether the non-attorney's participation is minimal, and whether the participation results in prejudice to the opposing party.

The Commission finds *Downtown Disposal Services, Inc.* controlling. Mr. O'Dell was given the opportunity to secure counsel but declined. Mr. O'Dell's participation in this matter was significant as his testimony was relevant to the ultimate issue in this matter; whether Petitioner was an employee and whether VCO Development was working in the area at the time of the accident. Mr. O'Dell's testimony was averse to the Petitioner resulting in prejudice to the Petitioner. Therefore, the Commission strikes his participation and testimony from the record.

Having struck Mr. O'Dell's testimony from the record, the Commission finds that the remaining evidence supports the Arbitrator's finding that Petitioner failed to prove an employee-employer relationship and that Petitioner failed to prove accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 4 2020

D. Douglas McCarthy

DDM/tdm
O: 8/5/20
052

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRYER, ERIC Case# **14WC041588**
Employee/Petitioner

VCO DEVELOPMENT INC & ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

20IWCC0560

On 11/18/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0657 TURNER & SACKETT LLC
RICHARD L TURNER JR
107 W EXCHANGE ST
SYCAMORE, IL 60178

0000 AARON O'DELL
8531 S GRANGE RD
ROCHELLE, IL 61068

0000 ARLEN O'DELL
1556 GRAND DR
DeKALB, IL 60115

6212 ASSISTANT ATTORNEY GENERAL
DREW DIERKES
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

20IWCC0560

STATE OF ILLINOIS)

)SS.

COUNTY OF KANE)

☒ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Eric Bryer
Employee/Petitioner

Case # 14 WC 41588

v.

Consolidated cases: ______

VCO Development, Inc.. & Illinois State Treasurer as Ex-oficio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

20IWCC0560

An *Application for Adjustment 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 **Geneva**, on **August 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☒ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☒ What was the date of the accident?

E. ☒ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☒ What were Petitioner's earnings?

H. ☒ What was Petitioner's age at the time of the accident?

I. ☒ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

L. ☒ What is the nature and extent of the injury?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☒ Other **The liability of the Injured Workers' Benefit Fund**

Findings

On **September 22, 2013** Respondent-Employer ***was not*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent-Employer.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was not*** given to Respondent-Employer.

Order

Because an employee-employer relationship did not exist between Petitioner and Respondent-Employer, on the alleged date of accident, and that Petitioner did not sustain an accident that arose out of and in the course of employment, and that timely notice of the accident was not given to Respondent, Petitioner's claim is hereby denied.

Rules Regarding Appeals Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

Statement of Interest Rate If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

[signature] 11/15/2019

Signature of Arbitrator Date

NOV 18 2019

Procedural History

This matter was tried on August 19, 2019. Eric Bryer (hereinafter referred to as "Petitioner") sought relief from VCO Development, Inc., a dissolved corporation, (hereafter referred to as "Respondent") and the Illinois State Treasurer as custodian of the Injured Workers' Benefit Fund, (hereafter referred to as the "IWBF"). Petitioner was represented by counsel, the IWBF was represented by the Illinois Attorney General's Office and Aaron O'Dell appeared as the former owner of the dissolved corporation f/k/a VCO Development, Inc.

Findings of Fact

The Arbitrator's Findings as to Insurance Coverage

Without objection, Petitioner's counsel offered into evidence, Petitioner's Exhibit 8 "PX 8", which was a record from the National Council on Compensation Insurance, Inc. ("NCCI") showing no record of workers' compensation insurance on September 22, 2013 for Respondent. (PX 8). Based on Petitioner's Exhibit 8, the Arbitrator finds that Respondent-Employer lacked workers' compensation insurance coverage on September 22, 2013.

Summary of Testimony and Other Evidence

A. Testimony of Petitioner

Petitioner testified that he was born on August 25, 1976, single, and had two dependent children. Petitioner testified that, on September 22, 2013, he worked for Respondent as a construction laborer. Petitioner testified that he worked on and off for Respondent for a few years prior to September 22, 2013. Petitioner testified that his duties included rough construction, rough framing, and carpentry. Tools Petitioner used included hammer, nails, levels, nail guns, ladders, and scaffolding. Petitioner testified that he would bring is own hammer, level and tape measure to the job sites and everything else was provided by Respondent including pneumatic tools, scaffolding, ladders and lumbar.

Petitioner testified that he earned wither $17.00 or $18.00 per hour and he worked 40 hours a week and that he was paid weekly. Petitioner testified that he was paid by check issued by Respondent and withholding, and other benefits were deducted from his check. The checks were handed out by Aaron O'Dell, Aaron's brother, Arlen, or Aaron's wife, Melissa, at the end of the week. Petitioner was told which job sites to go by Aaron or Arlen. Petitioner testified that he did

not work exclusively for Respondent and that he was able to work for others and he did not need to notify Aaron or Arlen if was working elsewhere.

Petitioner testified that, on September 22, 2013, he was at a jobsite in Sycamore hanging typar Paper, which is the paper that covers the outside of buildings. Petitioner testified that the property he was working at was a one-story residence. Petitioner testified that he was handing Typar paper with Koulton Miller, his daughter's uncle, who also worked for Respondent. Petitioner testified that he was on a ladder when the ladder slid out from underneath him causing him to fall. Petitioner testified that he was on an extension ladder. Petitioner testified that he was 10 feet in the air when he fell.

Petitioner testified that he fell on his back in a twisting motion. Petitioner testified that Mr. Miller was in the immediate area and he helped Petitioner up off the ground and brushed him off. Petitioner testified that he told Aaron O'Dell, who was at the jobsite, that he fell and was leaving. Petitioner testified that he was experiencing pain in his shoulders and upper back.

Petitioner testified that, when he fell, he was on probation and wearing a GPS bracelet. Petitioner testified that he notified his parole officer who told him to go home.

Petitioner testified that he sought medical care on September 25, 2013, with Dr. Salwan of Advance Internal Medicine, who recommended physical therapy. Petitioner testified that his pain was located in his shoulders and upper back. Petitioner did not return to treatment with Dr. Salwan until November 19, 2014.

Petitioner testified that he returned to jail on December 1, 2013, at Western Illinois Correctional Center. Petitioner testified that this shoulder and upper back pain did go away while in jail and he sought medical care while in jail.

Petitioner testified that upon being released from Jail, he returned to Dr. Salwan, who referred him to an orthopedic surgeon. Petitioner testified that he was still experiencing shoulder and upper back pain which did not go away. Petitioner testified that he treated with Dr. Jacinthe Malalis, a rehabilitation physician, at Midwest Orthopedics. An MRI of the low back was ordered. Regarding the ordering of a lumbar MRI Petitioner testified that "I guess it was hurt at the same time". (T. pg. 33).

Petitioner testified that he did physical therapy for a short time, but it did not help. Petitioner testified that he was referred to Dr. Faubel in July 2015. Petitioner testified that he was referred to a pain clinic and given muscle relaxers and Norco, which helped a little.

Petitioner testified that he started working at CCA Midwest on June 27, 2016. Petitioner testified that, prior to June 27, 2016, he had not worked since the date of the accident and was not paid any TTD from September 22, 2013 through June 27, 2016.

Petitioner testified that he was involved in another work accident on January 9, 2017 when a piece of dry wall fell on his head. That workers' compensation case is still pending. Petitioner testified that he still had difficulty lifting things and loss of motion in his shoulder since the January 2017 accident. Petitioner testified he could not remember any prior injuries to his back or shoulder. Petitioner testified that he previously worked for Marty Krpan but denied ever settling a workers' compensation claim with him.

B. Testimony of Koulton Miller

Koulton Miller testified that he was not sure whether he was working for Respondent on September 22, 2013. (T. Pg. 50). Mr. Miller testified that believes that he was working with Petitioner on a second story window, but that he is not sure, when he fell off a ladder. Mr. Miller testified that he was up on the second story, pretty high up on the ladder, when the board the ladder was sitting on slid out from underneath causing him to fall. Mr. Miller testified that he fell on the ladder. Mr. Miller testified that Petitioner was at the second story or first story window when he fell. Mr. Miller testified that he dropped Petitioner off at his residence.

C. Testimony of Aaron O'Dell

Aaron O'Dell testified that he was the owner of Respondent. Mr. O'Dell testified that Respondent furnished tools to the laborers. Mr. O'Dell testified that as of September 22, 2013, Respondent was not performing work in DeKalb County. Mr. O'Dell testified that on September 22, 2013, Respondent was working jobs for Dodds Carpentry, in Champaign, Illinois, and in Davenport, Iowa. Mr. O'Dell testified that he did not have worker's compensation insurance, on September 22, 2013, because he was working for another company.

Mr. O'Dell testified that after Petitioner was released from prison, Petitioner returned and requested a job. Mr. O'Dell testified that he did not offer Petitioner a job and, thereafter, he received notice of the workers' compensation claim. Mr. O'Dell testified that the claim was the first notice received on the alleged work place injury.

D. Petitioner's Medical Treatment

On September 25, 2013, Petitioner presented to Dr. Manav Salwan of Advanced Internal Medicine. (PX 1). At that time, Petitioner complained of pain his lower back after falling off a

ladder. Dr. Salwan diagnosed Petitioner with an unspecified back ache and prescribed Ibuprofen and suggested physical therapy if there was no improvement. *Id.*

On January 2, 2014, Petitioner was incarcerated at Western Illinois Correctional Center and asked for an evaluation of his back pain and whether he needed seizure medication. (PX 3). Petitioner saw Dr. Thomas Baker on January 13, 2014, but Dr. Baker only addressed seizures at that time. *Id.* On January 24, 2014, Petitioner complained of extreme back pain. *Id.* On February 4, 2014, Petitioner reported he had fallen 30 feet from a ladder and while he was able to perform his activities of daily living, it was difficult for him to walk at times. *Id.* Petitioner was encouraged to reduce time lying in his bunk and increase his activity. *Id.* On March 3, 2014, he was prescribed ibuprofen. *Id.* On March 11, 2014, he was given a back exercise sheet and advised to do them several times a day for weeks and months. *Id.* On June 17, 2014, he presented begging for additional pain relief. *Id.* Petitioner was given rubbing cream and Tylenol and referred to Dr. Baker. *Id.* Dr. Baker saw him on July 10, 2014, and noted no difference in exam from March 11, 2014 except more mobility and less stiffness. *Id.* Dr. Baker opined the medication he had gotten previously was adequate to meet his needs. *Id.*

On November 19, 2014, Petitioner returned to see Dr. Salwan. (PX 1). Petitioner complained of low back pain and occasionally numbness in his legs. Petitioner also complained of feeling some shooting pains through his right shoulder. Dr. Salwan's records state that Petitioner reported not seeing a physician while in prison and a history of chronic back pain. Dr. Salwan prescribed ibuprofen, Medrol dosepak and referred him to an orthopaedic doctor. *Id.*

On December 3, 2014, Petitioner presented to Dr. Jacinthe Malalis of Midwest Orthopaedic Institute. (PX 2). Petitioner complained of low back pain after falling 30 feet off a ladder. *Id.* X-rays of the lumbar spine showed very mild degenerative changes at L5-S1. *Id.* Petitioner was prescribed a course of physical therapy and meloxicam. *Id.* Petitioner had a physical therapy evaluation on January 5, 2015 and was to attend twice a week for four to six weeks, however his father called on January 8, 2015 and cancelled the remaining sessions because Petitioner was in county jail. *Id.*

On June 29, 2015, Petitioner saw Dr. Salwan for a medication refill. (PX 1). On July 15, 2015, Petitioner saw Dr. Chris Faubel of Midwest Orthopaedic Institute. (PX 2). Dr. Faubel diagnosed him with axial low back pain and prescribed an MRI of the lumbar spine. *Id.* The MRI taken on July 17, 2015 showed a small slightly superior displaced broad-based central to right

central disc extrusion causing no significant stenosis or nerve impingement at L4-5, moderate disc degeneration with central endplate Schmorl's nodes and mild modic 2 endplate changes and mild disc bulging causing no significant central canal or foraminal stenosis at L5-S1. *Id.* Dr. Faubel recommended physical therapy and potentially steroid injections. *Id.*

On August 20, 2015, Petitioner saw Dr. Salwan who prescribed Naproxen, ibuprofen, and to consider physical therapy. (PX 1). Dr. Salwan also recommended having his hips checked out because the spine MRI was normal. *Id.* Petitioner saw Dr. Rajeev Jain of Midwest Orthopaedic Institute on August, 2015. (PX 2). X-rays of the pelvis were normal. *Id.* Petitioner was told to continue to follow up with Dr. Faubel. *Id.*

On October 5, 2015, Petitioner saw Jeannine Fair, APN at Kishwaukee Community Hospital. (PX 4) Ms. Fair diagnosed Petitioner with low back pain and radicular pain of lower extremity. *Id.* Ms. Fair thought it was best to continue with Midwest Orthopaedics. *Id.* Petitioner had an EMG done at Rochelle Community Hospital on February 24, 2016 that was normal. (PX 5).

The Arbitrator does not find the testimony of Portioner to be credible.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as 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).

The Arbitrator does not find the testimony of Petitioner to be credible. Petitioner testified that he injured his shoulders and upper back while working for Respondent on September 22, 2013. The medical records from Dr. Salwan, dated September 25, 2013, states that Petitioner reported injuring his low back and that the injury had occurred recently. Petitioner did not report an injury to his upper back and shoulders to Dr. Salwan. The Arbitrator notes that Petitioner did not return to Dr. Salwan until November 19, 2014 but he did not return to jail until December 1, 2013. Petitioner sought no medical treatment from September 25, 2013 until returning to jail. When Petitioner return to Dr. Salwan, on November 19, 2014, Petitioner complained of low back pain and occasional right shoulder pain.

Dr. Salwan's records, of November 19, 2014, state that Petitioner did not see a physician while in prison. The records from Western Illinois Correction Center show that Petitioner treated with Dr. Backer on numerous occasions. (PX 3).

Petitioner testified that he fell off a ladder about 10 feet while working on a single-story house. The Arbitrator notes that Dr. Baker's records show that, on February 4, 2014, Petitioner reported falling 30 feet from a ladder. Petitioner testified that he was hanging Typar paper when he fell. Mr. Miller did not testify he and Petitioner were handing Typar paper. Mr. Miller testified that they were working on a window. Petitioner testified the building was a single-story residence, but Mr. Miller testified that they were working on second story window.

Petitioner denied settling a prior workers' compensation claim with Marty Krpan, however the Arbitrator takes judicial notice of case number 06 WC 33255, a case Petitioner filed against Krpan Construction was settled on January 12, 2008 for $1,500.00 for an injury to Petitioner's 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 Petitioner failed to prove by the preponderance of the evidence that Respondent as operating under and subject to the Illinois Workers' Compensation Act on the date of his alleged injury. Mr. O'Dell testified that Respondent completed work in DeKalb County prior to September 22, 2013 and he was working for another construction company at that time.

The Arbitrator further finds that Petitioner failed to prove by the preponderance of the evidence that an employee-employer relationship existed. Mr. Miller could not even recall what company he worked for on September 22, 2013. The Arbitrator found the testimony of Petitioner not to be credible. Petitioner testified that he worked on and off for Respondent prior to September 22, 2013 and that he could work for other employers at that time. The Arbitrator notes that Petitioner did not introduce into evidence copies of any paystubs or tax returns showing that he worked for Respondent in 2013.

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?

The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that an accident occurred that arose out of and in the course of his employment nor date of the accident. A petitioner bears the burden of proving by a preponderance of the evidence that he "has suffered a disabling injury arising out of and in the course of ... her employment." *Metro.*

Water Reclamation Dist. of Greater Chicago v. Illinois Workers' Comp. Comm'n, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 803 (2011) see also 820 ILCS 305/2 (West 2004). Mr. O'Dell testified that Respondent was not in operation at the time of the accident. The Arbitrator finds the Petitioner's testimony regarding the accident to be inconsistent with the history Petitioner provided the treating physicians. Petitioner testified that he injured his upper back and shoulder. Dr. Salwan's medical records, dated September 25, 2013, indicate that Petitioner reported injuring his low back "recently" after falling off a ladder. The Arbitrator notes that Dr. Salwan's records do not state that Petitioner was injured at work or that Petitioner was injured on a specific date. Petitioner did not testify that he injured his low back on September 22, 2013.

ISSUE (E) Was timely notice of the accident given to the Respondent?

The Arbitrator finds that timely notice of the accident was not given to Respondent. Mr. O'Dell testified that the first notice he received that Petitioner sustained a work injury was the workers' compensation claim filed on December 2014 after Petitioner was released from prison.

Remaining Issues in dispute.

Regarding the remaining issues in dispute, the Arbitrator having found that Petitioner failed to prove employee-employer relationship, that Respondent was operating under the Act, timely notice, and that Petitioner did not sustain an accidental injury that arose out of and in the course of his employment, the Arbitrator further finds all other issues are moot and need not be addressed.

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Susana Cancino,

Petitioner,

20 I W C C 0 5 6 1

vs. NO. 17WC 16131

Sheraton Grand,

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, 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 November 12, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2020

Stephen J. Mathis

SJM/sj
o-9/9/2020
44

Deborah Simpson

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

CANCINO, SUSANA
Employee/Petitioner

Case# **17WC016131**

SHERATON GRAND
Employer/Respondent

20IWCC0561

On 11/12/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0307 ELFENBAUM EVERS & AMARILIO
JOSEPH D AMARILIO
900 W JACKSON BLVD SUITE 3E
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN A RUDD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

20 IWCC0561

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)

Susana Cancino
Employee/Petitioner

v.

Sheraton Grand
Employer/Respondent

Case # **17 WC 16131**

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 **10/25/2018 and 11/21/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

B. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

F. X Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. X Is Petitioner entitled to any prospective medical care?

L. X What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance X TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

FINDINGS

On the date of accident, **5/22/2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$38,637.04**; the average weekly wage was **$743.02**.

On the date of accident, Petitioner was **44** years of age, ***married,*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**10,111.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**10,111.72**.

Respondent is entitled to a credit of $**0** under §8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**495.35**/week for **69 & 3/7** weeks, from **6/2/2017** through **12/15/2017** and from **1/10/2018** through **11/21/2018**, as provided in §8(b) of the Act.

Respondent shall pay reasonable and necessary medical services as provided in §8(a) of the Act. Determination of the amounts due will be deferred to a later proceeding and adjusted in accord with the medical fee schedule provided in §8.2 of the Act

Respondent shall authorize and pay for the further medical care recommended by Dr. Chhadia, including right shoulder surgery and post-operative care and further evaluation and treatment for Petitioner's left shoulder and cervical symptoms.

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.

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

Petitioner testified through a Spanish translator.

FINDINGS OF FACT

Petitioner Susana Cancino testified that she had worked as a housekeeper in Respondent's hotel for 20 years. She was born in Mexico and came to the United States in 1996 at age 24. She started working for Respondent in July 1998. Petitioner testified that the photographs in PX #6 are of typical guest rooms in Respondent's hotel, and that her job requires her to clean 16 rooms per shift. Each room contains either a single king-size bed or 2 double beds, along with a large mirror, picture window, carpeting, miscellaneous furniture and an attached bathroom.

Petitioner testified that cleaning a room includes changing the beds and removing dirty linens, towels, and garbage; vacuuming carpets; cleaning windows and mirrors; and dusting and cleaning furniture. Bathroom surfaces are also scrubbed, including bathtubs and toilets. Shower curtains are changed as needed. She reviewed the employer's job description for housekeeping attendants (RX #3) with a translator at her lawyer's office. It was accurate, although the list of tasks did not include cleaning of windows, pictures, and doorframes.

Petitioner testified that her work involves constant use of both arms, including scrubbing bathroom surfaces on hands and knees at times. Making beds, changing shower curtains, and cleaning mirrors requires a lot of reaching. Housekeepers are also required to push a cart loaded with tools and supplies from room to room. PX #6, p. 4 shows a typical work cart, with a vacuum cleaner hooked on the front of the cart, a bag for dirty linens, and a rack for clean glassware on the bottom. The cart can be pushed from either end. It has 4 wheels but only 2 of them turn. As a result, it can only turn in

report was prepared by Brenda Blakely. It describes the injury as a "Strain/Sprain" to both shoulders. The report also notes that Petitioner's primary language is Spanish, and that no translator was used. Petitioner signed as "employee" and Ms. Blakely signed as "preparer." A typed narrative states:

> Attendant Susanne (*sic*) Cancino stated she was pushing her housekeeping cart on the 9th floor at 1425 hours, and that when she tried to make a turn with the cart she felt a sharp pain in both of her shoulder. Susanne stated she just wanted to file a report and refuse any medical treatment at this time. Susanne stated she was done for the day and would go home and ice her shoulders.

A section entitled "Accident Details" contains a handwritten note in Spanish, followed by one in English which states that "while pushing her cart on the ninth floor she tried to turn with the cart which caused pain to both of her shoulder" (*sic*). A "Supplemental Report" includes a human figure diagram with both shoulders circled to indicate the body parts injured. An accompanying note states that Petitioner was given an ice pack and then "put her cart away so she could go home for the day."

Page 8 of RX #1 is in English, entitled "Refusal of Medical Assistance", and is dated May 22, 2017. It states that medical assistance was offered to Petitioner for her "accident, injury or illness" but that "the offered medical assistance was refused." The time of the offer was made and refused at "2:25." The next paragraph states "I hereby release from liability the Sheraton Grand Chicago, Starwood Hotels and Resorts Worldwide, Inc., together with their past or present officers, directors, associates, agents and affiliates from any and all claims and demands relating in any way to said accident, injury or illness. I have read and understand the foregoing refusal." The form is signed by Petitioner and by Brenda Blakely as witness.

Petitioner testified that she speaks and understands some English. She testified that she understands more than she speaks, but "if someone talks too fast I get lost." She communicates at work using both English and "Spanglish," as well as hand gestures. Petitioner stated that Laura Gagne speaks "a little" Spanish, but they spoke mainly in English on the date of accident. Petitioner testified that she learned her limited English on the job. She never studied English in school and she cannot read or write in English.

Petitioner testified that Julia (Mastrangeli) left after escorting her to the office, and that no union representative was present. It was just herself and Ms. Blakely, who does not speak Spanish. She explained the accident in English as best she could but was not sure how much Ms. Blakely understood. Petitioner testified that she never saw the completed accident report (RX #4) until shortly before trial. The note in Spanish on Page 6 was in her handwriting. The circles on the figure on Page 7 were possibly hers as

PA Harsant noted that he phoned Respondent's "WC HR rep," Ivan Hernandez-Torres, who advised that "there are ways to do her job with proper biomechanics where her shoulders do not get further strained." Mr. Hernandez-Torres stated that Petitioner did not need to lift her arms above her head while making beds, he stated, and she could use her torso instead of her trapezius to push the cart. Petitioner was returned to full duty with restrictions of "no lifting arms above head." She was told to consult Mr. Hernandez for instructions. In a subsequent phone call to the clinic, Mr. Hernandez-Torres indicated Petitioner could be excused from cleaning mirrors to avoid overhead use of her arms.

On May 31, 2017, Petitioner reported to PA Harsant at PIC that there was no way to avoid lifting her arms overhead to clean rooms. She had 5/10 pain at rest and 10/10 while working, with pain radiating down both arms (PX #3). PA Harsant issued restrictions of "no lifting above shoulder" and asked Mr. Hernandez-Torres to "make sure she is not doing this." Petitioner was again returned to full duty with use of "proper lifting techniques." She was also prescribed 5 days of oral cortisone, and a recheck was scheduled.

Petitioner testified that on May 26 the clinic staff told her not to do overhead work, but when she returned to work "her job was the same." On May 31 the pain was strong, and they gave her some steroid pills. When she returned to the hotel she was sweating and felt dizzy, and that was when she decided to see a doctor of her own.

On June 1, 2017 Petitioner sought care from a chiropractor at Midway Medical Center (PX #3). She was evaluated Dr. Glenn Lemus, who noted a history of injury on May 21, 2017 while "twisting and pulling a heavy supply cart" at work. She reported that she regularly lifted up to 20 lbs. and pushed a cart weighing up to 150 lbs. Petitioner reported pain in both shoulders as well as her neck and upper back. Her shoulder pain was somewhat worse on the right and was increased with lifting or over-the-shoulder reaching. She rated her pain from 4/10 to 7/10, depending on the affected part of the body. She was working regular duty but with difficulty.

On examination Dr. Lemus found tenderness and muscle spasticity over the neck and upper back. There was full motion of the cervical spine with pain at the end points. There was pain and weakness with assessment of range of motion of the shoulders. Dr. Lemus diagnosed cervical sprain, thoracic sprain, left shoulder sprain, and right shoulder and upper sprain. He noted that these diagnoses were causally related to Petitioner's work accident. Dr. Lemus took her off work, discontinued prior medications of Tylenol and Naproxen, and prescribed PT, and diclofenac (Voltaren). He also referred Petitioner for evaluation by Dr. Agrawal. His evaluation was reviewed by

bilateral positive Neer's, Hawkins, and O'Brien's signs. Dr. Stanley noted that every muscle test, including strength testing, reproduced neck pain. Petitioner complained of a burning sensation over the right C5 nerve distribution. Spurling's and Lhmermitte's testing reproduced neck pain only.

Dr. Stanley found no objective findings other than non-organic pain. He noted 3 positive Waddell signs. He found Petitioner's history consistent with a cervical strain on May 22, 2017 but opined that the ongoing pain complaints did not follow any known injury pattern. Dr. Stanley did recommend a cervical MRI to rule out other etiology for Petitioner's symptoms. Dr. Stanley further opined that physical therapy was appropriate for cervical strain but that there was no indication for pain management.

On August 18, 2017, Petitioner saw orthopedic surgeon Chandrasekhar Sompalli, M.D., on referral from Dr. Najera (PX #4). Petitioner complained of bilateral shoulder pain due to a work-related injury on May 21, 2017. Dr. Sompalli noted Petitioner's history of accident indicated that "the cart tilted and fell over and because patient was holding on the cart to try and avoid falling her bilateral shoulders pulled causing immediate pain." Petitioner testified that she did not tell Dr. Sompalli that the service cart fell over; rather, she said that the cart tipped, and that she had tried to straighten it using her arms. Petitioner further testified that the doctor did not speak Spanish, and his interpreter wrote things down. Dr. Sompalli's progress note carried the following notation: "I, Lourdes, am scribing for Dr. Sompalli. I, Dr. Sompalli agree with the above documentation."

Petitioner complained of bilateral shoulder pain, right and left, neck pain and mid back she reported that the service cart weighed about 200 pounds. She completed 10 weeks of physical therapy and had had an MRI. Petitioner complained of 6/10 right shoulder pain which radiated to the neck mid back and down the arm with numbness and tingling in the right hand and fingers. Left shoulder pain was constant, sharp, and throbbing at 3/10. Petitioner denied any pain in the shoulders neck or back prior to her work injury.

Dr. Sompalli's exam noted limited range of motion above shoulder level due to pain. Hawkins and impingement signs were positive bilaterally. Dr. Sompalli reviewed the July 28 right shoulder MRI, noting that it showed a full thickness rotator cuff tear. Dr. Sompalli diagnosed a full-thickness rotator cuff tear of Petitioner's right secondary to her work-related injury. The doctor noted that steroid injection is contraindicated for rotator cuff tear. Plain X-rays of the right shoulder were unremarkable; plain X-rays of the left shoulder noted minimal degenerative changes. The doctor also diagnosed left shoulder pain secondary to work-related injury. Dr. Sompalli recommended right shoulder surgery. The doctor ordered a left shoulder MRI and administered a steroid

left shoulder, impingement syndrome of right shoulder, superior glenoid labrum lesion of right shoulder, incomplete rotator cuff tear/rupture of unspecified shoulder, bursitis of right shoulder, and osteoarthritis of right shoulder. Dr. Sompalli ordered a right shoulder MRI arthrogram and continued medications.

On November 17, 2017 Petitioner began physical therapy at Athletico (PX #8). The evaluation report, addressed to Dr. Sompalli, recorded "complaints of L shoulder pain after a work injury on 5/21/17. Pt was exiting room with the cart and the cart flipped and took the patient arm with it (*sic*)." It also stated that Petitioner continued to work through "11/9/2017" and was "possibly getting a labral repair on her right shoulder on Dec. 12."

There were no significant changes when Petitioner returned to Dr. Sompalli on December 15, 2017, January 9 and January 23, 2018. On December 15 the doctor noted Petitioner's right shoulder full thickness tear of rotator cuff and left shoulder pain, both secondary to Petitioner's work-related injury. Petitioner was returned to work with restrictions and advised to finish physical therapy. On January 23 Dr. Sompalli reviewed the MRIs with Petitioner, reviewed an IME report, ordered a left shoulder MR arthrogram, and kept Petitioner off work. The doctor submitted an authorization request for arthroscopy of the right shoulder.

On December 15, 2017, Dr. Sompalli noted that Petitioner's right shoulder condition had reached a plateau, with pain at 5/10 and that surgery had not been approved. She was attending physical therapy for her left shoulder. At Petitioner's request Dr. Sompalli released her for light duty work, with minimal lifting or use of her right arm. She was instructed to finish therapy for her left shoulder, and to return as soon as her right shoulder surgery was approved.

Petitioner testified that her light duty work for Respondent consisted of folding towels and checking rooms, with no pushing of carts or cleaning of rooms. At Respondent's direction, she took some earned vacation time during this period. On January 8, 2018 she returned to work and was given a letter instructing her to report for full duty work the next day. Petitioner testified that Dr. Sompalli did not release her for regular duty, and she did not believe she could handle full-duty work. She wanted the surgery so she could be OK; so she could work again.

On January 9, 2018 Dr. Sompalli issued a revised work status note taking Petitioner off work and requested a copy of Respondent's recent IME. On January 23, 2018 he re-examined Petitioner and reviewed Dr. Monaco's report. Dr. Sompalli noted his disagreement with Dr. Monaco's denial of causation, noting that the study he cited

On April 9, 2018, Petitioner was evaluated by orthopedic surgeon Dr. Chhadia pursuant to §12, at her attorney's request. Dr. Chhadia refreshed his memory by referring to his April 9, 2018 narrative report to Petitioner's counsel (DepX #2). The offer of admission of the report into evidence was rejected on hearsay grounds.

Dr. Chhadia is a board-certified orthopedic surgeon, specializing in treating shoulder and knee problems. Dr. Chhadia testified that he performs 1-2 IMES a year, mostly for the defense. Dr. Chhadia reviewed Petitioner's medical records from Dr. Sompalli, Midway Medical Center, and Physicians Immediate Care. He also reviewed the original MRI images and reports of MRIs performed July 28, 20917 and October 11, 2017. He also reviewed IME reports from Drs. Stanley and Monaco.

Dr. Chhadia examined Petitioner in Spanish and with a Spanish interpreter present. He noted that Petitioner had worked as a hotel housekeeper for 20 years, and that her job required "frequent bending, reaching and vigorous repetitive scrubbing." Petitioner reported that she had been injured on the job on May 21, 2017. She had been pushing a cart weighing well over 50 pounds and had had to make a sharp left turn to maneuver the cart through a set of double doors. There was a "step off" from the carpeted hallway upon passing through the doors, which resulted in the floor surface being slightly uneven. As she attempted to turn the cart it "started to tip over towards the left side." Petitioner attempted to hold up the cart with her non-dominant left arm and pull it back up from falling with the right arm. She experienced pain in both shoulders and her cervical area immediately.

Petitioner had received physical therapy which provide no lasting relief. She received 2 injections in her right shoulder and 3 injections in her left shoulder. Dr. Sompalli of Elite Orthopedics had recommended surgery on both shoulders, for which approval had been denied.

Petitioner reported constant pain in both shoulders, aggravated by activity, which radiated from her shoulders into her arms, along with numbness and tingling in the 4th and 5th fingers of both hands, right greater than left. She complained that she cannot do any heavy lifting and that her range of motion was limited. Her symptoms were significantly worse in the right shoulder than the left.

On examination Dr. Chhadia found tenderness to palpation in both shoulders. She had normal cervical range of motion but motion in both shoulders was limited, particularly in flexion and internal rotation, more so on the right. Neer and Hawkin's tests were positive for impingement in both shoulders. Speed's test for biceps tendon involvement was also positive bilaterally. Rotator cuff strength was significantly

Dr. Monaco testified by evidence deposition on August 16, 2018. He performed a §12 IME of Petitioner on December 12, 2017 at Respondent's request. A Spanish translator was utilized for the examination. The offer of his narrative report of that examination, DepX #2, was rejected on hearsay grounds. Dr. Monaco refreshed his memory with the report.

Dr. Monaco is an orthopedic surgeon but no longer performs surgery. His current practice is evenly divided between non-surgical patient treatment and medico-legal exams, 98% of which are for the defense. Petitioner's exam had been arranged by Integrity, which sends him only defense work.

Dr. Monaco reviewed Petitioner's records from PIC (Physician Immediate Care), chiropractor Lemus, Dr. Emmanuel, Dr. Divya Agrawal, Dr. Larry Najera, and Dr. Sompalli. He also reviewed the original imaging and reports of Petitioner's MRIs.

Dr. Monaco noted that Petitioner's medical records contain varying dates of accident and the mechanism of the accident. He noted that the date of accident was reported as May 21 and also May 22. He also noted that some records noted Petitioner's report that the service cart tipped to one side and also that the cart tipped over onto the floor. Dr. Monaco read the July 28, 2017 MRI of the right shoulder as showing a partial tearing of the supraspinatus without retraction and AC joint arthrosis. The labrum and biceps were intact. He read the October 11, 2017 right shoulder MRI as showing tendinosis of the supraspinatus and changes consistent with a partial tearing without a full thickness tear. There were mild degenerative changes in the acromioclavicular without signs of impingement and mild subacromial bursitis. He did not find any injury to the subscapularis, infraspinatus, teres minor, or the labral bicipital complex.

At the exam Petitioner gave a history of pushing a housekeeping cart which tilted as she was turning a corner. Petitioner reported that she felt a pop in her left shoulder and immediate pain. Petitioner stated that the cart did not fall over but that the cart pulled her shoulder.

Petitioner complained of bilateral shoulder pain, right greater than left. She complained of painful movement with pain radiating down the right arm and into the 4th and 5th digits of the hand. Left shoulder pain also radiating down the arm into the 4th and 5th digits. Petitioner also complained of numbness and tingling in the left thumb. She rated her pain at the IME at 6/10 but reported that her pain sometimes was as bad as 9/10. Petitioner also complained that her ability to taste had altered since her accident.

On exam Dr. Monaco found Petitioner's neck and upper back were normal, with

quite similar and, unlike the account recorded by Dr. Sompalli, they did not state the cart fell over. Dr. Monaco testified that during his own exam Petitioner had not claimed that the cart fell. She had described a pushing-pulling injury, and said the cart had tilted. His own history had been taken with the aid of a Spanish translator. He did not know whether the other histories had been taken directly or through an interpreter.

If Petitioner were his patient, Dr. Monaco would encourage her to pursue conservative care such as therapy and medications, which is what she had done. The arthrogram prescribed for her was something he would recommend in order to evaluate a possible labral injury. Dr. Monaco opined that if Petitioner's symptoms persisted despite conservative care, they would be either "baked in or pre-existing," rather than related to her May 2017 injury. However, he had seen no medical records concerning Petitioner's condition before the date of accident, including her 2001 or 2016 injuries, and was not aware of any other accidents or possible alternate causes of her shoulder pain.

Finally, Dr. Monaco testified that he would not second-guess recommendations for further treatment. He opined that Petitioner might benefit from rotator cuff surgery, although not from surgery on the labrum.

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 proved that she sustained an accidental injury that arose out of and in the course of employment as a housekeeper for Respondent. The Arbitrator notes that there was no genuine dispute regarding this issue.

Petitioner credibly testified that her job duties included moving and maneuvering service cart weighing approximately 200 pounds. Petitioner testified at trial that has she attempted to turn the service cart when it began to tip. There was evidence that Petitioner gave a history to one or another of her healthcare providers that the cart tipped over and fell. The Arbitrator finds a discrepancy of this nature to be insignificant. Whether the service cart tipped or wobbled or fell to the floor, these mechanisms were sufficient to cause the complaints and diagnoses in Petitioner's shoulders.

Petitioner consistently reported to her employer, or treating healthcare providers, and Respondent's IME examiner that she was holding onto the service cart as it was tipping. Her initial report to her employer contained a body diagram where complaints

Respondent.

F: Is Petitioner's current condition of ill-being causally related to the accident?

The Arbitrator finds that Petitioner proved that her condition of ill-being in her shoulders and her neck were causally related to her workplace accident on May 22, 2017.

Petitioner complained of bilateral shoulder pain to Respondent's supervisory staff the day of her accident. She sought medical care for her complaints at PIC with 2 days of her accident. She had consistent complaints and clinical findings with her neck and shoulders throughout a series of healthcare providers, ultimately being diagnosed by Dr. Sompalli with a right rotator cuff tear and rotator cuff tears in both shoulders by Dr. Chhadia. Both physicians related the diagnosed pathologies to Petitioner's workplace accident. Moreover, Petitioner testified credibly that she did not have problems with either shoulder before her accident. She did have a prior cervical spine injury which had resolved before her accident. She was working full time without restrictions at the time of her accident.

Respondent disputes causation based on the opinions of its §12 examiner, orthopedic surgeon Dr. Monaco. Dr. Monaco had reviewed Petitioner's medical records in addition to performing a clinical examination of Petitioner. At deposition Dr. Monaco acknowledged that approximately 98% of the IMEs he performs are on behalf of the defense. Based on his review of Petitioner's medical records and his IME of Petitioner Dr. Monaco diagnosed a mild strain of the left shoulder but apparently did not come to a specific diagnosis of the right shoulder. It is noteworthy the Dr. Monaco read the MRIs of the right shoulder as showing a partial tear of the supraspinatus without commenting on whether that pathology was related to Petitioner's accident.

The Arbitrator does not find Dr. Monaco's opinions regarding causation persuasive. Dr. Monaco based his opinions on his impression that the physical therapy notes of Midway Medical showed Petitioner had achieved a "2/10 pain level" by August 7, 2017. In fact, Dr. Lemus' notes state that her pain had decreased to 2/10 in her thoracic and cervical spine, but remained at 5/10 in the right shoulder. Dr. Monaco cites the near-normal shoulder range of motion recorded by Dr. Lemus, but omits repeated references to pain and weakness at end ranges. Also disregarded are Dr. Najera's findings of ongoing pain and his orthopedic surgery referral just 4 days later.

The Arbitrator finds Dr. Monaco's review of the medical records to be less than rigorous at best, and selective at worst. This is suggestive of a defense bias as demonstrated by his 98% IME rate for the defense. In addition, Dr. Monaco failed to

K: Is Petitioner entitled to prospective medical care?

The Arbitrator finds that Petitioner proved that she is entitled to any prospective medical care recommended by her treating surgeon, Drs. Sompalli and Chhadia. In light of all the evidence, the arbitrator finds the opinions of these surgeons were persuasive.

As noted above, Respondent's IME examiner, Dr. Monaco, did not dispute the opinions of Dr. Chhadia and Dr. Sompalli that Petitioner required right shoulder surgery for her rotator cuff tear, although he disputed causation. Both Dr. Chhadia and Dr. Sompalli also recommended a "staged" treatment process for the low-grade rotator cuff tear and possible labral injury in Petitioner's left shoulder, re-evaluating the need for surgery 2-3 months following her right shoulder procedure.

Respondent is ordered to authorize and pay for the recommended right shoulder surgery as well as all reasonable post-operative care, as well as for subsequent evaluation and treatment of Petitioner's left shoulder and cervical spine symptoms. Respondent is also found liable for all reasonable and necessary medical charges incurred through the date of trial for care of Petitioner's bilateral shoulder, neck and arm symptoms. The Arbitrator notes that the parties have stipulated to defer the exact amount of such charges to a future hearing.

L: What temporary benefits are in dispute? TTD

In light of finding causal connection, the Arbitrator notes that every medical provider who treated Petitioner found bilateral shoulder symptoms which interfered with the performance of her job. With the sole exception of PIC, Respondent's occupational health clinic, they found Petitioner unable to return to full-duty employment. The approval of full duty employment was issued in spite of the clinician's findings of injury and the repeated recommendation that Petitioner avoid use of her upper extremities above shoulder level. The full-duty release did not seem to be based on a medical opinion, but, rather, on the judgment of Respondent's "workers' comp HR representative," Ivan Hernandez, that Petitioner could do her job without raising her arms above shoulder level if she used "proper body mechanics." Petitioner's credible testimony as to her job duties, the fact that she is only five feet tall, and the failure of her efforts to follow Mr. Hernandez's advice all demonstrate that the purported full-duty release issued by PA Harsant of PIC was unrealistic and incompatible with her physical restrictions.

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

Dennis Frye,

Petitioner,

20IWCC0562

vs.

NO. 17WC 22432

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 30, 2020 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: SEP 2 5 2020

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

SM/sj
o-9/15/2020

44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRYE, DENNIS
Employee/Petitioner

Case# **17WC022432**

CITY OF CHICAGO
Employer/Respondent

20IWCC0562

On 1/30/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0113 CITY OF CHICAGO CORP COUNSEL
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dennis Frye
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17** WC **22432**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **January 15, 2020**. 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **January 13, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**92,212.64**; the average weekly wage was $**1,773.32**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**145,081.42** for TTD and $**34,285.83** for maintenance for a total credit of $**179,367.25**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,182.21/week for 122 5/7 weeks, commencing January 16, 2017 through May 24, 2019, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,182.21 per week for 29 2/7 weeks, commencing May 25, 2019 through December 15, 2019, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,337.32 to ATI Physical Therapy, $3,869.55 to Porter Regional Hospital, and $730.97 to North Indiana Emergency Physicians as provided in Sections 8(a) and 8.2 of the Act. With respect to the claimed bill from Midwest Orthopaedics at Rush (PX 10), the Arbitrator awards all charges other than any relating to treatment of a right hand/middle finger injury Petitioner sustained in December 2016. [See the attached decision for further details.] Respondent shall be entitled to credit for any amounts paid.

For accidents on or after 9/1/11: Respondent shall pay Petitioner permanent partial disability benefits, commencing December 16, 2019, of $876.80/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C. Mason

1/30/20

JAN 30 2020

Dennis Frye v. City of Chicago
17 WC 22432

Summary of Disputed Issues

The parties agree that Petitioner, a longtime union bricklayer, sustained a work-related accident on January 13, 2017. There is also no dispute that Petitioner injured his head, left thumb, right knee and low back as a result of the accident. Petitioner underwent a left thumb arthroplasty, conservative low back treatment and ultimately, a right total knee replacement. Petitioner testified he developed swelling in his right calf after the replacement and sought treatment at an Emergency Room, where providers ruled out a blood clot.

A valid functional capacity evaluation performed in May 2019 showed that Petitioner was capable of medium duty. Respondent does not dispute the results of the evaluation and agrees Petitioner is not able to resume working as a bricklayer. Petitioner began a self-directed job search in June 2019. He offered records concerning this search. PX 7. In September 2019, he began receiving assistance from Vocamotive, a vendor of Respondent's selection. Following an initial evaluation, a Vocamotive counselor concluded Petitioner would most likely be able to earn between $13 and $17 per hour. In December 2019, Petitioner received a written job offer from Rogers Roofing. The offer was for full-time work paying $14 per hour. Petitioner testified that Vocamotive agreed the job was appropriate. Respondent offered no evidence to the contrary.

Under cross-examination, Petitioner acknowledged he did not accept the job offer and did not know whether the job would have afforded bonuses or overtime. He retired from Respondent in December 2019 and began collecting his pension benefits.

The disputed issues include medical expenses and nature and extent, with Petitioner seeking an award of wage differential benefits under Section 8(d)1 of the Act. Respondent argues that Petitioner was not truly interested in re-employment, sabotaged vocational rehabilitation efforts and failed to establish entitlement to a wage differential award.

Arbitrator's Findings of Fact

Petitioner testified he began working as a bricklayer for Respondent in September 1986. On January 13, 2017, he was getting out of his work truck when he slipped on ice and fell. He was transported via ambulance to the Emergency Room at Advocate Christ Medical Center. The Chicago Fire Department run sheet reflects that Petitioner reported slipping on ice while exiting his pick-up truck at work, falling backwards, striking his head and briefly losing consciousness. The paramedics noted complaints of left thumb and lower back pain. They also noted that Petitioner reported feeling dazed. PX 1, p. 14 of 110.

The examining Emergency Room physician recorded a consistent history of the work fall. He noted tenderness at the lower lumbar spine and left first metacarpal on examination. He

ordered CT scans of the head and lumbar spine along with left hand X-rays. The head CT scan showed no acute intracranial process. The lumbar spine CT scan showed mild degenerative disease in the lower thoracic spine and stenosis at various levels. PX 1, pp. 87-88 of 110. The left hand X-rays showed degenerative change at the first carpometacarpal joint. PX 1, p. 89 of 110. Petitioner was diagnosed with a concussion and was instructed to seek follow-up care. PX 1, p. 66 of 110.

Petitioner saw Dr Anderson at MercyWorks on January 17, 2017. The doctor recorded a history of the work fall and Emergency Room care. He noted complaints of headaches, dizziness and pain in the neck, lower back, left hand and right knee. He diagnosed a head contusion, concussion syndrome, cervical sprain, left wrist sprain, right knee sprain and lumbar spine sprain. He prescribed Norco and took Petitioner off work. PX 2, pp. 6-7.

Petitioner returned to MercyWorks on January 23, 2017 and again saw Dr. Anderson. The doctor noted that Petitioner stated his headaches "stopped" on January 21st but he felt confused at times. He also noted complaints of 6/10 left wrist pain, 5/10 right knee pain and 4/10 lower back pain. He provided Petitioner with a knee stabilizer and prescribed a right knee MRI. He directed Petitioner to remain off work and continue his medication. PX 2, p. 4.

On January 30, 2017, Dr. Anderson noted that Petitioner's head was "much better" but that he was still experiencing right knee pain, pain at the base of his left thumb and some lower back pain. He also noted that Petitioner had scheduled an appointment to see Dr. Cohen (who was already treating his right hand secondary to an earlier injury) for his left thumb and intended to see Dr. Cole for his knee and Dr. Goldberg for his lower back. He refilled the Norco and Ibuprofen and directed Petitioner to continue to use the knee support. He discharged Petitioner from care. PX 2, pp. 1-2.

Petitioner saw Dr. Cohen, a hand surgeon, on February 3, 2017. The doctor noted a history of the January 13, 2017 work fall and subsequent care. He described Petitioner as "suffering from a left thumb metacarpal-base hairline fracture at the CMC joint." He sent Petitioner to therapy for fabrication of a short-arm thumb spica splint. He directed Petitioner to remain off work. PX 3, pp. 1-3.

Petitioner saw Dr. Goldberg, an orthopedic surgeon, on March 13, 2017. In his note of that date, the doctor described Petitioner as "known to [him] for having undergone a discectomy years ago at L4-L5 and a subsequent interbody fusion at L4-L5." He indicated that Petitioner described himself as "doing extremely well regarding his lumbar spine" until he slipped on ice at work and fell to the ground, injuring his left hand, right knee and low back. He noted complaints of low back pain aggravated by bending. He indicated that Petitioner denied radicular complaints. On examination, he noted pain with forward flexion and tenderness in the lumbar paraspinal muscles left in the midline at L5-S1. He ordered lumbar spine X-rays which showed a "well-healed interbody fusion at L4-L5." He prescribed a lumbar spine MRI and kept Petitioner off work. PX 3, p. 6-8.

The lumbar spine MRI, performed with and without contrast on March 20, 2017, showed evidence of the prior laminectomy and fusion and "mild disc bulge with superimposed mild central and left paracentral disc protrusion at L5-S1 causing moderate left foraminal stenosis." PX 3, p. 9.

Dr. Goldberg subsequently reviewed the lumbar spine MRI results with Petitioner. Based on the MRI, he concluded that Petitioner "likely suffered a lumbar strain due to his work-related injury." He prescribed therapy and directed Petitioner to remain off work. He noted that Petitioner was seeing his partners, Drs. Cohen and Cole, for other injuries. PX 3, p. 11.

On April 3, 2017, Dr. Cohen noted that Petitioner had been attending therapy and using his splint. On examination, he noted "full digital motion, with the exception of the left thumb CMC joint", which he described as "slightly stiff." He also noted significant tenderness to palpation around this joint, positive grind and shear tests and significant pain with pinch strength testing. He injected the left first carpometacarpal joint with Marcaine and Depo-Medrol. He directed Petitioner to obtain a new Neoprene thumb support and resume therapy. He obtained left thumb X-rays which showed interval healing of the CMC fracture and some arthritis of the first CMC joint. PX 3, pp. 13-14.

Dr. Cole saw Petitioner in April 2017. He noted that Petitioner previously underwent two right knee meniscectomies and was "functioning quite well" until the work fall of January 13, 2017. He noted complaints of right knee pain and swelling. On examination, he noted a trace effusion, lateral joint line tenderness with range of motion from 0 to 100 degrees, no medial pain and ligamentous stability. He interpreted the MRI as showing severe lateral compartment osteoarthritis with degenerative meniscal tearing. He administered an injection and prescribed therapy. He directed Petitioner to limit his kneeling, bending, squatting and climbing. PX 3, pp. 20-21.

When Dr. Cole next saw Petitioner, he noted that the cortisone injection provided only two weeks of relief and that therapy was not helping. He described his examination findings as unchanged. He recommended three HA and PRP injections. PX 3, pp. 23-24. Petitioner underwent these injections in June and July 2017. PX 3.

On May 15, 2017, Dr. Goldberg noted that Petitioner had completed six weeks of therapy for his back and that additional therapy was denied. He also noted that Petitioner reported having more problems with his knee and wrist than his back. He found that Petitioner was not a candidate for back surgery and that he was at maximum medical improvement with respect to his back. He recommended that Petitioner continue seeing Drs. Cohen and Cole. He released Petitioner to work subject to his previous permanent restrictions. PX 3, pp. 26-27.

Petitioner also saw Dr. Cohen on May 15, 2017. The doctor noted that the previous CMC joint injection provided only ten days of pain relief and that therapy had been denied. On re-examination, he noted significant tenderness to palpation over the left first CMC joint and positive grind testing. Grip strength measured 60 pounds bilaterally. Repeat X-rays showed

20IWCC0562

healing of the hairline fracture and evidence of basilar thumb arthritis. Dr. Cohen found Petitioner to be a candidate for a left basilar thumb arthroplasty. He recommended that Petitioner continue wearing his splint at night and a soft support during the day. He released Petitioner to work with no use of the left arm. PX 3, pp. 28-30.

On July 14, 2017, Dr. Cohen noted that Petitioner's left thumb was still bothering him. He again recommended a left basilar thumb arthroplasty. He tentatively scheduled this surgery. He released Petitioner to work with no use of the left arm. PX 3, pp. 40-41.

Dr. Cohen operated on Petitioner's left thumb on July 31, 2017, performing a left thumb carpometacarpal joint arthroplasty and a tendon transfer of the flexor carpi radialis to the abductor pollicis longus. PX 3, pp. 42-43.

On August 9, 2017, Dr. Cohen noted that Petitioner was nine days out from surgery and experiencing mild swelling about his left thumb and wrist. He removed the sutures and placed Petitioner into a short arm thumb spica cast. He directed Petitioner to work on finger motion and thumb range of motion. PX 3, pp. 44-45.

On August 16, 2017, Dr. Cole noted that Petitioner denied obtaining relief from the injections. He also noted that Petitioner previously underwent two right knee surgeries "with relief of his symptoms at that time." On right knee examination, he noted a trace effusion, a range of motion from 0 to 115 degrees and lateral joint line tenderness. He described Petitioner as having failed various conservative measures. He indicated Petitioner might require a partial right knee replacement and provided him with the names of three specialists. He released Petitioner to sedentary duty with minimal walking. PX 3, p. 49.

On August 30, 2017, Dr. Cohen noted slight swelling of Petitioner's left hand and subjective numbness to the dorsal thumb from the incision to the IP joint. He obtained left thumb X-rays which showed evidence of the arthroplasty and "adequate suspension of the thumb." He directed Petitioner to have his splint adjusted and work on range of motion. He released Petitioner to work with no use of the left arm. PX 3, pp. 50-52.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Breslow on December 13, 2017. In his report of that date, Dr. Breslow indicated he reviewed the right knee MRI reports and images of June 8, 2010 and January 24, 2017 along with Dr. Cole's August 11, 2010 operative report and other treatment records.

Dr. Breslow described Petitioner as having an "extensive history" of right knee problems dating back over 25 years. He indicated that Petitioner reported first undergoing right knee surgery over 25 years earlier and making a full recovery thereafter. He also noted that Dr. Cole performed a meniscectomy on August 11, 2010 and released Petitioner to full duty on January 10, 2011. He indicated that Petitioner subsequently suffered a right knee flare-up while undergoing work conditioning and a functional capacity evaluation and had been placed at

maximum medical improvement subject to permanent restrictions. He noted that Petitioner denied having right knee symptoms prior to the January 13, 2017 work fall.

Dr. Breslow noted that Petitioner complained of constant, sharp right knee pain that worsened with activity. He also noted that Petitioner could walk with his knee extended but experienced a great deal of pain when flexing his knee. He also noted that Petitioner remained off work and had recently undergone left hand surgery.

On examination, Dr. Breslow noted a 5 degree lack of extension, pain with flexion past 100 degrees, valgus alignment of the knee, no medial joint line tenderness, lateral joint line tenderness, patellofemoral crepitus and no instability.

Dr. Breslow compared the 2010 and 2017 right knee MRI images. He obtained right knee X-rays. He interpreted the images as showing complete loss of the lateral joint space and degenerative changes of the patellofemoral joint.

Dr. Breslow opined that Petitioner's "osteoarthritis is not related to the incident but the aggravation is." He characterized the treatment to date as reasonable and necessary. He opined that Petitioner "requires a knee replacement secondary to the aggravation of the asymptomatic osteoarthritis from the work incident on January 13, 2017." He found Petitioner capable of sedentary duty. He recommended that Petitioner avoid climbing, kneeling and squatting. He described the need for these restrictions as temporary, indicating that Petitioner "will be able to return to full duty without restrictions after recovering from his knee replacement surgery." He noted he had not been provided with a job description. Given the demands of Petitioner's bricklayer trade, he recommended that Petitioner not resume full duty at that time. He anticipated that Petitioner would reach maximum medical improvement six months after the knee replacement. PX 5.

Petitioner returned to Dr. Cohen on January 31, 2018 and reported improved left hand grip strength. On re-examination, the doctor noted that Petitioner was better able to oppose his left thumb and could make a complete fist. He measured grip strength at 120 pounds on the right versus 50 pounds on the left. He recommended that Petitioner continue using a home paraffin unit and performing home exercises. He released Petitioner to work with no use of the left arm. PX 4, pp. 79-80.

On February 14, 2018, Dr. Levine noted that he was seeing Petitioner for evaluation of a possible knee replacement. He also noted that Petitioner was still undergoing left hand treatment. After obtaining X-rays and examining Petitioner's right knee, he recommended that Petitioner wait as long as possible before undergoing a replacement. He referred Petitioner to Dr. Weber for consideration of injections. PX 4, pp. 73-74.

On March 14, 2018, Dr. Cohen noted some left thumb improvement and some ulnar-sided wrist pain. He measured grip strength at 115 pounds on the right and 45 pounds on the

left. He found Petitioner to be at maximum medical improvement with respect to the thumb. He recommended that Petitioner follow Dr. Levine's work restrictions. PX 4, pp. 69-70.

Petitioner first saw Dr. Weber on April 4, 2018. The doctor acknowledged Dr. Levine's referral, noting the doctor's opinion that Petitioner maximize non-surgical care in an attempt to hold off on a replacement. She described Petitioner's gait as "fairly normal." She noted that right knee flexion was limited to approximately 90 degrees. She recommended against any additional injections, noting that Petitioner "had no benefit from injections in the past." She recommended physical therapy to work on quadriceps weakness and the IT band. She found Petitioner capable of light duty with no lifting/pushing/pulling over 20 pounds and no climbing, kneeling or squatting. PX 4, pp. 62-63.

On May 18, 2018, Dr. Weber noted that Petitioner's strength had improved secondary to therapy but that his pain had not lessened. She recommended an unloader brace and home exercises. She continued the previous restrictions. PX 4, pp. 56-57.

On July 13, 2018, Petitioner returned to Dr. Weber and noted no improvement of his symptoms after four weeks of brace usage. She referred Petitioner back to Dr. Levine and continued the previous work restrictions. PX 4, pp. 47-48.

Dr. Ting of Midwest Orthopaedics evaluated Petitioner's right knee on September 13, 2018. He recorded a history of the work accident and noted that Petitioner's right knee symptoms had recently improved somewhat. He discussed various options with Petitioner, noting that Petitioner elected to try weight loss before proceeding with surgery. PX 4, pp. 117-120.

On November 29, 2018, Dr. Sporer evaluated Petitioner's right knee and recommended a total replacement. PX 4, pp. 30-31.

Dr. Sporer performed a right total knee arthroplasty on January 3, 2019. PX 4, pp. 109-110.

Petitioner testified he experienced swelling of his right calf on January 9, 2019 and went to the Emergency Room at Porter Regional Hospital, where a blood clot was ruled out.

On February 20, 2019, Dr. Sporer recommended two weeks of physical therapy. PX 4, p. 14.

On March 18, 2019, Dr. Sporer noted greater than 100 degrees of right knee flexion. He did not recommend a manipulation. He suggested that Petitioner continue aggressive therapy and home exercises, followed by work conditioning and a functional capacity evaluation. PX 4, p. 9.

Petitioner underwent a functional capacity evaluation at ATI on May 6, 2019. The evaluator rated the results as valid. He noted that Petitioner reported right knee and lower back pain during the evaluation. He also noted he did not assess crawling or kneeling due to restrictions imposed by Petitioner's surgeon. He found Petitioner to be functioning at a medium physical demand level. He noted that Petitioner's former bricklayer job fell into the medium to heavy physical demand level category. PX 4, pp. 127-135.

Petitioner last saw Dr. Sporer on May 19, 2019. The doctor noted the results of the functional capacity evaluation. On re-examination, he noted full right knee extension, flexion to 120 degrees and stability to stress testing. He released Petitioner to work per the restrictions of the functional capacity evaluation. He indicated that Petitioner would be at maximum medical improvement one year after the replacement. PX 4, pp. 4-5.

Petitioner began a self-directed job search on June 15, 2019. The documents in PX 7 consist of job search records Petitioner completed between that date and December 5, 2019.

Kari Stafseth, CRC, a certified vocational counselor affiliated with Vocamotive, met with Petitioner on September 9, 2019 and performed a vocational evaluation. Stafseth noted that Respondent retained Vocamotive to perform this evaluation. She described Petitioner as "fully cooperative with all aspects of the interview process." Stafseth recorded a history of the work accident and subsequent care. She noted that Drs. Cohen and Sporer had imposed restrictions postoperatively and that Petitioner was scheduled to return to Dr. Sporer in January or February 2020.

Stafseth indicated she reviewed the functional capacity evaluation and Dr. Sporer's post-evaluation notes. She also reviewed a Respondent bricklayer job description.

Stafseth noted that Petitioner reported graduating from high school in 1983 and attending college for one year. She also noted that Petitioner reported becoming a journeyman bricklayer after working as a laborer for thirteen years. She indicated that Petitioner acknowledged owning a computer but having only "hunt and peck" keyboarding skills. She also indicated that, during the preceding ten to twelve weeks, Petitioner had been using the Internet to look for work, with his wife's assistance. She noted that Petitioner reported participating in phone interviews with employment agencies and a company called "Two Men and a Truck." She indicated that, according to Petitioner, the job at this company exceeded his restrictions.

Stafseth noted that, according to the Social Security Administration, Petitioner, at age 54, was considered a person "closely approaching advanced age." She also noted that "the extent of [Petitioner's] employment history has been within the construction industry," that his former job fell into the heavy physical demand category and that the functional capacity evaluation placed him at a medium physical demand level.

Stafseth opined that Petitioner "has lost access to his usual and customary job and line of occupation of a bricklayer." She found Petitioner to be "prospectively employable" and having a "most probably wage earning potential of $13 to $17 per hour." She also found Petitioner to be a candidate for vocational rehabilitation. She recommended that he undergo vocational testing and training in Microsoft Word and Excel. PX 6, pp. 1-11.

Petitioner underwent vocational testing on October 23, 2019, about two weeks after he began keyboarding training with Vocamotive. Theresa Kopitzke, M.A., CRC, the individual who conducted the testing, described Petitioner as demonstrating "excellent effort" and showing "good initiative," although she also noted he struggled to perform some tasks that were visual in nature, due to dizziness. PX 6, pp. 38-47.

In a progress report dated December 1, 2019, Kari Stafseth, CRC, noted that Petitioner attended job search workshops, attended computer lab classes and gradually increased his keyboarding speed. PX 6, pp. 48-52.

Petitioner identified PX 8 as a letter he received from John M. Rogers, the president of Rogers Roofing, offering him a job starting December 16, 2019. In the letter, Rogers indicated Petitioner would be working as a permit and license expeditor, earning $14 per hour to start and working 40 hours per week. He also indicated that his company was "very small" and did not offer any type of medical benefits.

Petitioner testified he cleared the offered job with Vocamotive.

Petitioner testified his former bricklayer job is a union position. He identified PX 9 as the bargaining agreement covering the period June 1, 2019 through May 31, 2020. This agreement provides for an hourly wage of $46.88. Bricklayers work 40 hours per week.

Under cross-examination, Petitioner testified he does not know whether he would have been eligible for bonuses or overtime in the job that Rogers Roofing offered him. As of the hearing, he had not accepted this job. He retired from Respondent on December 16, 2019 and began collecting his pension benefits. He is not looking for other work. He is ambidextrous. He writes with his right hand. He injured his right knee in the past, about six years ago. [Petitioner stipulated he has received settlements or awards totaling 30.5% of the right leg.] He did not recall injuring his left thumb in the past. He believes he injured his right thumb. He underwent a lumbar fusion about six years ago. He has not injured his left thumb, right knee or lower back since the work fall of January 13, 2017.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise.

None of the physicians who treated or examined Petitioner noted symptom magnification.

The functional capacity evaluation was valid.

Kari Stafseth, CRC, a vocational rehabilitation counselor affiliated with Vocamotive, described Petitioner as "fully cooperative" with the initial evaluation. PX 6, pp. 1, 17. She observed no inappropriate pain behaviors. PX 6, pp. 8, 24. She opined that Petitioner would have a "most probable wage earning potential" of $13 to $17 per hour. The job offer Petitioner later obtained involved an hourly rate of $14.

In a subsequent progress report, Stafseth noted that Petitioner missed some days due to a sinus infection (for which he had a doctor's note) but also noted that Petitioner attended several job search workshops and had increased his keyboarding speed. PX 6, pp. 48-52.

Theresa Kopitzke, M.A., CRC described Petitioner as demonstrating "excellent effort" during vocational testing conducted on October 23, 2019. PX 6, p. 41. She also noted that Petitioner expressed interest in studying HVAC. PX 6, p. 40.

Arbitrator's Conclusions of Law

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid fee schedule charges from the following providers: 1) Porter Regional Hospital, $3,869.55; 2) Northern Indiana ER Physicians, $730.97; 3) ATI, $6,337.32; and 4) Midwest Orthopaedics, $13,946.74. PX 10.

At the hearing, Respondent agreed to pay the Porter Hospital bill. This bill relates to Petitioner's post-knee replacement Emergency Room visit of January 9, 2019. PX 10.

The Arbitrator awards the Northern Indiana Emergency Physicians bill, subject to the fee schedule. This bill relates to physician services provided at the same Emergency Room visit. The bill shows a date of service of January 9, 2019 and a CPT code of 99284 which corresponds to "professional services" under the fee schedule. Because the services in question were rendered out of state, Respondent is obligated to provide payment at 53.2%, which equates to $730.97.

Respondent disputes some ATI charges relating to occupational therapy Petitioner underwent for his left thumb in 2017, citing RX 3, a utilization review report. The Arbitrator notes, however, that RX 3 does not correlate with any of the claimed ATI bills that appear in PX 10. None of those bills relate to occupational therapy for the left thumb performed in April 2017. The first bill in PX 10 correlates time-wise, in that it covers a period beginning April 11, 2017, but that bill relates to physical therapy for the back ordered by Dr. Goldberg. A subsequent bill relates to occupational therapy performed between August 31, 2017 (the date

Dr. Cohen operated on Petitioner's left thumb) and October 12, 2017 but that therapy was post-operative. Other bills relate to pre- and post-replacement knee therapy. Another bill relates to work conditioning and the functional capacity evaluation of May 6, 2019 The Arbitrator awards the claimed ATI charges, subject to the fee schedule.

The Arbitrator also awards the claimed Midwest Orthopaedics at Rush bill, subject to the fee schedule, but excluding any charges that might relate to treatment of the right hand or middle finger. Records in PX 3 reflect that Petitioner injured his right hand/middle finger at work on December 9, 2016 and subsequently saw Drs. Fernandez and Cohen for this injury, as well as his left thumb injury of January 13, 2017. It appears to the Arbitrator that some of the charges listed in the bill in PX 10 relate to the right hand/middle finger. For example, on July 14, 2017, Petitioner saw both Dr. Fernandez and Dr. Cohen, with each physician billing separately.

What is the nature and extent of the injury?

Petitioner seeks an award of wage differential benefits. To qualify for such an award, a claimant must prove (1) a partial incapacity that prevents him from pursuing his usual and customary line of employment and (2) an impairment of earnings. 820 ILCS 305/8(d)(1). First Assist, Inc. v. Industrial Commission, 371 Ill.App.3d 488, 494 (2007). The valid functional capacity evaluation established that Petitioner is unable to resume his usual and customary bricklayer occupation. Respondent offered no evidence disputing the diminution in Petitioner's earning capacity. Petitioner testified he received an offer of a job at a roofing company, paying $14.00 per hour, and that Respondent's rehabilitation vendor, Vocamotive, found the job and wage to be appropriate. [The $14/hour wage was within the $13 to $17/hour range that Kari Stafseth, CRC, projected in September 2019.] Respondent also did not dispute Petitioner's testimony as to the wages he would currently be earning if he were still employed as a bricklayer. The fact that Petitioner did not pursue the job, and instead opted to retire, does not preclude an award of wage differential benefits. Copperweld Tubing Products Co. v. IWCC, 402 Ill.App.3d 630, 634 (2010). Wood Dale Electric v. IWCC, 2013 IL App (1st) 113394WC. Instead, a wage differential award is determined by comparing the claimant's prior earning capacity to the amount he "is earning or is able to earn in some suitable employment or business after the accident." Respondent has not challenged the suitability of the roofing company job.

Respondent contends that Petitioner was not sincere in his efforts at re-employment and effectively sabotaged vocational rehabilitation efforts. The evidence does not support this contention. Petitioner looked for work on his own for about three months before Respondent secured Vocamotive's involvement. The Vocamotive representatives who performed the evaluation and testing did not question Petitioner's motivation. Petitioner missed a few days, in early November 2019, but this was due to a sinus infection for which he produced a doctor's note. Petitioner attended job search workshops and increased his keyboarding rate in the later part of November 2019. PX 6, pp. 48-52. At no point did any Vocamotive representative suggest that Petitioner was sabotaging the process. Petitioner testified that Vocamotive

approved the job offer he received in December and Respondent offered no evidence contradicting this testimony.

The Arbitrator has reviewed the two Commission decisions cited by Respondent: Aaron Conway v. City of Chicago, 15 IWCC 810, and Marzullo v. City of Chicago, 18 IWCC 379. In both of these cases, the Commission awarded permanency benefits under Section 8(d)2 rather than Section 8(d-1). The facts of the cases are distinguishable from the facts of the instant claim. The claimant in Conway offered no job search records, misrepresented his abilities on a questionnaire relating to a watchman position with Respondent and admitted he resisted the efforts of MedVoc to find him alternative employment. No similar evidence exists in the instant case. The claimant in Marzullo failed to follow up with prospective employers, resisted attending hiring events and "failed or refused to complete and file any of the forms required for him to receive an accommodation for employment" with Respondent. The counselors affiliated with Vocamotive, a vendor of Respondent's choice, noted no similar behavior on Petitioner's part. Respondent introduced no evidence indicating it submitted an accommodation-related questionnaire to Petitioner.

The Arbitrator finds that Petitioner participated in the vocational rehabilitation process and secured an offer of an appropriate job. The Arbitrator concludes that Petitioner is entitled to wage differential benefits pursuant to Section 8(d-1) of the Act until he reaches age 67 or 5 years from the date the award becomes final, whichever is later. The Arbitrator calculates the rate at which such benefits should be paid by comparing the current weekly pay rate of his former union bricklayer job ($1,875.20) with the weekly pay rate of the job that was offered to him ($560.00) and taking 66 2/3% of the difference, arriving at $876.80.

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

ALAN HAMILTON,

Petitioner,

vs. NO: 11 WC 27186

SAFETY-KLEEN SYSTEMS, INC.,

Respondent.

ORDER

This matter comes before Commissioner Maria E. Portela pursuant to the parties' stipulation to amend the Settlement Contract Lump Sum Petition and Order ("Settlement Contract"), previously approved by Arbitrator Kurt Carlson on September 13, 2016.

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

That by the terms of the Settlement Contract, Respondent had agreed that Petitioner's rights under Section 8(a) of the Act would remain open.

That since the approval of the referenced contract, Respondent has obtained and submitted a Workers' Compensation Medicare Set Aside (WCMSA) to the Centers for Medicare and Medicaid Services (CMS) for consideration.

That the parties have advised the Commissioner of the decision of CMS, dated December 20, 2018, approving a WCMSA in the amount of $11,217.00. CMS has determined that $11,217.00 adequately considers Medicare's interests with respect to Medicare-covered future medical items and services, including prescription drugs.

That in conjunction with the terms of the Settlement Contract, approved on September 13, 2016, Respondent will fund the WCMSA approved by CMS by lump sum. Petitioner agrees to self-administer the WCMSA, understanding that said monies are to be placed in an interest-bearing account and agrees to only use the funds towards Medicare Allowable Expenses and in accordance with Medicare guidelines.

That by the parties' stipulation, Petitioner's medical benefits under Section 8(a) of the Act shall terminate as of the WCMSA funding date.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Kurt Carlson on September 13, 2016, is hereby modified by the terms of the stipulation of the parties and Rider #4, a copy of which is attached hereto and made a part hereof, so as to conform to the requirements of CMS pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission;

2. That it is the further Order of the Commission that pursuant to the referenced Settlement Contract and the parties' subsequent stipulation, Petitioner's continuing rights under Section 8(a) of the Act are hereby closed as of the WCMSA funding date; and,

3. That the heretofore approved Settlement Contract, as was approved by Arbitrator Kurt Carlson on September 13, 2016, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

DATED: SEP 25 2020
MEP/dmm
7/16/19

Maria E. Portela 11/8/19
Commissioner Maria E. Portela

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FERNANDO ALCALA,

Petitioner,

vs. NO: 14 WC 16864

KEHE DISTRIBUTORS, LLC,

Respondent.

ORDER

This matter comes before Commissioner Portela pursuant to the parties' "Agreed Motion to Recall and Amend Approved Contracts."

Pursuant to Section 9070.40(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the parties may reserve the right to amend an approved Settlement Contract by stipulation and Order of a Commissioner to conform with regulatory requirements including, but not limited to, those of Social Security and Medicare. In no event may those amendments abridge the substantive rights of the parties as listed in the previously approved Settlement Contract.

That by the terms of the Settlement Contract Lump Sum Petition and Order ("Settlement Contract"), approved by Arbitrator Barbara Flores, on March 26, 2018, the original approved contracts contained the following language:

> Claimant affirms that he/she is not Medicare eligible, has not filed for SSDI, has never been approved or denied for SSDI, is less than 62 ½ years old, and does not have any expectation of becoming a Medicare Beneficiary, for any reason, within thirty (30) months of the date of this settlement. (See Exhibit A)

That since the approval of the referenced contract, both parties agreed that a Medicare Set Aside Allocation should have been included with the settlement.

That the parties have advised the Commissioner that an MSA Allocation report was prepared by Nuquist/Bridge Pointe on March 12, 2019 which estimates that $32,568.00 should be set-aside in order to protect Medicare's interests (Refer to attached "Rider") and that the proposed MSA Allocation has been submitted to CMS.

That by the parties' stipulation, at this time all of the Petitioner's rights under 8(a) are preserved in reference to the accepted conditions causally related to the Petitioner's work with the Respondent.

Therefore, the Commission having jurisdiction over said claim, it is hereby ordered:

1. That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Barbara Flores on March 26, 2018, is hereby modified by the terms of the stipulation of the parties, a copy of which is attached hereto and made a part hereof, so as to conform to the requirements of CMS;
2. That the heretofore approved Settlement Contract, as was approved by Arbitrator Barbara Flores on March 26, 2018, remains in full force and effect, and shall be read in concert with this Order and Stipulation.

DATED: SEP 25 2020

Maria E. Portela

APPROVED BY AUTHORITY OF THE
ILLINOIS WORKERS' COMPENSATION COMMISSION
pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Diseases Acts

DEC 17 2019

Maria Elena Portela
By: Maria Elena Portela, Commissioner

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

Pawel Kulach,
Petitioner,

20 I W CC0563

vs. NO: 11 WC 19848

Chris Carpentry Co and Krzysztof Kowalkowski and
State Treasurer as Ex-Officio Custodian of the
Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability and benefits under Sections 8(e) and 8(d)2 and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2019, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION 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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 5 2020
o9/17/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 I W CC 0563

KULACH, PAWEL
Employee/Petitioner

Case# **11WC019848**

CHRIS CARPENTRY CO AND KRZYSZTOF KOWALKOWSKI AND STATE TREASURER AS EX-OFFICIAL CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND (IWBF)
Employer/Respondent

On 4/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1505 SLAVIN & SLAVIN LLC
DAVID VaNOVERLOOP
100 N LASALLE ST SUITE 2500
CHICAGO, IL 60602

0000 FUKSA KHORSHID LLC
LUCAS FUKSA
70 W ERIE ST 2ND FL
CHICAGO, IL 60654

6097 ASSISTANT ATTORNEY GENERAL
ANA VAZQUEZ
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

20 I W CC0563

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

- [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

PAWEL KULACH
Employee/Petitioner

Case # **11** WC **19848**

v.

Consolidated cases: **n/a**

CHRIS CARPENTRY CO. and
KRZYSZTOF KOWALKOWSKI, and
STATE TREASURER as Ex-Official Custodian
of the Injured Workers' Benefit Fund (IWBF),
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JANUARY 23, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [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. [x] Is Respondent due any credit?
O. [x] Other: **IWBF LIABILITY**

FINDINGS

On **April 18, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**23,725.10 over 46 weeks**; the average weekly wage was $**515.76**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*:

1) Respondent shall pay Petitioner temporary total disability benefits of $343.84/week for 81-1/7 weeks, commencing 4/19/11 through 11/6/12, as provided in Section 8(b) of the Act.

2) Respondent shall pay Petitioner maintenance benefits of $343.84/week for 16-2/7 weeks, commencing 11/7/12 through 2/28/13, as provided in Section 8(a) of the Act.

3) Respondent shall pay reasonable and necessary medical services of $572,419.08, as provided in Sections 8(a) and 8.2 of the Act.

4) Respondent shall pay Petitioner permanent partial disability benefits of $466.13/week for 114 weeks, because the injuries sustained caused 50% loss of the left thumb, 50% loss of the left index finger, 50% loss of the left middle finger, 50% loss of the left ring finger, and 100% loss of the left little finger, as provided in Section 8(e) of the Act.

5) Respondent shall pay Petitioner permanent partial disability benefits of $309.46/week for 300 weeks, because the injuries sustained caused 60% loss of the person-as-a-whole, as provided in Section 8(d)2 of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award hereby is entered against the Fund to the extent permitted and allowed under §4(d) of the Act. In the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner, Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injury Workers' Benefit Fund.

20IWCC0563

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

APRIL 16, 2019
Date

APR 17 2019

PAWEL KULACH v. CHRIS CARPENTRY CO., and KRZYSZTOF KOWALKOWSKI, and STATE TREASURER as Ex-Officio of the Injured Workers' Benefit Fund

11 WC 19848

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on January 23, 2019. All issues were in dispute per the parties' stipulation. (Arbitrator's Exhibit 1). The parties also requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (Arbitrator's Exhibit (*hereinafter*, AX) 1). They also agreed to receipt of this Arbitration Decision via e-mail. (AX 1).

FINDINGS OF FACT

Petitioner, Pawel Kulach ("Petitioner") testified he was hired by Respondent, Krzysztof Kowalkowski, to work as a carpenter for Mr. Kowalkowski's company, Respondent Chris Carpentry, Co. ("Chris Carpentry"). He worked for Chris Carpentry from July 1, 2010 through April 18, 2011. Petitioner testified that as of April 18, 2011, he was 25 years old and single, with no dependents. (TX)

Petitioner worked for Chris Carpentry as a carpenter, engaged in the building and remodeling of homes, particularly the framing. Petitioner testified his work day began at 7am and would typically end around 5pm. Petitioner further stated he would work Monday through Friday and sometimes on Saturdays, averaging about 50-55 hours a week. Petitioner stated he always reported to work except on the few occasions the weather did not permit. Petitioner stated such exceptions were when it rained or snowed, and they had to work outside, however, they still worked when it was very cold outside. Petitioner testified for the year of 2010 he worked every week from his start date, June 1, 2010, through the end of the year on December 31, 2010. Petitioner testified for the year of 2011 he worked every week from January 1, 2011, through his date of injury on April 18, 2011. (TX)

Petitioner would normally report to work with his own tool belt which consisted generally of a hammer, square, and screwdriver. His work as a carpenter typically involved

working with saws, and all of the saws, drills, or other power tools he used were provided to him by Chris Carpentry. (TX))

Throughout Petitioner's employment with Chris Carpentry, he was not concurrently employed with anyone else; he only worked for Chris Carpentry. Petitioner stated he never engaged in any contracts with building owners, he solely he performed each job based on direction from Mr. Kowalkowski. Petitioner was paid hourly and earned 12 dollars an hour. Petitioner was paid on a biweekly basis and received payment by check. The checks Petitioner received for the work he performed were always paid by Chris Carpentry Company. Petitioner testified the IRS 1099 forms for the years of 2010 and 2011 demonstrate the entirety of the wages Petitioner was paid for the work he performed by Chris Carpentry from his start date through his date of injury. The last check Petitioner received was dated on May 26, 2011, for the work he performed on April 18, 2011. (TX, PX 6, PX 7, PX 9)

Petitioner testified that during the time he worked for Chris Carpentry, Chris Carpentry had one other employee named Janusz who worked alongside Petitioner. Mr. Kowalkowski would also work with Petitioner and Janusz. (TX)

Petitioner testified that one of the jobs he worked on for Chris Carpentry was a remodeling job in Summit, Illinois. As with other jobs, Janusz and Mr. Kowalkowski worked with Petitioner on the carpentry work for the Summit job. Petitioner was aware that the house they were working on remodeling was owned by Mr. Kowalkowski. (TX)

On April 18, 2011, Petitioner reported to his assignment at the Summit job as instructed by Respondent. On this day, Petitioner was specifically engaged in the task of making frames for the windows. Petitioner was using a table saw, provided by Respondent, to cut pieces of trim for the window frames. As Petitioner passed a piece of trim through the saw from right to left, he attempted to receive the board with his left hand and sliced his hand and fingers on the blade. Petitioner described the accident as, "cut[ting] my hand in half." Petitioner testified he felt immediate pain. (TX)

Petitioner testified that Mr. Kowalkowki and Janusz both witnessed the accident, and Mr. Kowalkowski drove Petitioner to Advocate Christ Medical Center Emergency Room. (TX)

Petitioner was treated by Dr. James D. Schlenker who provided a diagnosis of complete amputation through the distal phalanx of the left little finger and incomplete amputation of the left thumb, the left index finger, the left middle finger, and the left ring finger. Petitioner immediately underwent various surgical procedures performed by Dr. Schlenker. The following procedures were performed to the left little finger: debridement of soft tissue and bone; V to Y advancement flap for coverage of distal phalanx; full-thickness skin graft 2x1 cm to secondary defect from the amputated part. The procedures performed on the left thumb include:

debridement of fracture of proximal phalanx; repair of volar plate interphalangeal joint; repair of radial collateral ligament of interphalangeal joint; repair of the flexor pollicis longus tendon; microscopic repair of ulnar digital artery; microscopic repair of ulnar digital nerve; microscopic repair of radial digital nerve; fluoroscopy with recording. The following procedures were performed on the left index finger: debridement of soft tissues; repair of volar plate of the metacarpophalangeal joint; repair of ulnar collateral ligament of the metacarpophalangeal joint; repair of volar interosseous tendon and muscle; repair of flexor digitorum superficialis in zone III; repair of flexor digitorum profundus in zone III; microscopic repair of ulnar digital artery; microscopic repair of ulnar digital nerve; microscopic repair of radial digital nerve; fluoroscopy with recording. The following procedures were performed in the left middle finger: debridement fracture proximal phalanx; open reduction internal fixation of fracture of proximal phalanx; repair of volar plate; repair of ulnar collateral ligament; repair of radial collateral ligament; repair of dorsal interosseous muscle and tendon on ulnar side; repair of dorsal interosseous muscle and tendon on the radial side; microscopic repair of the ulnar digital nerve; microscopic repair of the radial digital nerve; repair of flexor digitorum superficialis zone II and III; repair of flexor digitorum profundus in zone III; microscopic repair of radial digital artery; repair of extensor over metacarpophalangeal joint; fluoroscopy with recording. The following procedures were performed to the left ring finger: debridement fracture of the middle phalanx; open reduction internal fixation fracture of the middle phalanx; repair of flexor digitorum superficialis zone II; repair of flexor digitorum profundus in zone II; repair of the extensor digitorum communis proximal phalanx; microscopic repair of ulnar digital artery; microscopic repair of ulnar digital nerve; microscopic repair of radial digital nerve; microscopic repair of radial digital artery; fluoroscopy with recording. The following procedures were performed to the palmar aspect of first web space: release of contracture; covered with full-thickness skin graft 6 cm squared. The petitioner was then supplied with a dynamic flexion splint. (PX 1, PX 2)

On April 22, 2011, Petitioner followed-up with Dr. Schlenker at the Hand and Plastic Surgery Center for Reconstructive Surgery, and again on April 23, 2011. Dr. Schlenker diagnosed Petitioner with vascular compromise with venous congestion in the left ring finger and partial necrosis of the skin in the left palm. Petitioner then underwent more surgical procedures including: debridement of nonviable skin; microscopic repair of dorsal vein #1; microscopic repair of dorsal vein #2 and #3 with vein graft; coverage of exposed skin with transposition flap; split-thickness skin graft to defect, ulnar dorsal aspect; split-thickness skin graft to radial dorsal aspect, and removal of nail plate. (PX 1, PX 2)

Petitioner followed-up with Dr. Schlenker again on April 25, 2011. Petitioner reported continued directed use of medication an anti-biotics. The next day, April 26th, Dr. Schlenker removed 4x4's from Petitioner's hand and reported there was a moderate amount of serious drainage, with skin noted as clammy and sweaty to touch. (PX 1, PX 2)

On April 27, 2011, Petitioner reported to Palos Community Hospital to have lab tests done as a result of discoloration in the left hand. Petitioner was diagnosed with an infection. Petitioner followed-up with Dr. Schlenker again on April 29th where a new dressing was applied to the injured hand. Dr. Schlenker prescribed Petitioner with more medication. On May 2, 3, 5, 6, 9, 10, 11, 12, and 13 Petitioner continued to follow-up with Dr. Schlenker.Petitioner had new dressings applied and had his medication re-evaluated. (PX 2, PX 3)

The Petitioner underwent his third operation on May 14, 2011. Petitioner was diagnosed with necrosis of the skin palmar aspect of the index, middle, ring, little finger, and dorsal aspect of the ring finger. Petitioner then underwent the following surgical procedures to the to the left index finger: debridement of non-viable soft tissue; split-thickness skin graft from lateral aspect of left thigh 1.5 x 1.5 cm. The following procedures to the left middle finger were performed: debridement of non-viable soft tissue; coverage of exposed flexor tendon with double transposition flap, each flap 1 x 2 cm; split-thickness skin graft to primary and secondary defects, totaling 4 cm squared. The following procedures were performed to the left ring finger: coverage of exposed flexor tendons with cross finger flaps from dorsum of proximal phalanx of little finger 3 x 4 cm; coverage of exposed flexor tendons with transposition flap from distal palm 1 x 2 cm; split-thickness skin graft, a total of 9 cm squared, to the primary and secondary defects in distal palm and base of ring finger; full-thickness skin graft, a total of 5 cm squared, to dorsum of ring finger. The following procedures were performed to the left little finger: full-thickness skin graft to secondary defect from cross finger flap over dorsum of proximal phalanx 12 cm squared. (PX 1)

Petitioner continued to follow-up on May 16, 18, 20, 23, 25, and 27 for dressing changes and regular inspection of the injured hand. Dr. Schlenker documented Petitioner's wounds to be healing well and noted on May 27th that Petitioner was able to wiggle his fingers. (PX 2)

On May 28, 2011, Petitioner underwent his fourth operation with Dr. Schlenker. Petitioner was diagnosed with: a cross finger flap little finger to the left ring finger; scar contracture of first web space; and adhesions of flexor tendons. The surgical procedures performed to the left hand were: division inset of cross finger flap from left little finger to left ring finger; a release of contracture of first web space; full-thickness graft from first web space on ulnar border of the hand 2x2 cm; and a manipulation of the index finger. (PX 1)

Petitioner reported for a follow-up on June 1, 2011, where he made complaints of shooting pain noted in the left palm, the left ring finger, and left middle finger. Dr. Schlenker noted Petitioner had numbness in the left ring finger with discoloration. On June 7, 2011, Petitioner followed-up to have his splint and sutures removed as well as more dressing re-applied. (PX 1)

On June 18, 2011, Petitioner underwent yet another operation with Dr. Schlenker. The diagnosis was: retained hardware in the left ring finger and left middle finger; flexion contraction of ring finger, palm, and first web space. Petitioner underwent surgical procedures including: removal of hardware from the left ring and left middle finger; fluoroscopy with recording, repair of non-union proximal phalanx of left ring finger with bone graft; release of flexion contracture of ring finger with skin grafts and transposition flap; insertion of k-wires across distal interphalangeal and proximal interphalangeal joint; release of fracture flexion contracture in palm and application of multiple skin grafts; release of contracture in first web space and coverage with transposition flap on dorsum of index finger; full thickness skin graft to secondary defect dorsum of index finger; closure of 2 donor sites in right lower abdomen and left lower abdomen; and application of cast. (PX 1)

Petitioner followed-up with Dr. Schlenker on June 20, 21, 27, 28 and July 5, 19, and 27th to monitor healing progress, have staples removed, and have dressing re-applied. Petitioner reported symptoms of shooting pain in the left middle and index finger as well as numbness in the left ring finger. On July 15th Petitioner began therapy with Advocate Christ Medical Center for Rehabilitation Services and continued to attend therapy on July 21, 26, and 29th. (PX 1, PX 2)

Petitioner followed-up with Dr. Schlenker on August 2, 2011, and again on August 5, 2011, where he requested a return to work status to which the doctor stated he is unable to return to work. Petitioner followed-up again on August 8th and 30th reporting pain and difficulty bending fingers. Petitioner attended therapy on August 2, 5, 8, 12, 15, 19, 23, 24, and 30th. (PX 1, PX2)

On September 16, 2011 Petitioner reported to Advocate Christ Medical Center with reports of his left ring finger appearing swollen and red, with no pain. Petitioner was diagnosed with osteomyelitis of the left ring finger and was admitted for IV antibiotic therapy. Petitioner underwent an operation procedure of left ring finger debridement of osteomyelitis of distal phalanx. An x-ray was ordered which reported an impression of: 1. amputation of the fourth and fifth distal phalanx with erosion at the amputated fourth phalangeal base suspicious for osteomyelitis; 2. sclerosis in the fourth middle phalanx as well as the proximal phalangeal head with adjacent soft tissue swelling which could be due to osteomyelitis. Plate and pins seen through the fourth proximal phalanx; 3. probable old fracture is seen through the base of the third proximal phalanx; and 4. sclerosis visualized in the triquetrum which could be due to old trauma or osteomyelitis. (PX 1)

On September 17, 2011, Petitioner met with Dr. Aneta Bush for an infectious disease consultation at Advocate Christ Medical Center. Petitioner underwent a bone-scan and was noted to be at-risk for loss of ring finger. Petitioner was then provided with a recommended plan to follow-up, continue physical therapy, wound care, and six weeks of IV antibiotic

therapy. Petitioner followed-up with Dr. Schlenker on September 21, 2011 and reported that his left ring finger was slowly healing. Dr. Schlenker provided Petitioner with a work status stating Petitioner could return to work with restrictions of no use of left hand. Petitioner attended therapy on September 1, 6, 9, and 12th. (PX 1, PX2)

On September 28, 2011 Petitioner began treating with Dr. Joseph Kent at Metro Center for Health to monitor progress of osteomyelitis in the left ring finger. Petitioner treated with Dr. Kent on October 19th, 26th, and November 16th with progress reports of healing and decreased swelling to the left ring finger. Petitioner also continued to follow-up with Dr. Schlenker throughout this time. (PX 1, PX 2, PX 4)

On November 23, 2011, Petitioner underwent a seventh operation which consisted of procedures including: removal of hardware, tendolysis of extensor tendon over proximal phalanx, and repair of extensor tendon of proximal phalanx to the left ring finger; and neurolysis of digital nerves, tendolysis of FDS and palmar digit, and tendolysis of FDP and palmar digit to the left middle finger and left index finger. (PX 1)

Petitioner followed-up post-operation with Dr. Schlenker on December 1, 2011 and reported decreased discomfort. Petitioner returned again on December 9, 2011, and the doctor approved Petitioner to begin occupational therapy. On December 23, 2011, Petitioner followed-up again and was provided with a return to work status of no more than five pounds on the left hand. Petitioner attended occupational therapy on December 22, 2011, and January 4, 9, 12, 17, 19, 23, 27, and 31 of 2012. (PX 1, PX 2)

On February 2, 2012, Petitioner returned to Dr. Schlenker with complaints of intermittent pain to the tips of his left ring and middle finger with some tingling to his left palm. Occupational Therapy dates for February were: 2, 6, 9, 14, 16, 20, and 22. (PX 1, PX 2)

Petitioner then underwent an eighth operation with Dr. Schlenker on February 26, 2012. Petitioner had the tip of his middle finger surgically removed. The diagnosis was: arthrosis and severe flexion contracture of DIP joint of left ring finger. The procedure performed was: left ring finger arthrosis of DIP joint with bone graft and 3-millimeter synthes headless screw; and fluoroscopy with recording. (PX 1)

Petitioner continued to follow-up with Dr. Schlenker to monitor progress of symptoms and attended regularly scheduled occupational therapy visits. On July 2, 2012, Petitioner reported to Advocate Christ Medical Center Rehabilitation Services. Petitioner was provided with decreased sensation protection guidelines and was discharged from therapy. On November 6, 2012, Petitioner followed-up with Dr. Schlenker and was provided a final work status of light duty with a permanent 15-pound weight limitation. (PX 1, PX2)

As part of his treatment for the left-hand injury, Petitioner received prescription medication for his pain, infection, swelling, and other symptoms. Petitioner had to pay for his medication out of pocket. Petitioner testified he was never reimbursed for any of the expenses he incurred in treating his injury, and that all of the medical bills for the treatment the Petitioner received remain outstanding and unpaid. (TX)

Petitioner testified that after he was given work restrictions he was offered work by Chris Carpentry. Petitioner testified Chris Carpentry did not tell him what type of work he would be doing. Petitioner further testified he did not know if the work Chris Carpentry offered him was within the permanent work restrictions. As such, Petitioner did not return to work for Chris Carpentry. (TX)

Petitioner was never paid any benefits for the time he was off work. Petitioner did not receive pay from any other employment during his time off work. (TX)

Petitioner testified that after his release from care on November 6, 2012, he began looking for work within his permanent restrictions. He would look for available jobs through friends or advertisements and would contact about two potential employers a week. Petitioner ultimately found work within his restrictions and began that job as a mechanic on March 1, 2013. Petitioner currently works in a body shop, painting cars, and has worked there since July of 2013. (TX)

As a consequence of the work injury, Petitioner has no feeling in his left hand. Petitioner also testified he lacks coordination and has difficulty performing small tasks which require coordination of his hand. Petitioner is no longer able to enjoy his hobby of playing soccer; he has a fear of hurting his hand due to the hardware he has in place. (TX)

Mr. Kowalkowski testified on behalf of Respondent. He confirmed he was and is the owner of Chris Carpentry, a company engaged in the construction of buildings. Mr. Kowalkowski further testified Chris Carpentry currently has three employees, and that as of April 18, 2011, Chris Carpentry had two employees, those being Petitioner and Janusz. (TX)

Mr. Kowalkowski testified regarding the Summit job, which he identified as located at 7435 West 56th Place, Summit, Illinois. Mr. Kowalkowski and his wife were the owners of this property and Mr. Kowalkowski acted as the general contractor, hiring subcontractors to perform different work at the Summit job. Mr. Kowalkowski hired a subcontractor to perform the electrical, he hired a subcontractor to perform the plumbing, and he hired a subcontractor to put up the drywall. He furthermore hired his own company, Chris Carpentry, to perform the 'rough' carpentry. Mr. Kowalkowski did not hire a subcontractor to perform the 'finished carpentry'. Mr. Kowalkowski testified that Chris Carpentry did not engage in performing 'finished carpentry' only 'rough carpentry which he defined as carpentry that focused on

framing or building the house from the foundation to the roof. He defined 'finished carpentry' as involving carpentry inside the house such as the floors or framing of the windows or doors. He testified that he did not hire a 'finished carpentry' subcontractor because he wanted to ask the employees of Chris Carpentry, Petitioner and Janusz, if they wanted to perform this work. The employees of Chris Carpentry were then hired to perform the 'finished carpentry'. (TX)

Mr. Kowalkowski testified that he purchased a Workers' Compensation insurance policy for Chris Carpentry with Liberty Mutual in August of 2010. The insurance policy was a one-year policy to be effective in August of 2010 through the next year until August of 2011. In October of 2010, the insurance policy was cancelled with the cancellation to be effective in December of 2010. Mr. Kowalkowski confirmed that after the cancellation he did not purchase any other policy prior to April 18, 2011 and therefore did not have a Workers' Compensation insurance policy in place on April 18, 2011. Respondent Kowalkowski testified he later attempted to purchase a policy to cover the date of incident, but none of the policies would cover retroactively. (TX)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Issue A: *Respondent operating under and subject to Act*

The Arbitrator finds Respondent was operating under and subject to the Illinois Workers' Compensation Act. In so finding, the Arbitrator relies on the corroborative testimony of Petitioner and Respondent that the accident occurred in Illinois and that Respondent had multiple employees, *i.e.*, persons in the service of Respondent under a contract for hire, on April 18, 2011.

Petitioner testified consistently that he believed himself to be any employee of Respondent, and Respondent himself testified that on the job during which the accident of April 18, 2011 occurred, he had two employees, one of whom was Petitioner. That job was located in Summit, Illinois. Accordingly, the unrebutted evidence is that Respondent had persons in it service under a contract for hire on April 18, 2011, and any accident resulting in injury on that date that was suffered by one of those persons and, as here, occurred in Illinois is subject to the jurisdiction of the Illinois Workers' Compensation Act.

Furthermore, the Arbitrator notes the work performed by those in the service of Respondent to be carpentry for the purposes of either remodeling homes or building new homes and, as such, that work constitutes either "erection, maintaining, removing, remodeling, altering or demolishing any structure"; or "construction, excavating, or electrical work" such that the work falls under the provisions of Section 3(1) or Section 3(2) of the Workers' Compensation Act thereby instituting Automatic Coverage pursuant to Section 3 of the Act.

Issues B, C, & D: *Employee-employer relationship/Accident/Date of Accident*

There is no evidence in the record to provide any reason to question that on April 18, 2011, Petitioner was operating a table saw to cut wood while performing carpentry work when he suffered a severe injury to his left hand when his hand came in contact with the running saw blade. The testimony and medical records all corroborate this history, and there is no evidence to suggest otherwise. Such an accident by its very nature "arises out of" work as a carpenter. At issue is whether there existed an employee-employer relationship between Petitioner and Respondent, and whether the table saw accident arising out of Petitioner's work as a carpenter also occurred "in the course of" such an employment relationship with Respondent.

The Arbitrator finds an employee-employer relationship existed between Petitioner and Respondent. In so finding, the Arbitrator notes Respondent's own admission that on April 18, 2011 he had two employees, one of whom was Petitioner. In further support of this finding, the Arbitrator notes Petitioner's credible testimony regarding the direction and control of his work exercised by Respondent.

Petitioner testified that on April 18, 2011 he was employed by Respondent, Chris Carpentry, owned by Krzysztof Kowalkowski, who was present at arbitration and testified on behalf of Respondent. Petitioner began worked for Respondent as a carpenter performing framing work. His work required using tools such as saws that were provided by Respondent. Throughout his time working for Respondent, he performed the work at various job sites, and Respondent directed him to which job site to appear at and what work to perform at the job sites. He received pay from Respondent for the work he performed by check.

While Petitioner admitted that he did provide some of his own tools, the Arbitrator finds such admission insignificant in weighing the factors of determining whether or not Respondent exercised direction and control over Petitioner. Petitioner testified that the tools of his own which he brought to the job sites were minimal, such as a hammer and a T-square, or the general tools normally found in a tool belt. Petitioner credibly testified that the tools required for the specialized work performed under Respondent's direction and control, *i.e.*, power tools

and saws, were provided by Respondent, including the table saw Petitioner was using when he suffered his accident.

Respondent admitted that Petitioner was an employee of Respondent on the date of accident, and that in that capacity as an employee Petitioner was performing carpentry work at the Summit, Illinois jobsite where the accident occurred. However, Respondent claims that at the time of the accident, Petitioner was operating as an independent contractor such that the accident occurred outside of the scope of his employment with Respondent, as Petitioner was performing "fine" or "finishing" carpentry outside the scope of the "rough" carpentry that Respondent, Chris Carpentry, had been "hired" to perform.

Testifying on behalf of Respondent, Mr. Kowalkowski testified that he and his wife were the owners of the property where the accident occurred. As the owner, Mr. Kowalkowski acted as the general contractor for the project and hired subcontractors to perform the individual tasks associated with construction or remodeling. Mr. Kowalkowski admitted that he subcontracted his own company, Chris Carpentry, of which Petitioner and Janusz were the sole employees, to perform the "rough" carpentry work on the project. Mr. Kowalkowski also confirmed that acting as general contractor he hired other companies to perform other specific work, with separate subcontractors hired to work on plumbing, drywall, and electrical. However, Mr. Kowalkowski did *not* hire a specific subcontractor to perform the "fine" or "finish" carpentry on the project, but claims Petitioner and Janusz, the sole employees of Chris Carpentry, mutually offered their services independently from their jobs as employees of Chris Carpentry to perform that work. The Arbitrator finds Respondent's assertion that the individuals constituting the entire workforce of Chris Carpentry, while engaging in carpentry work that no other subcontractor had been hired to perform, were *not* acting as employees of Chris Carpentry is disingenuous at best and wholly lacking in credibility. Furthermore, Petitioner testified that the check entered into evidence paid to Petitioner by Chris Carpentry covered the work he was performing on April 18, 2011 when he was injured; Respondent did not rebut this assertion. The credible evidence is clear that Petitioner's table saw accident occurred in the course of work he was performing as an employee of Chris Carpentry.

As such, the Arbitrator finds that an employee-employer relationship existed between Petitioner and Respondent on April 18, 2011, and on that date, Petitioner suffered an accident arising out of his work as a carpenter that occurred within the course of that employment.

Issue E: *Notice*

Petitioner testified that both his coworker Janusz and Respondent himself witnessed the accident. Furthermore, Petitioner testified that Respondent drove Petitioner to the hospital immediately following the accident. Respondent did not rebut this assertion. Accordingly, the Arbitrator finds Respondent was provided timely notice of the accident.

Issue F: *Causal connection*

As noted above, Petitioner suffered a severe injury to his left hand when he touched a running table saw blade. The medical records introduced at trial document a consistent history of continuous treatment including multiple surgeries and directed care for the lacerations to Petitioner's hand and fingers, as well as the infection and necrosis that resulted from the injury, up through Petitioner's release from care at maximum medical improvement on November 6, 2012. Petitioner testified credibly that he continues to experience pain and not have any feeling in his left hand and lacks coordination. Furthermore, the Arbitrator observed at trial severe disfigurement of Petitioner's left hand consistent with the type of injury one would expect from touching a running table saw blade.

There is nothing in the record to disassociate Petitioner's current left-hand condition from the severe table saw accident of April 18, 2011. As such, the Arbitrator finds Petitioner's current condition of ill-being to be causally related to the injury.

Issue G: *Earnings*

The Arbitrator finds Petitioner's earnings at the time of injury to have been $23,725.10 over 46 weeks, resulting in an Average Weekly Wage of $515.76. In so finding, the Arbitrator relies on Petitioner's credible testimony, as well as the IRS Form 1099s issued by Respondent through the Federal Government establishing the pay provided to Petitioner for the work performed for Respondent.

Petitioner testified that he began working for Respondent on June 1, 2010 and worked regularly every week up through the April 18, 2011 accident. He further testified that he did not work for Respondent prior to June 1, 2010 or after the April 18, 2011 accident. Additionally, he did not perform work for any other employer during that time. Therefore, the Arbitrator finds it appropriate to take the total earnings indicated on the 1099s for 2010 and 2011 and divide it by the number of weeks worked from June 1, 2010 through April 18, 2011, *i.e.*, 46, resulting in the AWW of $515.76.

The Arbitrator notes Petitioner admitted that he did not always work a full week, such as when weather did not permit working on any given day. However, no specific evidence was introduced by any party to specify exactly how many of the 46 weeks were incomplete, and there was no allegation that Petitioner failed to work entirely in any of the 46 weeks; Petitioner credibly testified that he never went as long as a week without performing at least some work. Furthermore, as incomplete weeks would result in a weeks and parts thereof calculation that would necessarily amount to a *higher* AWW than that which Petitioner alleged, the Arbitrator finds no reason to so speculate.

Moreover, the Arbitrator notes that the individual two-week paycheck introduced by Petitioner represents a relatively similar wage to the AWW established by the method articulated above, thereby corroborating such method as appropriate.

As such, the Arbitrator finds Petitioner's earnings at the time of injury to have been $23,725.10 over 46 weeks, amounting to an AWW of $515.76.

Issue H: *Age*

Petitioner testified that on April 18, 2011 he was 25 years old. His testimony was unrebutted and, as above, the Arbitrator has found Petitioner's testimony to be credible. The Arbitrator therefore finds Petitioner's age at the time of the accident to have been 25 years old.

Issue I: *Marital status*

Petitioner testified that on April 18, 2011 he was single. His testimony was unrebutted and, as above, the Arbitrator has found Petitioner's testimony to be credible. The Arbitrator therefore finds Petitioner's marital status at the time of the accident to have been "single."

Issue J: *Medical bills*

Petitioner provided medical bills totaling $572,419.08 for treatment of the Petitioner's left hand between April 18, 2011 and November 16, 2012, including $144.09 in receipts for out of pocket payments for prescriptions. The Arbitrator notes the entirety of the medical bills submitted relate to records of the office visits, surgeries, recovery, and infection treatment of Petitioner's left hand following the April 18, 2011 accident. Those medical records, specifically those of Dr. Schlenker, provide credible basis and justification for the multiple procedures performed and extensive treatment rendered to cure or relieve Petitioner's left-hand condition

resulting from the April 18, 2011 accident. Moreover, Respondent offered no evidence to dispute the reasonableness and necessity of the medical services provided. The Arbitrator further notes that due to this treatment, Petitioner was able to be released at maximum medical improvement on November 6, 2012. The Arbitrator therefore finds that the medical services provided to Petitioner were reasonable and necessary, and that Petitioner has received all reasonable and necessary medical services for his left-hand condition resulting from the April 18, 2011 accident.

Petitioner testified credibly that the entirety of the medical bills remains unpaid, and that he never received reimbursement for the out of pocket payments he made for the prescriptions. Respondent offered no evidence to rebut this. As such, the Arbitrator finds Respondent has not paid all appropriate charges for the reasonable and necessary medical services provided to Petitioner.

Respondent shall pay reasonable and necessary medical services of $572,419.08, as provided in Sections 8(a) and 8.2 of the Act.

Issue K: *TTD*

Petitioner testified that he never returned to work for Respondent after the April 18, 2011 accident. The medical records support a complete inability to work from April 19, 2011 through September 21, 2011. As this complete inability to work was due to the work injury suffered on April 18, 2011, Petitioner is entitled to TTD for that 22-2/7 week period.

Petitioner further testified that when he was given restrictions, Respondent offered for him to come back to work. However, Respondent gave no description of the work that Petitioner would be performing and did not provide any information regarding what Petitioner would be paid. Petitioner testified that from his experience working for Respondent, he did not know of any work that could be performed for Respondent that would fall within his restrictions. Respondent testified on various issues at trial but did not provide any testimony regarding what type of work was available or offered to Petitioner within his restrictions.

The Arbitrator finds that there is no evidence in the record that work was available within Petitioner's restrictions. As such, Petitioner is likewise entitled to TTD for the 58-6/7 week period of September 22, 2011 through November 6, 2012, when he was released at maximum medical improvement.

Petitioner furthermore testified that after he had reached maximum medical improvement, he began to look for work within his permanent restrictions of a 15-pound lifting

limit. Petitioner looked for work through friends and advertisements and contacted potential employers. Through his self-directed efforts, Petitioner ultimately found work as a mechanic within his permanent restrictions. He began working as a mechanic on March 1, 2013. Although no longer with the same company, Petitioner continues to be employed painting cars as of the date of hearing.

The Arbitrator finds Petitioner's successful efforts at finding new work within his permanent restrictions constitute a diligent self-directed job search such that Petitioner is entitled to maintenance benefits for the 16-2/7 week period of November 7, 2012 through February 28, 2013.

Accordingly, Respondent shall pay Petitioner temporary total disability benefits of $343.84/week for 81-1/7 weeks, commencing April 19, 2011 through November 6, 2012, as provided in Section 8(b) of the Act. Additionally, Respondent shall pay Petitioner maintenance benefits of $343.84/week for 16-2/7 weeks, commencing November 7, 2012 through February 28, 2013, as provided in Section 8(a) of the Act.

Issue L: *Nature and extent of injury* [1]

The initial emergency room diagnosis by Dr. Schlenker identifies complete amputation through the distal phalanx of the left little finger and incomplete amputation of the left thumb, the left index finger, the left middle finger, and the left ring finger. As such, Petitioner is entitled statutory amputation benefits in the amount of:

50% loss of use of the left thumb

50% loss of use of the left index finger

50% loss of use of the left middle finger

50% loss of use of the left ring finger

100% loss of use of the left little finger

[1] As Petitioner's accident date (April 18, 2011) precedes the June 28, 2011 effective date of 820 ILCS 305/8.1b, this Arbitration Decision ***will not*** utilize the factors set forth in Section 8.1b in determining the nature and extent of the Petitioner's injury.

Pursuant to Section 8(b)4.1, the compensation paid for amputation of a member shall be paid at the rate of $466.13. Accordingly, Respondent is to pay to Petitioner $53,138.82 in amputation benefits, representing 38 weeks for the loss of use of the left thumb, 21.5 weeks for the loss of use of the left index finger, 19 weeks for the loss of use of the left middle finger, 13.5 weeks for the loss of use of the left ring finger, and 22 weeks for the loss of use of the left little finger (114 total weeks X $466.13 = $53,138.82).

Furthermore, the Arbitrator notes the severe damage to Petitioner's left hand as a whole, visible at hearing and corroborated by the treatment records documenting multiple surgeries with complications including necrosis and infection, as well as Petitioner's own testimony of pain, loss of sensation, and lack of coordination. These injuries resulted in unrebutted permanent restrictions that preclude Petitioner from continuing as a carpenter. Although Petitioner was able through his self-directed job search to secure new employment within his permanent restrictions, the Arbitrator finds the nature and extent of Petitioner's injury, in addition to the amputation benefits listed above, to be a "loss of trade". As such, the Arbitrator finds the nature and extent of Petitioner's injury to be the above amputation benefits AND a 60% loss of use of the person-as-a-whole. Accordingly, Petitioner is entitled to 300 weeks of compensation pursuant to Section 8(d)2 of the Act at the rate of $309.46, totaling $92,838.00, in addition to the amputation benefits identified above.

Issue N: *Respondent's credit*

Respondent offered no evidence of any benefits paid to Petitioner. Accordingly, the Arbitrator finds Respondent is not due any credit.

Issue O: *IWBF liability*

Respondent testified that on April 18, 2011, there was no workers' compensation insurance in place. Specifically, Respondent confirmed he had purchased a policy that would cover from August of 2010 through August of 2011, but that the policy was cancelled in October of 2010 with the cancellation to be effective in December of 2010. Respondent testified that he was not aware that his policy had been cancelled until after Petitioner's accident of April 18, 2011 and attempted to secure new insurance at that time; however, no insurer would retroactively cover the accident of April 18, 2011. Respondent's testimony of obtaining insurance that was cancelled prior to the expiration of the policy and prior to April 18, 2011 is corroborated by the certification from the National Council on Compensation Insurance. (PX 8).

The Arbitrator finds Respondent's explanation of noncoverage to be irrelevant in the current matter, as the admitted and established evidence is that on April 18, 2011 Respondent did not have workers' compensation insurance. The Injured Workers' Benefit Fund is therefore a proper party to this case and the Petitioner is entitled to recover from the Injured Workers' Benefit Fund to the extent as provided by the Act. Specifically, the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. (AX 1). The Treasurer was represented by the Illinois Attorney General. This award hereby is entered against the Fund to the extent permitted and allowed under §4(d) of the Act. In the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner, Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injury Workers' Benefit Fund.

Signature of Arbitrator

APRIL 16, 2019
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

[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

Joselin Arana,

Petitioner,

20 I W C C 0 5 6 4

vs.

NO: 17 WC 13430

Autumn Leaves Nursing Home,

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 temporary disability, credit for temporary disability, medical and prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2020, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 5 2020
o9/17/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

20 IWCC0564

ARANA, JOSELIN
Employee/Petitioner

Case# **17WC013430**

AUTUMN LEAVES NURSING HOME
Employer/Respondent

On 1/15/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0787 MEYERS & FLOWERS LLC
JOHN N HARP III
3 N SECOND ST
ST CHARLES, IL 60174

2965 KEEFE CAMPBELL BIERY & ASSOC
LILIA Y PICAZO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

20IMCC0564

20 I W C C 0 5 6 4

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)

JOSELIN ARANA
Employee/Petitioner

v.

AUTUMN LEAVES NURSING HOME
Employer/Respondent

Case # **17 WC 13430**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **New Lenox**, on **September 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

F. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [ ] Were 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 24, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $11,960.00; the average weekly wage was $230.00.

On the date of accident, Petitioner was 20 years of age, ***single*** with 2 dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$3,373.27** for TTD, $0.00 for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of **$3,373.27**.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

Order

Petitioner's current condition of ill-being regarding her lumbar spine is not causally related to the injury beyond a lumbar sprain resolved as of March 6, 2017.

Petitioner's claim for TTD is denied. Respondent is entitled to a TTD credit of $3,373.27.

Petitioner's claim for prospective medical care recommended by Dr. McGivney 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] 1/13/20

Signature of Arbitrator — Date

ICArbDec19(b)

JAN 15 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

20 I W CC0564

JOSELIN ARANA)
Petitioner,)
)
v.) **17 WC 13430**
)
AUTUMN LEAVES NURSING HOME,)
Respondent.)

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing on September 10, 2019 pursuant to Section 19(b) of the Act (Arb. 1). There is no dispute Petitioner sustained an accident to her low back on that date (Id.). Respondent dispute causal connection, prospective medical care and TTD (Id.).

Petitioner was hired by Respondent as an assistant caregiver in 2016. Her duties included bathing and lifting patients.

On November 24, 2016, Petitioner was lifting a patient from a bed to a wheelchair, with a co-worker, when she heard a "pop" and felt pain in her back. The next day Petitioner presented to Physicians Immediate Care ("PIC") (*PX#1 at 6*). Lumbar spine X-rays were unremarkable (*Id at 8*). Petitioner was diagnosed with a lumbar strain, prescribed light duty work restrictions and Aleve for pain relief (*Id at 9*).

On December 19, 2016, after several doctor visits at PIC and completion of prescribed physical therapy, the Petitioner was referred to an orthopedic surgeon (Id. at 63).

On January 9, 2017, the Petitioner presented to Dr. Thomas McGivney, an orthopedic surgeon at Castle Orthopaedics & Sports Medicine. Petitioner reported right lower lumbar pain (*PX#2 at 16-17*). She denied leg pain, numbness and tingling (*Id.*). Dr. McGivney testified Petitioner was able to bend "all the way over 90 degrees with just a little bit of discomfort" (*PX#3 at 12*). Petitioner exhibited normal strength, sensation and reflexes (*Id.*). Dr. McGivney testified he did not appreciate any muscle spasms and Petitioner was neurologically intact (*Id.*). Dr. McGivney diagnosed a lumbar strain. Physical therapy, Lodine and Flexeril were prescribed for pain relief, and light duty work restrictions were noted (*PX#2 at 16-17*).

On March 6, 2017, Petitioner returned to Dr. McGivney who noted Petitioner was making great progress with physical therapy, although she was still experiencing some discomfort bending forward (*PX#2 at 11*). Dr. McGivney recommended one additional month of physical therapy and anticipated maximum medical improvement in one month (*Id.*). Petitioner's work restrictions remained unchanged (*Id.*).

On April 3, 2017, Dr. McGivney noted Petitioner's report of improvement with physical therapy although she also reported new left-sided radicular symptoms (Id. *at 9*). Dr. McGivney recommended an MRI and three more weeks of physical therapy (*Id.*). Petitioner's work restrictions remained unchanged (*Id.*).

On April 7, 2017, Petitioner reported 65-70% improvement with physical therapy (*PX#2 at 8*). She reported she was still working with light duty work restrictions (*Id.*).

On April 17, 2017, lumbar MRI demonstrated disc degeneration, a large annular tear and a disc bulge at L5-S1 (PX 3 at 17, RX1 at 13).

On May 1, 2017, Dr. McGivney interpreted the MRI as revealing severe disk disease with Modic type II changes at L5-S1 (*PX#2 at 6*). Dr. McGivney testified Petitioner was not making any improvement with physical therapy (*PX#3 at 17*). Work restrictions remained essentially unchanged (*PX#2 at 6*). Dr. McGivney recommended Petitioner see Dr. Bansal for pain injections and undergo total disk arthroplasty at L5-S1 if injections failed (*Id.*). Petitioner returned to Dr. McGivney on May 9, 2017 at which time she was placed off work (*PX#2*).

Dr. Zelby IME and Deposition

On July 19, 2017, Petitioner presented to Dr. Andrew Zelby for a Section 12 exam (*RX#1, Zelby #2*). Dr. Zelby opined that on the date of injury the Petitioner had sustained a lumbar strain, had reached maximum medical improvement and that any ongoing low back symptoms were caused from being overweight and not from the injury at work (RX1 at 18). Dr. Zelby's deposition was taken on January 10, 2019 (*RX#1*). Dr. Zelby testified he performed a physical examination revealing normal findings (Id. *at 11*). Dr. Zelby reviewed an April 2017 MRI which noted mild degenerative disc disease at L5-S1 with mild loss of T2 signal intensity and no loss of disc space height (*Id, Zelby #2 at 4*). He did not appreciate any disk protrusion at L5-S1 (*RX #1 at 25*). He testified the degenerative changes in the MRI were mild with no acute or post-traumatic abnormalities (*Id at 13*).

Dr. Zelby testified he diagnosed mild degenerative disk disease and a lumbar strain (*Id at 16, 28*). Petitioner's increase in pain after improvement with therapy was inexplicable within the context of her objective medical findings (*Id.*). Medical treatment was also protracted and excessive (*Id at 17*). Dr. Zelby testified Petitioner was not a candidate for injections, surgery or further medical treatment (*Id.*). He testified weight loss could reduce the frequency and severity of pain (*Id at 18*). Dr. Zelby testified Petitioner reached MMI by March 2017. He opined Petitioner could work full duty without restrictions (*Id.*).

Deposition of Dr. McGivney

Dr. McGivney's deposition was taken on November 5, 2018 (*PX#3*). He testified he first placed Petitioner off work in May 2017 because he "was hopeful to get something else changed and --- something sooner" (*Id at 20*). Dr. McGivney did not diagnose an annular tear until four months into Petitioner's medical treatment (*Id at 21-22*). He testified Petitioner did not have a disc herniation, no loss of disc height and there was no nerve root impingement (*Id at 23*).

Dr. McGivney testified Petitioner weighed 190 pounds, was 64 inches tall and had a BMI of 32.61 during the course of his treatment (*Id at 29*). He testified Petitioner's weight was a contributing factor regarding pain from the annular tear (*Id at 35*). Though he recommended injections, he testified injections may not help annular tears (*Id at 22*). Dr. McGivney also testified arthroplasties remain viewed as investigational in nature as it relates to the lumbar disc (*Id at 23*). Dr. McGivney testified he had not seen Petitioner since 2017 (*Id at 20*).

At trial, Petitioner testified she last saw Dr. McGivney in August of 2017. The Arbitrator notes no medical records were entered into evidence to support further treatment after May 2017. Petitioner testified her back pain was improving with physical therapy in 2017. Petitioner also testified she had not seen any doctor or undergone any medical treatment for her low back since 2017.

20 I W C C 0 5 6 4

CONCLUSIONS OF LAW

WITH REGARD TO ISSUE (F) WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS:

There is no dispute Petitioner sustained an accident on November 24, 2016. Petitioner testified and the medical records show she complained of low back pain after lifting a resident/patient with a co-worker. The issue is whether Petitioner's current condition of ill-being is causally related to the November 24, 2016 lifting incident.

The credible evidence in the case demonstrates a consistent low back strain diagnosis with improvement following a course of physical therapy. In March of 2017, Dr. McGivney noted Petitioner would likely be placed at MMI by his April 2017 follow-up visit. An April 2017 medical note prepared by Dr. McGivney indeed indicates Petitioner was 65-70% improved with physical therapy and it was only after an MRI that Dr. McGivney diagnosed an annular tear, recommended injections and possible disk arthroplasty at L5-S1.

The Arbitrator notes the April 2017 MRI was not entered into evidence, though acknowledges a more detailed reading in Dr. Zelby's Section 12 report. Dr. Zelby reviewed the MRI and opined there was no loss of disc space height to suggest any severe degenerative disc disease. Dr. Zelby testified Petitioner sustained a low back strain that resolved by March 2017 when Dr. McGivney first noted improvement with physical therapy (*RX #1*).

At his November 2018 deposition, Dr. McGivney testified Petitioner did not have a disc herniation, no loss of disc height and there was no nerve root impingement. Dr. McGivney testified he was not certain if the recommended injections would even help reduce Petitioner's pain. He testified arthroplasties were viewed as investigational in nature within the medical field as it relates to the lumbar disc (*PX#3*).

While Petitioner testified she last presented for treatment in August 2017, the medical records suggest she last saw Dr. McGivney in May of 2017 – two years and four months prior to the date of the hearing. The Arbitrator notes Petitioner has not undergone any medical care for her lower back since 2017. The Arbitrator also notes Petitioner did not appear under any physical distress during the course of the hearing.

Based upon the medical records and lack of any reported medical care for the low back since 2017, the Arbitrator finds the preponderance of credible evidence supports a finding that Petitioner was correctly diagnosed with a low back strain which resolved by March 2017. Petitioner did not require further medical care, inclusive of injections or surgery after March 6, 2017.

With regard to the sudden off work restrictions prescribed in May 2017, the Arbitrator notes Petitioner was capable of working with work restrictions up until she was placed off work. Nothing in the record indicates Petitioner was placed off work because she was unable to perform her restricted work duties. Rather, Petitioner was suddenly placed off work because Dr. McGivney felt " hopeful to get something else changed and ---something sooner" (*PX#3 at 20*). The Arbitrator believes Petitioner could have continued to work within the prescribed work restrictions and there was no reason to place her off work.

Based upon the record in this matter including the Petitioner's testimony, the treating medical records, IME reports and depositions, the Arbitrator finds Petitioner has not sustained her burden of proving her current condition of ill-being is causally related to the work incident of November 24, 2016. The Arbitrator finds that as a result of the accidental injuries sustained on November 24, 2016,

the Petitioner sustained injuries to her lower back causing a low back strain that improved by March 2017. As such, the Arbitrator finds Petitioner reached MMI on March 6, 2017. The Arbitrator further finds Petitioner was capable of continued work with Respondent and that her pain symptoms have improved on their own.

Petitioner's demand for TTD and prospective medical benefits is denied and Respondent is given all credits due.

WITH REGARD TO ISSUE (K), WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS:

Petitioner argues prospective medical care recommended by Dr. McGivney should be authorized. In light of the determination that Petitioner suffered at most a low back strain which resolved by March 6, 2017, Petitioner's present condition of ill-being after March of 2017 is not causally related to the November 24, 2016 work incident. Benefits under Section 19(b)/(8(a) of the Act are hereby denied.

WITH REGARD TO ISSUE (L) AND (N), WHETHER TEMPORARY TOTAL DISABILITY AND MAINTENANCE BENEFITS ARE OWED TO PETITIONER, AND WHETHER RESPONDENT IS DUE ANY CREDIT, THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS:

Petitioner alleges entitlement of TTD benefits from May 9, 2017 through September 10, 2019. The Arbitrator notes Respondent paid TTD benefits from May 9, 2017 to July 24, 2017 and roughly one week after Dr. Zelby's IME of July 19, 2017 (*RX#2)*. In light of the determination Petitioner failed to establish her present condition of ill-being as it relates to the low back after March 2017 is causally related to the November 24, 2016 work incident, the Arbitrator finds Petitioner is not entitled to any TTD benefits.

The Arbitrator also points out Petitioner reported she was able to work within the prescribed work restrictions and she should not have been placed off work. Respondent is entitled to a TTD credit of $3,373.27 for any TTD paid between May 9, 2017 to July 24, 2017.

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos Castillo,
Petitioner,

20 I W CC0565

vs.

NO: 12 WC 35416

City of Chicago-Bureau of Forestry,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 25, 2020, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2020
o9/3/20
DLS/rm
046

Barbara N. Flores

Marc Parker

DISSENT

I respectfully dissent from the Decision of the Majority. This matter was consolidated at arbitration with 10 WC 37854. In 10 WC 37854, the Arbitrator awarded Petitioner 107&5/7 weeks of permanent partial disability benefits ("PPD") representing loss of 50% of the left leg for an

injury that eventually resulted in a total knee arthroplasty. In the instant claim, the Arbitrator awarded Petitioner 250 weeks of PPD representing loss of the use of 50% of the person-as-a-whole for bilateral shoulder injuries. The Majority affirmed and adopted the Decisions of the Arbitrator under separate Decisions of Review. The nature and extent of Petitioner's permanent disability was the only issue on review in both these claims.

I concur in the affirmation of the PPD award for the knee replacement, issued under separate opinion. However, in the instant claim, I believe the award of 250 weeks representing loss of the use of 50% of the person-as-a-whole is excessive. I would have modified the Decision of the Arbitrator to reduce the PPD award to 150 weeks, representing loss of the use of 30% of the person-as-a-whole.

Petitioner was working for Respondent as a tree trimmer. On October 1, 2012, he was loading tree trimmings into a chipper. He encountered a water hose tangled up in the trimmings which he had to pull out. In so doing he injured his shoulders bilaterally. Petitioner had a surgery on the right shoulder and two surgeries on the left shoulder. Petitioner was declared at MMI on January 20, 2017 and released to work with restrictions based on an FCE, which rated Petitioner as functioning at the medium physical demand level. Respondent provided Petitioner with vocational rehabilitation and provided him with a job as a watchman. Petitioner testified that if he had stayed a tree trimmer, as of March of 2019 he would have earned $37.76 an hour while he currently earned $22.92 as a watchman. In his current job, Petitioner sits in an office for eight hours looking at monitors all day.

Petitioner testified that currently his left knee causes pain all the time. He has to walk and keep stretching the knee. He limps when he walks. He can only sit for about 40 minutes at a time. Thereafter, he has to walk five to 10 minutes to stretch it out. He has difficulty walking on inclines. His left knee is numb all the time. Before the accident, Petitioner would ride his bike to work. Now when riding, he cannot "pedal as good" as he did, his knee keeps clicking, and his knee is sore after he rides. He used to like walking but can now walk only four or five blocks. He does not take pain killers but ices his knee down. If he sits around, his shoulders get stiff and has to move them. He has difficult reaching anything in the top of cupboards. He cannot lift anything heavy. He tries to keep things at shoulder height or lower.

In awarding Petitioner loss of 50% of the person-as-a-whole, the Arbitrator gave great weight to the fact that he was unable to return to his prior occupation requiring heavy labor. He also found that Petitioner's age (56 at date of accident and 63 at arbitration) increased his level of disability. On the issue of future earning potential, the Arbitrator noted that after his knee injury, Petitioner was able to return to work at his prior occupation, but was unable after his shoulder injuries and noted his reduced salary in the new position. The Arbitrator gave great weight to this factor. Finally, the Arbitrator also gave great weight to the factor of evidence of disability in the record. He outlined his deficits, permanent restrictions, and again noted his inability to return to work at his prior occupation.

I would have applied the statutory elements for PPD to the instant claim differently than did the Arbitrator. The Arbitrator used Petitioner's relatively advanced age as a factor to increase PPD. In my opinion, in this instance Petitioner's age should be a factor to reduce his permanency award. Because of his age, Petitioner has a relatively short prospective working life ahead of him in which he would have to deal with the disability.

In addition, I disagree with the Arbitrator's analysis regarding the factor of evidence of disability corroborated by the medical record. While Petitioner testified to continuing symptoms relating to his shoulders, he never sought any medical attention since January 20, 2017 and his FCE placed him in the medium physical demand level. In addition, while Petitioner may have some deficits in lifting heavy objects overhead, his current job does not require any lifting whatsoever. Finally the deficits and symptoms about which Petitioner testified at arbitration appeared centered around his knee rather than his shoulders. Any disability relative to Petitioner's knee condition was addressed in the award of loss of 50% of the leg in the companion case.

For the reasons stated above I would have modified the Decision of the Arbitrator to reduce the PPD award to 150 weeks representing loss of the use of 30% of the person-as-a-whole. Therefore, I respectfully dissent from the Decision of the Majority.

o-9/3/20
DLS/dw
46

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 IWCC0565

CASTILLO, CARLOS
Employee/Petitioner

Case# **12WC035416**

10WC037854

CITY OF CHICAGO - BUREAU OF FORESTRY
Employer/Respondent

On 3/25/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20IWCC0565

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

Carlos Castillo
Employee/Petitioner
v.
City of Chicago - Bureau of Forestry
Employer/Respondent

Case # **12 WC 035416**

Consolidated cases: **10 WC 037854**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **August 7, 2019**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's 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. [ ] Other _____

FINDINGS

On **10/1/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** 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 $**69,583.28** ; the average weekly wage was **$1,338.14**.

On the date of accident, Petitioner was **56** years of age, ***married*** with 0 dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**160,457.75** for TTD, $**-0-** for TPD, $**96,351.12** for maintenance, and $**-0-** for other benefits, for a total credit of $**256,808.87**.

Respondent is entitled to a credit of $**-0-** under Section 8(j) of the Act.

ORDER

- **Respondent shall pay Petitioner the sum of $712.55/week for a further period of 250 weeks, as provided in Section 8(e)12 of the Act, because the injuries sustained to the bilateral shoulders caused a 50% loss of use of the person as a whole.**
- **Respondent shall pay Petitioner the compensation accrued from 10/1/2012 through 8/7/2019 and shall pay the remainder of the award, if any in weekly payments.**

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 18, 2020

Date

MAR 2 5 2020

INTRODUCTION

This case was tried on August 7, 2019, along with companion case No. 10 WC 037854. The Arbitrator heard the testimony of Petitioner. The Arbitrator also received into evidence various exhibits, which included: 1) medical records; 2) diagnostic study reports; 3) operative reports; 4) physical therapy records; 5) FCE reports; 6) narrative report of Dr. Wolin; 7) job search logs; 8) vocational reports of Mr. Grzesik; 9) certification of achievement and attendance from Olive Harvey; 10) vocational reports of Mr. Belmonte; 11) print out of payments made by Respondent; and 12) Section 12 reports.

The Arbitrator is considering the disputed issues of medical causation and the nature and extent of the injury. Petitioner has elected to receive his permanent partial disability benefits pursuant to Section 8(d)2 of the Act. He waived his right to recovery pursuant to Section 8(d)1.

Petitioner's testimony was credible and unrebutted. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were submitted into evidence at the time of the hearing.

The Arbitrator will issue separate decisions regarding the consolidated cases.

FINDINGS OF FACT

A. Background and Work History

Petitioner is 63 years old. He previously testified in connection with the injury he sustained to his left knee on two occasions. Petitioner was working for Respondent as a Tree Trimmer II. He was a member of the laborers union, Local 1001. As of February 5, 2010, Petitioner had worked for Respondent for 19 years as a tree trimmer.

Petitioner performed work for Respondent Monday through Friday. He worked 8 hours per day, 40 hours per week. Petitioner worked on residential homes. Petitioner trimmed tree branches, stacked tree limbs, dragged tree

lines and removed stumps. Petitioner climbed ladders and worked out of buckets. Petitioner lifted and carried between 5 and 75 pounds.

Petitioner testified that his rate of pay as a union employee increases every 3 years. As of May 2019, the hourly scale for Local 1001 increased to $37.76 per hour.

A. Prior Medical Treatment

Petitioner testified that prior to October 1, 2012 he had not sustained any accidents or injuries involving his right or left shoulder. Further, prior to October 1, 2012 he had not received any medical treatment for his right or left shoulder. Petitioner did not have any problems with his shoulders prior to October 1, 2012.

B. Work-Related Accident of October 1, 2012

Petitioner sustained a work-related accident on February 5, 2010 while working for Respondent. The work-related accident of February 5, 2010 involved his left knee. The case is pending at the Commission under Case Number 10 WC 37854. While under medical care for the left knee condition, Petitioner returned to work for Respondent with restrictions. The restrictions were no lifting more than 40 pounds to the waist and 20 pounds to the shoulder. Petitioner returned to work as a trimmer with restrictions on December 22, 2011 and worked until October 1, 2012.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 1, 2012. Petitioner was working at 900 East 103rd Street at a lumber yard. Petitioner was sorting through debris so that there was no metal, bricks, rocks or tree debris around as the tree branches were fed into the tree grinder. Petitioner's job was to sort through the debris. As Petitioner was going through the debris, he noticed a rubber water hose. The diameter of the hose was about an inch. It was 30 to 40 feet long and twisted. Petitioner pulled the hose out. As he was pulling it, the hose snagged. He pulled it

with a lot of force and felt a pop in both of his shoulders. Petitioner was holding the hose in both hands and pulling it towards his body. Petitioner was wearing a knee brace on his left knee in connection with case number 10 WC 37854 at that time. He bounced backwards and tried not to fall. He had used a lot of strength to pull out the hose.

C. Medical Treatment

Following the work-related accident of October 1, 2012, Petitioner sought medical treatment. While he was receiving medical treatment for his bilateral shoulder condition, Petitioner also received treatment for the prior left knee injury. The left knee injury is discussed in the Decision in Case Number 10 WC 037854. As a result of the work-related accident involving the left knee, Petitioner received medical treatment from Dr. Wolin and Dr. Gonzalez. (PX 1). He was released with permanent restrictions by Dr. Gonzalez which included lifting at medium demand level and limited squatting, crawling and descending stairs or ladders. (PX 1).

Petitioner was examined by Dr. Wolin on October 16, 2012. (PX 10). Dr. Wolin charted that Petitioner sustained a bilateral shoulder injury at work on October 1, 2012 when he was pulling a piece of hose from debris. (PX 10). Dr. Wolin recommended bilateral MRI studies of the shoulders and that Petitioner remain off work. (PX 10).

Petitioner underwent the MRI studies on December 12, 2012 at Streetville Open MRI. (PX 11). The MRI of the left shoulder revealed a moderate full-thickness rotator cuff tear with retraction and muscle atrophy and AC joint and glenohumeral joint degenerative changes. (PX 11). The MRI of the right shoulder revealed a full-thickness rotator cuff tear at the junction of the supraspinatus and infraspinatus tendon with retraction and muscle atrophy, marked muscle atrophy of the teres minor muscle, glenohumeral joint change and mild AC joint degenerative changes. (PX 11).

On December 18, 2012, Dr. Wolin recommended that Petitioner undergo surgery. (PX 10). Dr. Wolin recommended that Petitioner undergo the right shoulder surgery first and then the left shoulder surgery. (PX 10). He set forth that Petitioner's right shoulder was worse than the left shoulder. (PX 10).

Petitioner underwent surgery to his right shoulder on February 25, 2013 at Weiss Memorial Hospital. (PX 12). The surgery was performed by Dr. Wolin. (PX 12). Petitioner underwent an arthroscopic rotator cuff repair complex, due to multiple tendons being involved and multiple anchors placed; arthroscopic biceps tenodesis; and subacromial decompression. (PX 12). The post-operative diagnosis was rotator cuff tear, biceps tendon tear and subacromial bursitis. (PX 12).

Petitioner remained under the post-operative care of Dr. Wolin. (PX 10). Post-operative care included follow up visits, physical therapy and activity modification. (PX 10). Petitioner participated in physical therapy at ATI Physical Therapy. (PX 13).

On August 23, 2013, Dr. Wolin documented that Petitioner continued to have left shoulder pain, weakness and lack of motion. (PX 10). Dr. Wolin noted that Petitioner's right shoulder had improved and plateaued. (PX 10). He recommended left shoulder surgery. (PX 10).

Dr. Wolin examined Petitioner on June 25, 2014. (PX 10). Petitioner continued to experience left shoulder pain. (PX 10). Dr. Wolin recommended an MRI of the left shoulder. (PX 10).

Petitioner underwent the MRI study of the left shoulder on July 22, 2015 at Weiss Memorial Hospital. (PX 14). The MRI study revealed a chronic complete tear of the supraspinatus and near complete tear of the infraspinatus and teres minor, AC joint widening, atrophy of the joint, joint effusion, degeneration of the superior labrum with suspected tear of the superior posterior labrum and biceps tendinosis. (PX 14).

On July 25, 2014, Dr. Wolin reviewed the MRI study of the left shoulder. (PX 10). He recommended surgery for the left shoulder. (PX 10).

Petitioner underwent surgery for the left shoulder on October 23, 2014 at Weiss Memorial Hospital. (PX 12). Dr. Wolin performed a massive rotator cuff repair with arthroscopic debridement. (PX 12). The post-operative diagnosis was massive rotator cuff tear with biceps tendon pathology. (PX 12).

Petitioner remained under the post-operative care of Dr. Wolin. (PX 10). Post-operative care included follow up appointments, physical therapy and activity modification. (PX 10). Petitioner participated in physical therapy at ATI Physical Therapy. (PX 13). On May 26, 2015, Dr. Wolin recommended that Petitioner undergo an FCE. (PX 10).

Petitioner underwent the recommended FCE on June 4, 2015 at ATI Physical Therapy. (PX 15). The FCE was valid. (PX 15). It stated that Petitioner could work at a modified medium physical demand level. (PX 15). Petitioner was not able to lift above his shoulders, which fell below the medium physical demand level. (PX 15).

Petitioner had a follow up appointment with Dr. Wolin on June 10, 2015. (PX 10). Dr. Wolin recommended a repeat MR arthrogram. (PX 10). He released Petitioner to return to work within the restrictions of the FCE. (PX 10). On September 2, 2015, Dr. Wolin recommended that Petitioner undergo surgery for the left shoulder condition. (PX 10).

Petitioner underwent the recommended surgery at Weiss Memorial Hospital on January 21, 2016. (PX 12). Dr. Wolin performed a superior capsular reconstruction. (PX 12). The post-operative diagnosis was recurrent rotator cuff tear. (PX 12).

Petitioner remained under the post-operative care of Dr. Wolin. (PX 10). Post-operative care included follow up appointments, physical therapy and activity modification. (PX 10). Petitioner participated in physical therapy at ATI Physical Therapy. (PX 13). On August 17, 2016, Dr. Wolin recommended another FCE. (PX 10).

Petitioner underwent the FCE on September 22, 2016 at ATI Physical Therapy. (PX 15). The FCE was valid. (PX 15). The results were that Petitioner could return to work at a medium physical demand level. (PX 15). The physical demand level for his occupation was medium to heavy. (PX 15). The FCE set forth that Petitioner could lift above shoulder up to 34.6 pounds occasionally; desk to chair 65.6 pounds occasionally; and chair to

floor 57.8 pounds occasionally; and carry up to 53 pounds occasionally. (PX 15). He was limited in his ability to walk and stand to 6 hours. (PX 15). Petitioner's physical capabilities fell below his job requirements. (PX 15).

Petitioner was examined by Dr. Wolin on October 18, 2016. (PX 10). Petitioner was sore and felt weakness in his left shoulder. (PX 10). Dr. Wolin released Petitioner to return to work within the restrictions of the FCE. (PX 10).

Petitioner was last examined by Dr. Wolin on January 20, 2017. (PX 10). Petitioner experiences soreness in his left shoulder and had pain with reaching and lifting activities. (PX 10). Dr. Wolin set forth an assessment of traumatic rotator cuff tear. (PX 10). He set forth that Petitioner had reached maximum medical improvement. (PX 10). Petitioner had not had a follow up appointment with Dr. Wolin since January 20, 2017.

D. Medical Opinions of Dr. Wolin

Dr. Wolin prepared a narrative report dated January 5, 2014. (PX 16). Dr. Wolin summarized the medical treatment and history of the accident. (PX 16). Dr. Wolin reviewed the MRI studies. (PX 16). He set forth that Petitioner had a right shoulder complete supraspinatus and infraspinatus tear with retraction to the level of the midhumerus and moderate muscle atrophy. (PX 16). The left shoulder had similar findings on the MRI study. (PX 16). Dr. Wolin reviewed the Section 12 report of Dr. Troy. (PX 16).

Dr. Wolin noted that Petitioner did not have symptoms in his shoulders prior to the accident of October 1, 2012 and worked in a heavy occupation without problems. (PX 16). Dr. Wolin opined that the work-related accident of October 1, 2012 aggravated the pre-existing condition in both shoulders and caused Petitioner to undergo surgery. (PX 16). He noted that it would be possible for Petitioner to work with rotator cuff tears and the further tearing caused an aggravation of the pre-existing condition. (PX 16). Dr. Wolin set forth that Dr. Troy's reference that Petitioner sustained a sprain of both shoulders was unclear since Petitioner had clear tearing of the tendons in the instant case. (PX 16). Dr. Wolin stated that the work-related accident of October 1, 2012

extended the rotator cuff tear. (PX 16). He noted that atrophy begins as soon as the tear occurs and that an acute tear could cause retraction to the midhumerus. (PX 16). Dr. Wolin also noted that the tear was not chronic due to the lack of difficulty repairing the tear. (PX 16). Dr. Wolin noted that prior to the surgery, Petitioner had not reached maximum medical improvement due to the ongoing decreased function of both shoulders. (PX 16). Dr. Wolin recommended that Petitioner undergo surgery for the left shoulder. (PX 16).

E. Medical Opinions of the Section 12 Physicians

1. Section 12 Report of Dr. Troy

At the request of his employer, Petitioner was examined by Dr. Troy on September 10, 2013. (RX 3). Dr. Troy set forth that Petitioner had subjective complaints of pain with palpation of the anterior aspect of the right shoulder with objective limitation of internal rotation secondary to tightness to the right shoulder. (RX 3). Petitioner also had left shoulder discomfort without objective findings on physical examination. (RX 3). Petitioner had positive Hawkins and Neer impingement bilaterally with the left being worse than the right. (RX 3). Petitioner had complaints of pain in the left and right shoulder. (RX 3).

Dr. Troy opined that Petitioner had long standing rotator cuff tears to the left and right shoulder. (RX 3). He stated that Petitioner sustained a temporary strain of the left and right shoulder as a result of the accident of October 1, 2012. (RX 3). Dr. Troy set forth that Petitioner sustained a strain to both shoulders as a result of the work-related accident of October 1, 2012 and that the rotator cuff tears predated the accident. (RX 3). He recommended that the strain be treated with anti-inflamatories and physical therapy. (RX 3). Dr. Troy set forth that any work restrictions would not be related to the work-related accident of October 1, 2012. (RX 3). He did not believe the rotator cuff tears were causally connected to the work-related accident, but did find that Petitioner sustained bilateral shoulder strains as a result of the work-related accident of October 1, 2012. (RX 3). He set forth that Petitioner reached maximum medical improvement in February 2013 in connection with the bilateral shoulder condition. (RX 3).

2. *Section 12 Report of Dr. Verma*

At the request of Respondent, Petitioner was examined by Dr. Verma on November 18, 2015. (RX 4). Dr. Verma set forth a diagnosis of left shoulder recurrent rotator cuff tear. (RX 4). He stated that the medical documentation supported a causal relationship between the left shoulder injury and the work-related accident of October 1, 2012. (RX 4). Dr. Verma recommended a trial of an injection prior to surgical intervention. (RX 4). He set forth that if the injection provided temporary relief than surgery would be appropriate. (RX 4). Dr. Verma set forth that following surgery, Petitioner would likely not be able to return to work without restrictions. (RX 4).

F. Vocational Rehabilitation

Following the work-related accident of October 1, 2012, Respondent did not provide Petitioner with work within his restrictions. Rather, Respondent provided Petitioner with vocational rehabilitation services. Joseph Belmonte interviewed Petitioner on December 21, 2016. Mr. Belmonte recommended that Petitioner participate in computer classes at the Vocamotive facility. Petitioner was also interviewed by Thomas Grzesik at the request of his attorney. Mr. Grzesik recommended computer training at a different location than Mr. Belmonte.

Petitioner participated in computer training. He participated in computer training at Olive-Harvey South Chicago Learning Center. Petitioner participated in the program at Olive-Harvey based on the recommendation of Mr. Grzesik. Petitioner successfully completed the program at Olive-Harvey. Petitioner received a certificates of achievement from the programs he completed at Olive-Harvey. (PX 19). Petitioner completed programs in Power Point, Excel, Word, Applied Computer Basics and Digital Literacy. (PX 19). Petitioner also received certificates of attendance. (PX 19).

Petitioner sought employment within his restrictions on his own. Petitioner participated in a job search. (PX 17). Petitioner participated in a job search from May 29, 2017 through December 7, 2018. (PX 17). In December 2018, Petitioner was contacted by Respondent regarding the possibility of returning to work as a watchman.

1. Vocational Opinions of Thomas Grzesik

Petitioner was interviewed by Thomas Grzesik on March 3, 2017. (PX 18). Mr. Grzesik prepared a report dated March 23, 2017. (PX 18). Mr. Grzesik summarized Petitioner's social demographics, work background, education and medical care. (PX 18). Mr. Grzesik also reviewed the reports of Mr. Belmonte, Respondent's vocational counselor. (PX 18).

Mr. Grzesik opined that based on the work restrictions of Dr. Gonzalez and Dr. Wolin, Petitioner would not be able to return to his pre-injury employment. (PX 18). Mr. Grzesik set forth that based on Petitioner's vocational profile, Petitioner would be a candidate for vocational training. (PX 18). He recommended that Petitioner participate in coursework at Olive Harvey College. (PX 18). He stated that completing the coursework would enhance Petitioner's employability. (PX 18). Mr. Grzesik noted that Petitioner was interviewed and underwent vocational testing at the request of Respondent. (PX 18). It was recommended that Petitioner participate in computer skills training. (PX 18). Mr. Grzesik set forth that Petitioner identified appropriate training by his house and began participating in the training. (PX 18). Mr. Grzesik stated that since Petitioner was participating in computer training at Olive Harvey, training at Vocamotive would be duplicable and unnecessary. (PX 18).

Mr. Grzesik stated that after Petitioner completed computer training, Petitioner would be employable. (PX 18). Mr. Grzesik set forth that Petitioner would be employable in various types of employment including as a clerk, in customer service and as a security guard, telemarketer, maid, salesperson or cashier. (PX 18). Petitioner would be able to earn between $8.79 and $14.55 per hour. (PX 18).

Mr. Grzesik prepared an addendum report dated April 4, 2017. (PX 18). He noted that Petitioner was participating in Basic Computer Skills at Olive Harvey College. (PX 18). At the conclusion of the basic skills course, Petitioner will participate in the Intermediate Computer Skills course. (PX 18). Petitioner's attendance is being documented by the instructor at Olive Harvey. (PX 18).

Mr. Grzesik prepared a report dated April 11, 2017. (PX 18). He set forth that Petitioner completed the Applied Computer Basics course at Olive Harvey. (PX 18). Petitioner enrolled in the intermediate class. (PX 18).

2. ***Vocational Opinions of Vocamotive***

Petitioner was interviewed by Joseph Belmonte of Vocamotive at the request of Respondent. (PX 20). Petitioner was interviewed on December 21, 2016. (PX 20). Mr. Belmonte documented Petitioner's social background, education, work experience and work restrictions. (PX 20). Mr. Belmonte stated that Petitioner was unable to return to his pre-injury employment as a tree trimmer. (PX 20). Further, Petitioner would be unable to perform material handling occupations. (PX 20). Mr. Belmonte set forth that Petitioner was employable. (PX 20). Mr. Belmonte set forth that Petitioner could return to work as a cashier, fast food worker, ticket taker, retail person or in other similar jobs. (PX 20). He also noted that Petitioner may be employable as a supervisor or in lawn care. (PX 20). Mr. Belmonte discussed developing Petitioner's keyboarding skills. (PX 20). Mr. Belmonte set forth that Petitioner could earn $13 per hour. (PX 20). With the development of computer skills, Petitioner could earn between $13 and $17 per hour. (PX 20). Mr. Belmonte recommended that vocational services be offered to Petitioner. (PX 20). He recommended vocational testing, development of keyboarding skills and job seeking services. (PX 20). He completed a vocational rehabilitation plan consistent with his recommendations. (PX 20).

Mr. Belmonte prepared an additional report dated May 30, 2017. (PX 20). Vocational services were authorized for Petitioner. (PX 20). The report documents an email exchange with Petitioner's attorney about the appropriateness of attending computer classes at Vocamotive vs. Olive Harvey. (PX 20). Mr. Belmonte's file was placed on hold pending a resolution of the computer classes. (PX 20).

G. Post-Accident Employment

Respondent offered Petitioner a job within his restrictions as a watchman. Petitioner returned to work for Respondent as a watchman on March 16, 2019. In his position as a watchman, Petitioner is earning $22.92 per hour.

Petitioner testified regarding his new position as a watchman. He worked at Eugene Sawyer Water Purification Plant at 79th and Lake Shore Drive. Petitioner works from 11:00 am to 7:00 pm. He works from Friday until Wednesday. Petitioner sits in an office for 8 hours per day watching monitors. Petitioner works by himself in an office. He watches 16 cameras with monitors. The monitors are located in front of him. Petitioner checks in every hour. Petitioner walks around after he checks in. Petitioner does not perform any lifting in his position as a watchman.

H. Current Subjective Complaints

Petitioner testified that while working as a watchman, he experiences pain in his shoulders. He testified he experienced more pain in his left shoulder than his right shoulder. He experiences stiffness in his shoulders. The left shoulder stiffens up more than the right shoulder.

Petitioner testified that at home, he asks his wife to get items in the top cupboards. If Petitioner reaches for items in the top cupboards, he has to reach slowly and make sure that the object is not too heavy. Petitioner is able to reach to shoulder level; however, he experiences difficulty reaching above shoulder level. Petitioner uses ice for the bilateral shoulder condition.

Petitioner testified that since October 1, 2012, he has not sustained any new accidents or injuries involving his bilateral shoulders.

While Petitioner was unable to work, he received payment of temporary total disability benefits and maintenance benefits. The Parties agreed that there was no overpayment or underpayment of benefits. A print out of payments made by Respondent was admitted into evidence. (RX 2).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds:

Petitioner's current condition of ill-being in with respect to his bilateral shoulders including the bilateral infraspinatus and supraspinatus tears requiring surgery and the recurrent left shoulder rotator cuff tear, are causally connected to the work-related accident of October 1, 2012. The Arbitrator bases this opinion on Petitioner's credible and unrebutted testimony, the medical records and the persuasive medical opinions of Dr. Wolin. The Arbitrator also relies on the persuasive medical opinions of Respondent's Section 12 physician, Dr. Verma. The opinions of Dr. Wolin and Dr. Verma best comport with the evidence adduced. The Arbitrator accords little weight to the opinions of Dr. Troy, Respondent's Section 12 physician. *See: International Vermiculite Company v. Industrial Commission*, 77 Ill.2d 1, 394 N.E.2d 1166 (1979) (holding that the Commission can accord greater weight to the medical opinions of the petitioner's treating physicians). Dr. Troy's opinions do not comport with the evidence of record and fail to consider that Petitioner had no prior injuries to his shoulders, had no prior

medical treatment for his shoulders and was able to perform the physical activities of the Tree Trimmer II job with respect to his upper extremities until the injury of October 1, 2012.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator finds:

The Arbitrator concludes that as a result of the work-related accident of October 1, 2012, Petitioner sustained serious injuries to his bilateral shoulders resulting in the loss of use of the person as a whole to the extent of 50% because the injuries sustained by Petitioner resulted in the loss of his occupation pursuant to Section 8(d)2 of the Act/ The Arbitrator relies on Petitioner's credible testimony, the medical records admitted into evidence and the vocational opinions of Mr. Grzesik and Mr. Belmonte. The Arbitrator notes that Petitioner waived his right to receive benefits pursuant to Section 8(d)1. Accordingly, the Arbitrator awards benefits pursuant to Section 8(d)2 based on a loss of occupation.

A claimant is entitled to an award under Section 8(d)2 of the Illinois Workers' Compensation Act "if, as a result of the accident, the employee sustains serious and permanent injuries" which "partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity." 820 ILCS 305/8(d)2.

The Arbitrator's finding is consistent with the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider certain factors and criteria in assessing permanent partial disability, including, the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. After considering the factors, the Arbitrator finds that Petitioner is permanently partially disabled due to loss of occupation to the extent of 50% loss of use of the person as a whole. With respect to the five factors, the Arbitrator finds the following:

A. Level of Impairment under the AMA Guides

Neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. The Arbitrator finds that an impairment rating is not necessary based on the Appellate Court's holding in *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016). The court held that an AMA Impairment Rating is not required for the Arbitrator to award permanent partial disability benefits. *Id.* Accordingly, the Arbitrator accords this factor no weight in determining PPD.

B. Occupation of Petitioner

At the time of the work-related accident, Petitioner was employed as a Local 1001 laborer working as a Tree Trimmer. Petitioner was working with restrictions set forth as a result of the work-related accident of February 5, 2010. However, Petitioner was still employed by Respondent as a Tree Trimmer.

Petitioner testified that tree trimmers trimmed tree branches, stacked tree limbs and dragged tree lines. Petitioner climbed ladders and worked out of buckets. Petitioner lifted and carried between 5 and 75 pounds. On October 1, 2012, Petitioner was working as a tree trimmer with restrictions. Petitioner was sorting debris at the lumber yard. The restrictions then in place were no lifting more than 40 pounds to the waist and 20 pounds to the shoulder. Following the work-related accident of October 1, 2012, the work restrictions changed and limited Petitioner's ability to lift over his shoulders. Petitioner was not able to return to his employment as a tree trimmer based on those restrictions.

The Arbitrator finds that based on Petitioner's credible testimony, the medical records of Dr. Wolin, the FCE report and the opinions of Msrs. Grzesik and Belmonte, Petitioner is partially incapacitated from performing his pre-injury employment as a tree trimmer. The Arbitrator finds it significant that Petitioner's pre-injury employment, even with restrictions, was physically demanding. The Arbitrator further finds it significant that Petitioner is not able to perform his pre-injury job tasks based on the work restrictions following the work-related accident of October 1, 2012. The Arbitrator accords great weight to this factor in determining PPD.

C. Age of Petitioner

At the time of the accident, Petitioner was 56. At the time of the hearing, Petitioner was 63 years old. Mr. Belmonte set forth in his vocational report that Petitioner's age was advanced and that he was a mature worker. Petitioner's age would be a hindrance in finding additional work within his restrictions. Happily, he was able to be placed in another job working for Respondent. Further, the Arbitrator notes that Petitioner's ability to heal is limited and impaired due to age. Accordingly, the Arbitrator finds that his age increases Petitioner's disability. In support of this finding, the Arbitrator relies on the holding *Flexible Staffing Services v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151300WC (1st Dist. 2016) (holding that the Commission can make reasonable inferences from the medical evidence as it relates to how the claimant's age affects his disability). Therefore, Petitioner's age increased his disability and the Arbitrator accords great weight to this factor in determining PPD.

D. Future Earning Capacity

Petitioner has permanent work restrictions as a result of the work-related accident of October 1, 2012. The permanent restrictions were recommended by Dr. Wolin and based on the FCE. Further, Dr. Verma agreed that Petitioner would require permanent work restrictions. It is also clear that the work restrictions prevent Petitioner from returning to his pre-injury employment. Specifically, Petitioner's testimony and the opinions of Msrs. Grzesik and Belmonte establish that the job duties of a tree trimmer exceeded Petitioner's physical capabilities. Thus, it is undisputed that Petitioner was partially incapacitated from returning to his pre-injury employment.

The Arbitrator notes that Petitioner was working within restrictions related to his prior left knee injury when he sustained the work-related accident of October 1, 2012. However, the Arbitrator notes that Petitioner was working as a tree trimmer with restrictions following the first work-related accident of February 5, 2010. It was not until after the second work-related accident of October 1, 2012 that Petitioner changed occupations based on his restrictions. He was provided new restrictions regarding his ability to lift. The work accident of October 1, 2012 prevented him from returning to his pre-injury employment.

Respondent provided Petitioner with work within his restrictions as a watchman. The position of watchman is less physically demanding than that of a tree trimmer and within Petitioner's work restrictions. As a watchman, Petitioner earns $22.92 per hour. He testified that the current pay scale for his prior position is $37.76 per hour. It is clear that as a result of the work-related accident of October 1, 2012, Petitioner sustained a significant loss of earnings.

Further, both Mr. Grzesik and Mr. Belmonte agreed that Petitioner would be able to earn less in suitable employment than he would as a tree trimmer. Therefore, it is undisputed that the work-related accident of October 1, 2012 negatively impacted Petitioner's future earning capacity.

The Arbitrator accords this factor great weight in determining PPD.

E. Evidence of Disability Corroborated by the Treating Medical Records

The medical records of Dr. Wolin establish that Petitioner sustained a left and right rotator cuff tear involving the infraspinatus and supraspinatus tendons and requiring bilateral shoulder surgery. Further, Petitioner sustained a recurrent rotator cuff tear of the left shoulder requiring surgery. As a result of the work-related accident, Petitioner required permanent restrictions which partially incapacitated him from returning to his pre-injury employment. The diagnosis was corroborated by the diagnostic studies, operative reports and objective evidence.

The medical records of Dr. Wolin document Petitioner's subjective complaints. Petitioner also testified regarding his subjective complaints. Petitioner experiences soreness in his left shoulder and has pain with reaching and lifting activities. Petitioner's right shoulder also reached a plateau. Petitioner testified that while working as a watchman, he experiences pain in his shoulders. He testified that he experiences more pain in his left shoulder than his right shoulder. He also experiences stiffness in his shoulders. The left shoulder stiffens up more than the right shoulder. Petitioner testified that at home, he asks his wife to get items in the top cupboards. If Petitioner reaches for items in the top cupboards, he has to reach slowly and make sure that the object is not too heavy. Petitioner is able to reach to shoulder level; however, he experiences difficulty reaching above shoulder level.

The medical records also document Petitioner's objective findings. It is significant that Dr. Wolin released Petitioner to return to work with permanent restrictions and the permanent restrictions were confirmed by the valid FCE. As a result of the work-restrictions, Respondent provided Petitioner with accommodated work, as Petitioner was not able to perform many essential functions of his job duties as a tree trimmer. As a result of the work-related accident, Petitioner was partially incapacitated from performing his pre-injury employment. Based on the permanent work restrictions, Petitioner has sustained a loss of occupation as set forth in Section 8(d)2 of the Act. Petitioner's work restrictions are documented in the medical records of Dr. Wolin and the FCE.

The Arbitrator accords this factor great weight in determining PPD.

After considering the above factors and the entirety of the evidence, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered the 50% loss of use of the person as a whole, in accordance with Section 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

Carlos Castillo,
Petitioner,

20IWCC0566

vs. NO: 10 WC 37854

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 25, 2020, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 25 2020
o9/3/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0566

CASTILLO, CARLOS Case# **10WC037854**

Employee/Petitioner

12WC035416

CITY OF CHICAGO

Employer/Respondent

On 3/25/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.80% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1987 RUBIN LAW GROUP LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20 IWCC0566

20IWCC0566

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

Carlos Castillo
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **10 WC 037854**

Consolidated cases: **12 WC 035416**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **August 7, 2019**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

F. [ ] Is Petitioner's 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. [ ] Other _____

FINDINGS

On **2/5/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$63,752.00** ; the average weekly wage was **$1,226.00**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$99,239.21** for TTD, **$-0-** for TPD, **$13,661.76** for maintenance, and **$-0-** for other benefits, for a total credit of **$112,900.97**.

Respondent is entitled to a credit of **$-0-** under Section 8(j) of the Act.

ORDER

- **Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for a further period of 107.5 weeks, as provided in Section 8(e)12 of the Act, because the injuries sustained to the left knee caused a 50% loss of use of Petitioner's left leg.**

- Respondent shall pay Petitioner the compensation benefits that have accrued from **2/5/2010** through **8/7/2019** in a lump sum 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

March 18, 2020

Date

MAR 2 5 2020

INTRODUCTION

This case and a companion, consolidated, case (No. 12 WC 035416) were tried on August 7, 2019. On that date, the Arbitrator heard the testimony of Petitioner. The Arbitrator also received into evidence various exhibits, which included: 1) medical records; 2) operative report dated December 16, 2013; 3) FCE report dated June 6, 2014; 4) reports of Dr. Coe; 5) prior Arbitration Decisions; and 6) print out of payments made by Respondent.

The Arbitrator is considering the disputed issue of nature and extent of the injury in this case. Petitioner has elected to receive permanent partial disability benefits pursuant to Section 8(e)12 of the Act. He waived his right to recovery pursuant to Section 8(d)1.

Petitioner's testimony was credible and unrebutted. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were submitted into evidence at the time of the hearing.

The Arbitrator will issue separate decisions regarding the consolidated cases.

FINDINGS OF FACT

Petitioner was employed by Respondent as a Tree Trimmer in the Department of Streets and Sanitation, Bureau of Forestry. The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on February 5, 2010 and that his current condition of ill-being regarding his left knee is causally connected to the injury.

A. Previous Hearings

This case was tried pursuant to Section 19(b) on two previous occasions. The previous Arbitration Decisions were admitted into evidence. (PX 6-7). The findings of fact and testimony are incorporated into the instant case.

The case was tried before Arbitrator Brian Cronin on December 21, 2010. (PX 6). Arbitrator Cronin found that Petitioner's current condition of ill-being regarding his left knee was causally connected to the work-related accident of February 5, 2010. (PX 6). He awarded payment of temporary total disability benefits, payment of medical bills and found that Respondent was liable for payment for the physical therapy and brace recommended by Petitioner's treating physician, Dr. Wolin. (PX 6).

The case was tried again before Arbitrator Cronin on May 14, 2012, pursuant to Section 19(b). (PX 7). Arbitrator Cronin found that Petitioner's left knee condition was causally connected to the work-related accident of February 5, 2010. (PX 7). The Arbitrator awarded payment for the left total knee replacement recommended by Petitioner's treating physician, Dr. Gonzalez. (PX 7).

B. Background

Petitioner is 63 years old. He previously testified in connection with the injury he sustained to his left knee on two occasions. Petitioner was working for Respondent as a Tree Trimmer II. He was a member of the laborers union, Local 1001. As of February 5, 2010, Petitioner had worked for Respondent for 19 years as a tree trimmer.

Petitioner performed work for Respondent Monday through Friday. He worked 8 hours per day, 40 hours per week. Petitioner worked on residential homes. Petitioner trimmed tree branches, stacked tree limbs, dragged tree lines and removed stumps. Petitioner climbed ladders and worked out of buckets. Petitioner lifted and carried between 5 and 75 pounds.

Petitioner testified that his rate of pay as a union employee increases every 3 years. As of May 2019, the hourly scale for Local 1001 increased to $37.76 per hour.

C. Prior Medical Treatment

Petitioner testified that he had not received any medical treatment for his left knee prior to February 5, 2010.

D. Work-Related Accident of February 5, 2010

On February 5, 2010, Petitioner sustained an injury to his left knee. Petitioner twisted his left knee. The specific facts of the accident were summarized in the previous hearings and incorporated into the instant decision. (PX 6-7). On February 5, 2010, Petitioner was wearing snow cleats. (PX 6). As he was walking in the street with the snow cleats, he stepped on a piece of metal with his right foot, causing his right leg to slide out from under him. (PX 6). As his right leg slipped, he fell and twisted his left knee. (PX 6).

E. Medical Treatment

The medical records in connection with the medical treatment that Petitioner received prior to August 7, 2019 were admitted into evidence at the previous hearings. (PX 6-7). Petitioner summarized the medical treatment provided to him prior to August 7, 2019. Petitioner was initially treatment by Dr. Nelson. Dr. Nelson performed surgery to the left knee on May 10, 2010. After the surgery, Petitioner sought medical treatment with Dr. Wolin. The medical treatment, including physical therapy, recommended by Dr. Wolin, was the subject of the first 19(b) hearing. (PX 6). Following, the hearing, Petitioner underwent physical therapy. Dr. Wolin referred Petitioner to Dr. Gonzalez. Dr. Gonzalez recommended a total knee replacement. The recommendation for the total knee replacement was the subject of the second 19(b) hearing. (PX 7).

Following the hearing of May 14, 2012, Petitioner continued to receive medical treatment for his left knee. While Petitioner was receiving medical treatment for his left knee, he also received medical treatment for his bilateral shoulders as a result of the work-related accident of October 1, 2012. The Arbitrator addressesthe bilateral shoulder injuries in a separate decision, filed concurrently herewith.

Petitioner was examined by Dr. Gonzalez on December 13, 2013. (PX 1). Petitioner's left knee treatment was delayed due to the treatment he was receiving for the bilateral shoulders. X-rays revealed advanced osteoarthritis to the left knee and tricompartmental arthritis. (PX 1). Dr. Gonzalez set forth an assessment of injury to the

meniscus and subsequent worsening of the osteoarthritis in the left knee. (PX 1). He recommended surgery for the left knee. (PX 1).

Petitioner underwent the left total knee arthroplasty on December 16, 2013 at Weiss Memorial Hospital. (PX 2). The surgery was performed by Dr. Gonzalez. (PX 2). The post-operative diagnosis was left knee osteoarthritis. (PX 2).

Petitioner remained under the post-operative care of Dr. Gonzalez. (PX 1). Post-operative care included office visits and physical therapy. (PX 1). Following the surgery, Dr. Gonzalez recommended an ultrasound of the calf, which was negative. (PX 1). Petitioner was advised to remain off work. (PX 1). Petitioner had a slow recovery complicated by cellulitis and swelling of the calf. (PX 1).

On May 20, 2014, Dr. Gonzalez recommended an FCE. (PX 1). Petitioner underwent the FCE on June 6, 2014 at ATI. (PX 3). The FCE was valid. (PX 3). The FCE set forth that Petitioner could work at a medium physical demand level. (PX 3). He could lift 60.6 pounds from desk to chair; 25.8 pounds above the shoulders; and 60.6 from chair to floor; and carry up to 42 pounds. (PX 3). Petitioner complained of knee and shoulder pain during the assessment. (PX 3). His physical capabilities fell below his job requirements as a tree trimmer. (PX 3).

Following the FCE, Petitioner was examined by Dr. Gonzalez on June 17, 2014. (PX 1). Dr. Gonzalez noted that Petitioner had reached maximum medical improvement. (PX 1). Dr. Gonzalez set forth that Petitioner was capable of working at a medium physical demand level. (PX 1).

Petitioner was examined by Dr. Gonzalez on December 16, 2014. (PX 1). Dr. Gonzalez set forth that Petitioner could return to work with the restrictions of no crawling, no extended climbing and no lifting more than 50 pounds. (PX 1). He recommended that Petitioner follow up in one year. (PX 1). Petitioner had an annual examination with Dr. Gonzalez on October 6, 2015. (PX 1).

Petitioner was last examined by Dr. Gonzalez on January 10, 2017. (PX 1). Dr. Gonzalez noted that Petitioner had occasional pain in his left knee and difficulty kneeling due to sensitivity of the anterior knee. (PX 1). Dr.

Gonzalez documented that Petitioner had a knot on the anterior medial aspect of the knee. (PX 1). Dr. Gonzalez stated that if the knot become bigger, he would consider removing it. (PX 1). He recommended that Petitioner follow up in a year. (PX 1). Since January 10, 2017, Petitioner had not no further treatment with Dr. Gonzalez. Further, he has not scheduled an appointment with Dr. Gonzalez.

F. Medical Opinions of Dr. Jeffrey Coe

Petitioner was examined by Dr. Jeffery Coe at the request of his attorney, on September 26, 2017. (PX 4). Dr. Coe obtained a history of the accident from Petitioner. (PX 4). He also reviewed the medical records in connection with the work-related accident of February 5, 2010. (PX 4).

Dr. Coe documented Petitioner's subjective complaints. (PX 4). He set forth that Petitioner had pain in the front and inner border of the left knee made worse with descending stairs and squatting. (PX 4). Petitioner avoided squatting and kneeling when possible. (PX 4). Petitioner noted worsening of his left knee pain with weather change and cold weather. (PX 4). Petitioner had left knee stiffness and occasional swelling. (PX 4). He occasionally walked with a limp. (PX 4).

Dr. Coe performed a physical examination of Petitioner. (PX 4). With range of motion, on extension, Petitioner had 180 degrees on the right, 175 on the left, with normal being 180; and on flexion, 130 degrees on the right, 115 on the left, with normal being 130. (PX 4). Petitioner had slight left knee crepitus with range of motion testing. (PX 4). Petitioner had decreased muscle strength on the left with resisted extension. (PX 4).

Dr. Coe set forth that Petitioner sustained a twisting injury to his left knee while working on February 5, 2010. (PX 4). The accident caused internal derangement of the left knee with a medial meniscus tear and aggravation of preexisting asymptomatic arthritis. (PX 4). Petitioner reached maximum medical improvement and was released to return to work with restrictions at a medium physical demand level with limited squatting, kneeling, crawling and climbing. (PX 4). Petitioner had a slight gait abnormality and left knee stiffness. (PX 4). Petitioner had decreased sensation in the distal portion of the left knee with tingling dysesthesias and decreased range of

motion of the left knee with flexion and extension. (PX 4). Petitioner also had atrophy of the left knee, swelling of the left knee and mild residual weakness. (PX 4).

Dr. Coe opined that there was a causal connection between the work-related accident of February 5, 2010 and the left knee symptoms and state of impairment. (PX 4). Further, Dr. Coe stated that the accident of February 5, 2010 caused permanent disability to the left lower extremity. (PX 4). Dr. Coe set forth that Petitioner required permanent restrictions due to his left knee condition, including lifting at the medium physical demand level and avoiding activities which required kneeling, squatting, crawling, climbing and descending stairs or ladders. (PX 4). Dr. Coe also stated that Petitioner would require future medical treatment, including follow up appointments with his treating surgeon, Dr. Gonzalez, on an annual basis. (PX 4).

Dr. Coe prepared an addendum report dated October 16, 2017. (PX 5). Dr. Coe opined that as a result of the work-related accident, Petitioner was unable to return to work in his pre-injury employment as a tree trimmer for Respondent. (PX 4). He stated that Petitioner required permanent work restrictions. (PX 4).

G. Post-Accident Employment

Petitioner was released to return to work by Dr. Gonzalez with permanent restrictions. Petitioner was also provided permanent restrictions in connection with case number 12 WC 35416. Respondent provided Petitioner with vocational services in connection with case number 12 WC 35416. As a result of the permanent work restrictions, Petitioner was not able to return to his employment as a tree trimmer.

Petitioner was offered employment within his restrictions as a watchman by Respondent. Petitioner returned to work for Respondent as a watchman. He returned to work for Respondent on March 16, 2019. In his position as a watchman, Petitioner was earning $22.92 per hour.

Petitioner testified regarding his new position as a watchman. He works at the Eugene Sawyer Water Purification Plant at 79th and Lake Shore Drive. Petitioner works from 11:00 am to 7:00 pm. He works from Friday until Wednesday. Petitioner sits in an office for 8 hours per day watching monitors. Petitioner works by

himself in an office. He watches 16 cameras with monitors. The monitors are located in front of him. Petitioner checks in every hour. Petitioner gets up to walk and stretch his knee after he checks in. Petitioner does not perform any lifting in his position as a watchman.

Petitioner testified that he was paid temporary total disability benefits while he was unable to return to work. The parties agree that all temporary total disability benefits have been paid. A print out of payments made by Respondent was admitted into evidence. (RX 1).

H. Current Subjective Complaints

Petitioner testified that while working as a watchman, he stretches his left knee out. He experiences pain in his left knee all the time. Petitioner also walks with a limp. Petitioner testified that he sits for approximately 40 minutes. He calls in every hour while working. Once he calls in, he walks around for approximately 5 to 10 minutes. Petitioner walks approximately half a block to work. He testified that he limps while he walks. He also experiences pain in his left leg when he walks up ramps. Petitioner has difficulty walking up and down stairs.

When Petitioner is not working, he also experiences pain in his left knee. He ices his left knee when he is sore. Petitioner does not kneel or squat because it is hard for him. He kneels on one knee only. Petitioner has trouble standing up. He has to reach for something to pull himself up. Prior to the work-related accident of February 5, 2010, Petitioner was able to bend, squat and kneel. Petitioner testified that his left knee is always numb. Petitioner testified that the top of his left knee around the patella and the anterior portion of the knee hurts when he touches it to the ground. Petitioner uses his right knee to protect his left knee when kneeling.

Petitioner testified that prior to February 5, 2010 he rode a bike. However, after the accident, he was not able to ride a bike. He could not pedal the bike and his knee clicked. Petitioner's left knee also became sore after riding the bike for a while. Petitioner used to walk a lot prior to the work-related accident of February 5, 2010. Petitioner testified that since the accident, he tried to walk. He would go to the park. However, he cannot walk far before he begins to experience pain after a while and he has to stop walking. Since the accident, Petitioner

has gained around 40 pounds because he has not been able to walk. Petitioner testified that he walks about 4 or 5 blocks before he starts to experience pain in his left knee. Petitioner uses ice for his left knee.

Petitioner testified that he has not sustained any new accidents or injuring involving his left knee since February 5, 2010.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

In support of the Arbitrator's decision relating to "L," nature and extent of the injury, the Arbitrator finds:

The Arbitrator finds that Petitioner sustained a permanent injury to the left knee to the extent of 50% loss of use of the left leg as a result of the work-related accident of February 5, 2010. In support of this conclusion, the Arbitrator finds Petitioner's testimony to be credible, unrebutted and corroborated by the medical records admitted into evidence. The Arbitrator also relies on the medical records of Dr. Gonzalez, the operative report, the FCE and the medical opinion of Dr. Coe.

The Arbitrator notes that Petitioner sustained a work-related accident on February 5, 2010. Since the accident occurred prior to September 1, 2011, the five factors set forth in Section 8.1(b) of the Act do not apply.

The Arbitrator finds that Petitioner sustained internal derangement of the left knee with a medial meniscus tear and aggravation of preexisting asymptomatic arthritis. As a result of the work-related accident, Petitioner underwent two surgeries, including a total knee replacement performed by Dr. Gonzalez on December 16, 2013. The diagnosis was confirmed by the operative report and diagnostic studies.

Petitioner has ongoing subjective complaints in connection with his left knee condition. The subjective complaints were documented in the medical records of Dr. Gonzalez and Dr. Coe and confirmed by Petitioner's testimony. Petitioner testified that he experiences pain his left knee all of the time. Petitioner walks with a limp. He also experiences pain in his left leg when he walks up ramps. Petitioner has difficulty walking up and down stairs. Petitioner does not kneel or squat. Petitioner testified that his left knee is always numb. Petitioner testified that the top of his left knee around the patella and the anterior portion of the knee hurts when he touches it to the ground.

Dr. Gonzalez documented that Petitioner had occasional pain in his left knee and difficulty kneeling due to sensitivity of the anterior knee. Dr. Coe documented that Petitioner had pain in the front and inner border of the left knee made worse with descending stairs and squatting. Petitioner avoided squatting and kneeling. Petitioner noted worsening of his left knee pain with weather change and cold weather. Petitioner had left knee stiffness and occasional swelling. He occasionally walked with a limp.

Petitioner had objective deficits in the left knee. Dr. Coe documented that Petitioner had slight gait abnormality and left knee stiffness. Petitioner had decreased sensation in the distal portion of the left knee with tingling dysesthesias and decreased range of motion of the left knee with flexion and extension. Petitioner also had atrophy of the left knee, swelling of the left knee and mild residual weakness.

Further, as a result of the work-related accident of February 5, 2010, Petitioner had permanent work restrictions. The permanent restrictions were documented in the FCE and set forth by Dr. Gonzalez. Additionally,

Dr. Coe agreed with the work restrictions of Dr. Gonzalez. Petitioner was released to return to work with the permanent restrictions at a medium physical demand level with limitated squatting, kneeling, crawling and climbing. Dr. Coe opined that as a result of the work-related accident, Petitioner was unable to return to work in the full capacity of a tree trimmer for Respondent. Petitioner was able to return to work with accommodations as a tree trimmer for Respondent. Although, Petitioner was released to return to work with permanent restrictions, he waived recovery under Section 8(d)1. However, the Arbitrator accords great weight to the fact that Petitioner has permanent work restrictions as a result of the work-related accident of February 5, 2010.

Based on Petitioner's significant subjective complaints, objective deficits and permanent restrictions confirmed by the FCE, which prevents Petitioner from returning to his pre-injury employment, the Arbitrator finds that as a result of the injury Petitioner suffered, he sustained a permanent injury to the left leg to the extent of 50% loss of use thereof.

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 18 INC 00121 - 18WC 30062
v.	)	
The Cooler	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondent, as this matter has settled.

L. Elizabeth Coppoletti

Commissioner L. Elizabeth Coppoletti

Dated: 9/28/2020

STATE OF ILLINOIS	)
	) SS.
COUNTY OF COOK	)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN SITAR,

Petitioner,

vs. NO: 18 WC 016848

CITY OF CHICAGO,

Respondent.

20IWCC0567

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2020 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $790.64 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused a 25% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner compensation that has accrued from July 9, 2019 through December 11, 2019 and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

20 I W CC0567

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 28 2020

D. Douglas McCarthy

LEC/cak

D: 9/9/2020

Stephen Mathis

43

DISSENT

I, respectfully, dissent. I would modify the Decision of the Arbitrator and find Petitioner sustained permanent disability of 10% loss use of the person as a whole pursuant to Section 8(a) of the Act. I arrive at my decision by utilizing a different analysis of the relevance and weight of the factors contained in Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014).

Section 8.1b(b)(i) – level of impairment

Neither party submitted a Section 8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), I assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner sustained injury while performing his duties as a laborer in the transportation department for Respondent. Following his injury, Petitioner returned to work for Respondent. Petitioner testified he is able to perform most aspects of his job but experiences pain when lifting heavy objects. T. 18. As Petitioner's occupation requires him to lift heavy objects, I find this factor weighs in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 52 years old on the date of accident. I observe Petitioner is relatively older, and as such, has a decreased work-life expectation. I find this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner provided no testimony regarding his future earning capacity. As such, I afford no weight to this factor.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Following his injury, on December 12, 2018, Petitioner underwent surgery to repair his rotator cuff and his biceps tendon. On June 21, 2019, Dr. Heller evaluated Petitioner for a final time at which time he noted an "excellent outcome six months s/p right shoulder arthroscopic cuff repair." Petitioner presented with a chronic biceps deformity; "otherwise no selling, erythema, ecchymosis, or deformity. He has excellent ROM with forward flexion and abduction beyond 160 degrees. Mild pain complaints. No crepitus." PX1. At trial Petitioner complained of pain with heavy lifting and a little lose of strength. T. 18. Given the excellent resulted reached as found by Dr. Heller, I find this factor weighs in favor of a decreased permanence.

I would award benefits of 10% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SITAR, BRIAN
Employee/Petitioner

Case# **18WC016848**

CITY OF CHICAGO
Employer/Respondent

20 I W C C 0 5 6 7

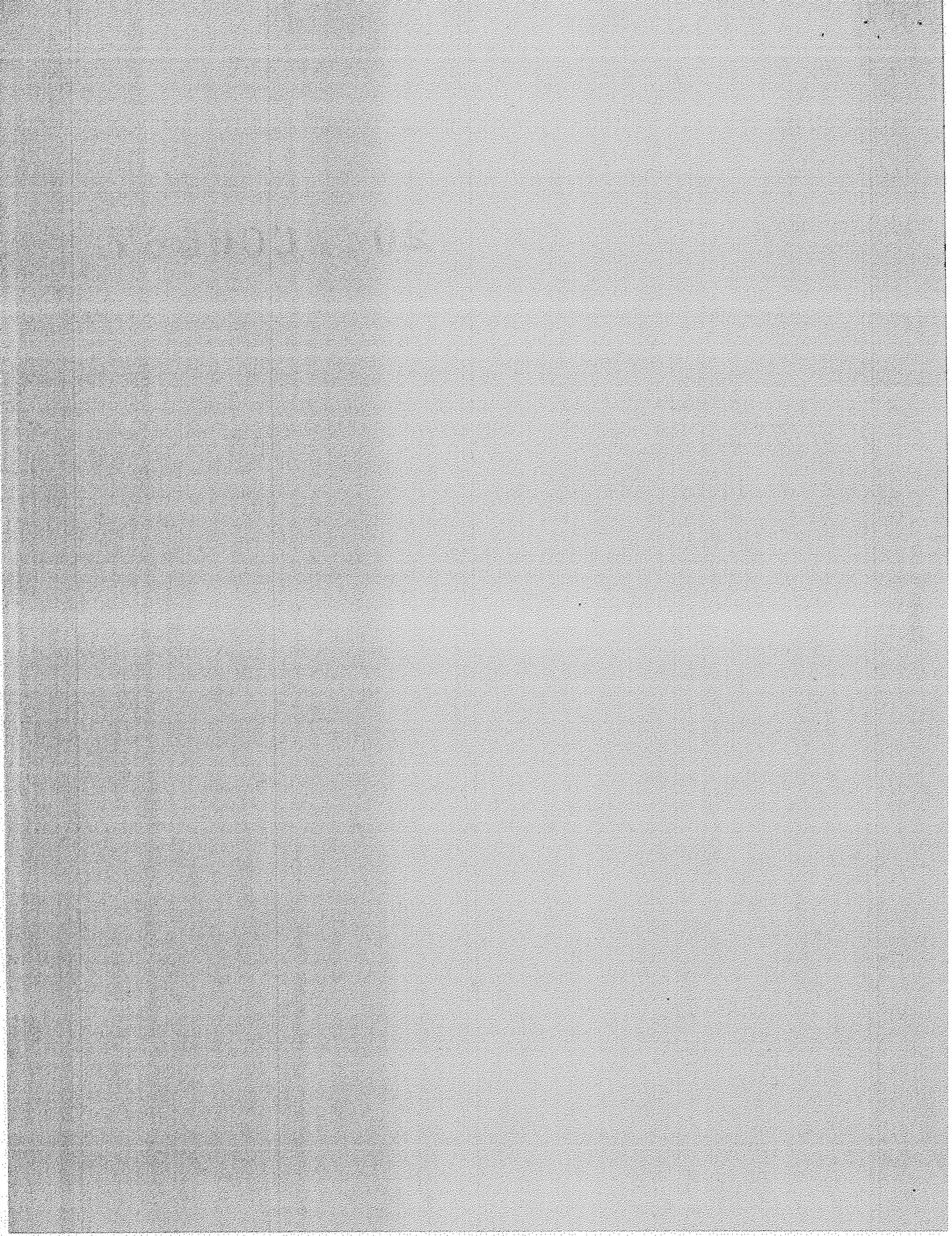
On 4/9/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

0010 CITY OF CHICAGO
MATTHEW LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602



STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Brian Sitar
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **18** WC **16848**

Consolidated cases: _____

20 I W CC0567

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 **Charles Watts**, Arbitrator of the Commission, in the city of **Chicago**, on **12/11/19**. By stipulation, the parties agree:

On the date of accident, **5/17/18**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**85,433.86**, and the average weekly wage was $**1,637.74**.

At the time of injury, Petitioner was **52** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**64,338.91** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $**790.64**/week for a further period of **125** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **25 % loss of use of the person**.

Respondent shall pay Petitioner compensation that has accrued from **7/9/19** through **December 11, 2019**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

April 6, 2020
Date

APR 9 - 2020

Findings of Fact

The facts of this case are undisputed and have been stipulated to. On the date of accident, petitioner was working for respondent's department of transportation. As he was using a shovel to move concrete down a chute he experienced immediate pain right upper arm. As directed by the employer, he reported to MercyWorks. There, he was immediately referred to a preferred orthopedic surgeon, Dr. Heller.

Following an MRI of the right shoulder, Dr. Heller met with petitioner on June 15, 2018 and diagnosed a high grade partial thickness rotator cuff tear and longhead biceps tendon rupture. He recommended immediate surgery and expected a 4-6 month recovery.

On July 9, 2018, Dr. Heller advised petitioner that a peer review process initiated by the employer recommended three months of therapy prior to surgery. Dr. Heller disagreed with this but complied. By August 13, 2018, Dr. Heller noted that therapy had increased petitioner's pain and declared it a failure. He again requested surgical authorization.

Unfortunately for petitioner, he did not receive surgical authorization for approximately three more months. On December 12, 2018, Dr. Heller performed arthroscopic repair of the right rotator cuff, subacromial decompression and resection of the long head biceps tendon. He noted in the surgical report that he observed a complete rupture in the biceps tendon and full thickness rupture in the rotator cuff.

Post-surgery, petitioner was enrolled in physical therapy. As of April 5, 2019, it was evident that petitioner would have a visible biceps deformity. Dr. Heller intimated that the rupture was not amenable to a tenodesis due to the delay in proceeding with surgery. It was expected that this would slow his recovery. Petitioner's last visit with Dr. Heller was on June 21, 2019. At that time, Dr. Heller released petitioner to his pre-injury job with a notation of the chronic biceps deformity.

Petitioner testified that he does experience strength issues with his right arm and pain when lifting and pulling. The arbitrator viewed the deformity noting an obvious and nearly grotesque muscle bulge near the right shoulder.

Conclusions of Law

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a laborer in the transportation department 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 petitioner's stated difficulties with some aspects of his employment. Because of the heavy duty nature of his employment, the Arbitrator therefore gives *greater weight* to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 52 years old at the time of the accident. Because of his expected 15 plus years of work expected, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no testimony on this issue. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes petitioner's deformity and strength issues. The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the person pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Fong,

Petitioner,

20 I W CC0568

vs.

NO: 16 WC 22435

Park District Risk Managment Agency: Hoffman Estates Park District,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 27, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $402.12 per week for a period of 66.8 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 40% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner compensation that has accrued from July 2, 2015 through August 8, 2018 and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties is denied as set forth in the Arbitrator's conclusions of law attached herein.

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 8 2020

LEC/cak

D: 8/26/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FONG, GARY Case# **16WC022435**
Employee/Petitioner

PARK DISTRICT RISK MANAGEMENT AGENCY;
HOFFMAN ESTATES PAK DISTRICT
Employer/Respondent

20 IWCC0568

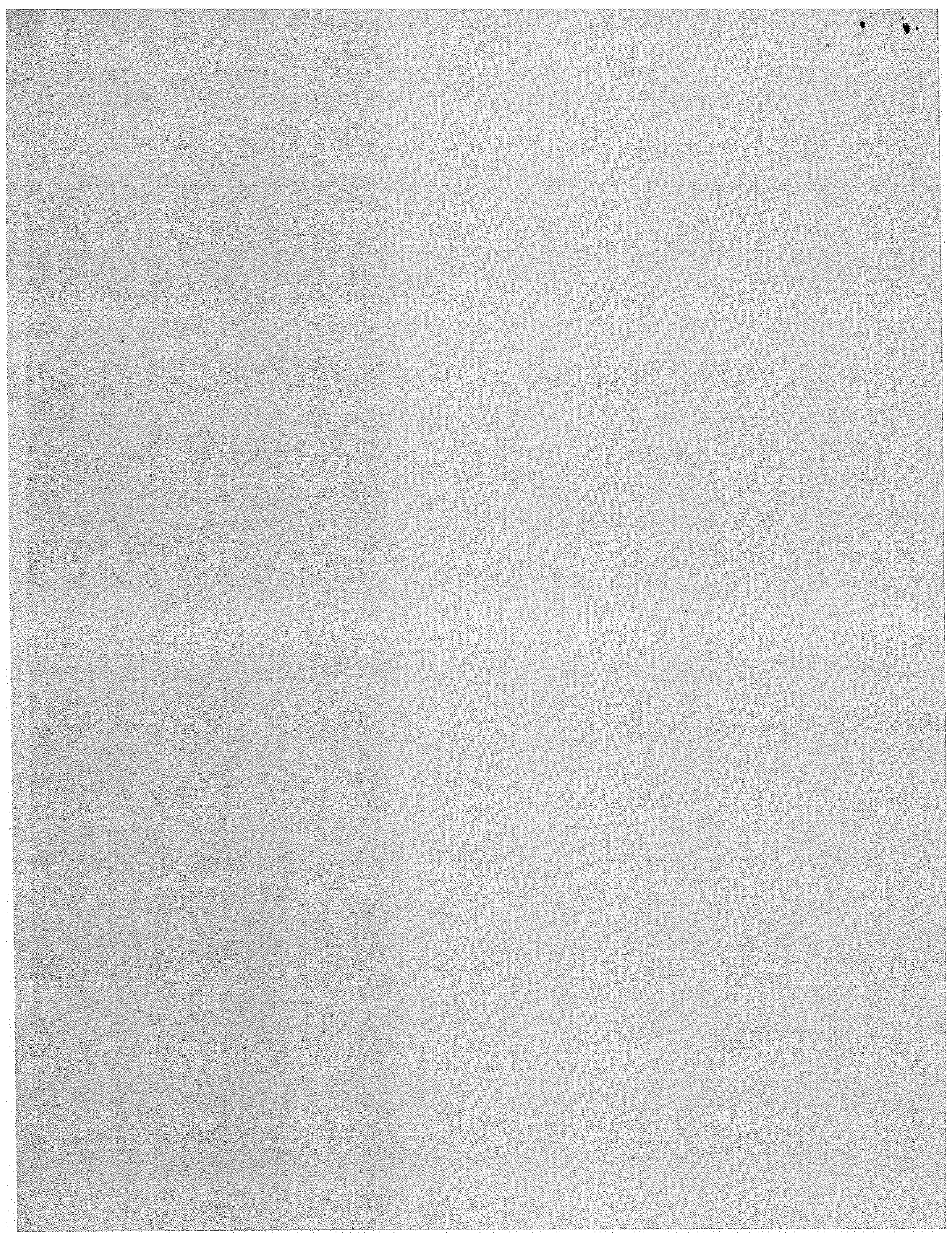
On 11/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5625 GRAUER & KRIEGEL LLC
ANDREW J KRIEGEL
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

0766 HENNESSY & ROACH PC
JILL M KASTNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603



20IWCC0568

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

Gary Fong
Employee/Petitioner

Case # **16 WC 22435**

v.

Consolidated cases:

Park District Risk Management Agency; Hoffman Estates Park District
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 Soto, Arbitrator of the Commission, in the city of **Chicago**, on **August 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. [ ] 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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **July 2, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $35,023.56; the average weekly wage was $673.53.

On the date of accident, Petitioner was **39** years of age, *married* with 2 dependent children.

Petitioner *has* received all reasonable and necessary medical services.

The parties stipulated at trial that all TTD/TPD and medical benefits had been properly satisfied.

ORDER

Respondent shall pay to Petitioner 66.8 weeks of compensation, at a PPD rate of $404.12, representing 40% loss of use of the right foot per Section 8(e) of the Act, as set forth in the Conclusions of Law attached herein;

Petitioner's request for penalties is denied as set forth in the Conclusions of Law attached herein.

Respondent shall pay Petitioner compensation that has accrued from July 2, 2015 through August 8, 2018 and shall pay the remainder of the award, in 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 11/27/2018 Date

NOV 27 2018

Procedural History

This matter was tried on August 8, 2018 before Arbitrator Frank Soto. The disputed issues are whether Petitioner's current condition of ill-being is causally connected to his injury and the nature and extent of Petitioner's injury. The parties stipulated that all medical bills had been satisfied and there were no issues regarding TTD benefits. (Arb. Ex. #1). Petitioner filed a petition for penalties and attorney's fees pursuant to Sections 19(k), 19(l) and 16 of the Act. (PX 8).

Findings of Fact

On July 2, 2015, Petitioner was employed as a facilities supervisor at the Triphahn Center. (T10). According to Petitioner's testimony, his job duties included keeping up the facility, the front desk staff, custodial staff, upkeep of the outside of the facility, room set ups for parties and room rentals. (T11). On that date, Petitioner inspecting the outside of the facility when his foot slid on black moss causing an injury to his right ankle. He felt a pop and radioed for help. (T12-13). Petitioner was taken to the Emergency Room at St. Alexius Medical Center and x-rays were taken of his right ankle which showed a fracture of the distal right tibia extending through the posterior malleolus and involving the medial malleolus with some displacement as well as a posterior talotibial dislocation. (PX1).

Petitioner then began a course of treatment with Dr. O'Hara at Barrington Orthopedic Specialists on July 6, 2015. (T16). On that date, Dr. O'Hara recommended surgery. Petitioner underwent surgery on July 8, 2015 with Dr. O'Hara. The post-operative diagnosis was a right ankle fracture with right ankle syndesmosis disruption. Dr. O'Hara performed an open reduction, internal fixation, medial malleolus on the right with open reduction internal fixation, ankle syndesmosis, right. (PX5). Petitioner underwent screw removal of the syndesmotic screw of the right ankle on August 28, 2015 and on February 10, 2016 the remaining hardware was removed by Dr. O'Hara. (PX5).

Petitioner received post-operative therapy and continued treatment with Dr. O'Hara. He was seen in follow up on February 29, 2016 complaining of pain on the right side with symptoms occurring occasionally but were aggravated by daily activities and prolonged walking. Following a physical examination, Dr. O'Hara placed Petitioner at MMI and he returned to work without restrictions and follow up as needed. (PX5; RX1).

After being release from care, Petitioner had continued complaints and he returned to Dr. O'Hare on June 29, 2016. Petitioner was given an injection into his right ankle. (T32). Petitioner followed up with Dr. O'Hare, on July 22, 2016, complaining of pain on the right side after prolonged walking. (PX5; RX2). Dr. O'Hara's records indicate that Petitioner's right ankle strength was normal with normal active and passive range of motion. Dr. O'Hare believed Petitioner's residual discomfort would dissipate and he was advised to return as needed. Petitioner was released to returned to work full duty and was placed at MMI. (PX5; RX2).

Petitioner testified that July 22, 2016 was the last time he was seen by a doctor about his right ankle and nothing had been recommended or prescribed by any treating physician. (T34-35). Petitioner testified that he was not taking any prescription medication for his right ankle and was currently making more money, per hour, than he was prior to the injury. (T35). Petitioner further testified that he experiences swelling and discomfort after sitting too long or walking too much. (T21). Petitioner also testified that he experiences stiffness after sitting at his desk for more than an hour, so he tries to get up at least once an hour and walk around. (T21-22).

Petitioner testified that he attempted to see Dr. O'Hara due to about a year before the trial but that the appointment was not approved. Petitioner testified that he has not resumed ice skating since his accident, takes Ibuprofen for pain, and uses an ankle brace for those days he intends to be on his feet for an extended amount of time. (T24-26). Petitioner testified that he hired a lawn service because he experiences pain after mowing the lawn. (T27). On cross-examination, Petitioner agreed that there were no medical restrictions keeping him from performing this job duties and the activities he no longer does. Petitioner testified that he has not seen a doctor since July 22, 2016.

Petitioner called his wife, Kathryn Fong, to testify on his behalf. Kathryn Fong testified that following a day at work she observed Petitioner's ankle to be swollen "at least a couple times a week" and that Petitioner does not ice his ankle every night. (T53-54).

The Respondent called Eric Leninger to testify on behalf of the Respondent. Eric Leninger testified that he is employed as the Superintendent of HR and Risk Management for the Park District. Eric Leninger testified that his job duties involves the administration

of HR related items, FMLA leave, reviewing accident/injury reports and communicating with PDRMA, who administrates claims. (T56-58). Eric Leninger further testified that Petitioner recently received a job promotion and he noticed that Petitioner was able to move offices, carry personal items and boxes, without any problem. Eric Lenninger also testified that Petitioner has never requested a job accommodation or expressed concerns that is unable to perform his job due to any medical restrictions involving right ankle. (T62). Eric Leninger testified that during the last 12 months he has not observed Petitioner limping and he had not received any complaints, from Petitioner, regarding his right ankle over the past 18 months. (T63-64). Eric Leninger also testified that Petitioner did not request assistance securing a follow up appointment with his treating doctor nor has Petitioner called in sick due to right ankle pain. (T66).

Dr. Michael Bryan Neal testified via evidence deposition on February 2, 2018. (RX3). Dr. Neal examined Petitioner pursuant to Section 12 of the Act. Dr. Neal testified that Petitioner reached maximum medical improvement because Petitioner was released from care by his surgeon. (RX3). On physical examination, Dr. Neal noted that Petitioner was able to get up and off the examination table and walk down the office hallway in a normal fashion. Dr. Neal also noted that Petitioner was able to walk up and down the office hallway twice, approximately 15 to 18 feet, and pivot at the end of the hallway without any pain. Dr. Neal further noted that Petitioner could walk on his toes and heels and could stand on each foot separately. (RX3). X-rays taken at the time of examination showed the medial malleolus fracture had completely healed and there was no evidence of any distal fibula fracture and it did not appear as if Petitioner had one. Dr. Neal noted the syndesmosis appeared reduced, but, Dr. Neal Petitioner also noted an irregularity between the medial malleolus and medial aspect of the talus which could be consistent with a subtle element of degenerative change. Dr. Neal performed an AMA rating giving an impairment of 13% of the lower extremity. (RX 3).

The Arbitrator found the testimony of Petitioner and all the witnesses to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law as 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).

With Respect to Issue (F) Whether Petitioner's Current Condition of Ill-Being Is Causally Connected To His Injury, The Arbitrator Finds As Follows:

An accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 797 N.E.2d 665, 672 (2003). Employers are to take their employees as they find them. *A.C.&S v. Industrial Commission*, 710 N.E.2d 8347 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (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 credible evidence that Petitioner's current condition is causally connected to his work injury of July 2, 2015, as set forth more fully below.

Petitioner testified as to a slip and fall on July 2, 2015 when he slipped on a mossy substance on the sidewalk while performing a facility check. He reported the incident immediately and was taken by ambulance to St. Alexius Medical Center where he underwent x-rays of his right ankle. The medical records support Petitioner underwent surgery and was subsequently placed at MMI and released from care. He testified consistent with ongoing complaints similar in nature to those complaints throughout his course of treatment.

With Respect to Issue (L), The Nature And Extend Of Petitioner's Injury, The Arbitrator Finds As Follows:

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability ("PPD"), for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of

impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:
- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

With regard to subsection (i) of Section 8.1b(b), the Arbitrator notes that an AMA rating was submitted and performed by Dr. Neal. Dr. Neal found an impairment of 13% of the left lower extremity. The Arbitrator gives some weight to this factor.

With regard to paragraph (ii) of Section 8.1(b) of the Act, the occupation of the employee. At the time of his injury, Petitioner's occupation was facilities supervisor and his job duties included overseeing the custodial staff and making sure the building and outside grounds are clean. Petitioner is also responsible for overseeing room setups for parties and front desk. The facilities include two (2) NHL-size ice rinks, gymnasium, eight (8) preschool rooms, fitness center and locker rooms. At the time of his injury, Petitioner was walking around the outside inspecting the facility. Petitioner was subsequently promoted to Facility and Ice Operation manger which includes overseeing the ice operations and hockey programs. Petitioner returned to work without restrictions and he was able to perform his job duties without the need for additional medical treatment or accommodations. Petitioner does wear a brace on occasion. The Arbitrator gives some weight to this factor.

With regard to paragraph (iii) of Section 8.1(b) of the Act, the age of the employee at the time of the injury. Petitioner was 39 years old at the time his injury. Petitioner is relatively young and will need to live with the residual effects of his injury for the rest of his work life expectancy. Petitioner testified that he experiences swelling and pain if he is on his feet for long periods of time. Petitioner also experiences problems if he sits too necessitates the need to walk around during the day. The Arbitrator gives significant weight to this factor.

With regard to paragraph (iv) of Section 8.1(b) of the Act, the employee's future earning capacity. Petitioner testified that he was promoted and is earning more money than he was prior to his injury. Petitioner did not proffer any testimony indicating that his future earning capacity will be diminished or compromised in the future due to his injury. The Arbitrator gives this factor minimal weight.

With regard to paragraph (v) of Section 8.1(b) of the Act, evidence of disability corroborated by medical records. Petitioner testified to ongoing subjective complaints of pain and swelling to his right ankle. Petitioner's treating physician and physician, who performed the IME, noted that Petitioner had normal strength and passive and active range of motion. Petitioner was released to return to work without restrictions. Petitioner testified that July 22, 2016 was the last time saw his doctor and no treatment or prescriptions was recommend. (T34-35). The medical records confirm that all hardware had been removed. The x-rays reviewed by Dr. Neal, who performed the Section 12 examination, showed a completely healed distal fibula fracture with some evidence of degenerative changes. Petitioner testified to ongoing swelling and pain depending upon his activity levels. Petitioner's wife testified to her observations, which the Arbitrator finds, were consistent with Petitioner's testimony. Dr. Neal diagnosed residual right ankle pain with ankle and subtalar joint stiffness. Dr. Neal measured Petitioner's left and right feet and calf diameters. The measurements at these various locations showed that Petitioner's right foot and calf were smaller than for his left foot and calf. The Arbitrator gives this factor great weight.

Based on the above factors and the record taken as a whole, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 40% loss of use the right foot pursuant to Section 8(e) of the Act.

With Respect To Issue (M), Whether Petitioner Is Entitled To Penalties And Attorney's Fees Pursuant To Sections 19(k), 19(l) And 16, The Arbitrator Finds As Follows:

The Petitioner seeks penalties claiming that Respondent unreasonable and vexatiously delayed payment and approval of benefits and medical treatment. The Arbitrator notes that the parties stipulated that all medical bills had TTD benefits had been paid by the Respondent. Petitioner was released from care, placed at MMI by his treating

physician and failed to proffer collaborating evidence that Petitioner's treatment was denied, and that the denial was unreasonable or vexatious. On cross examination Petitioner testified that nothing had been prescribed by any doctor. Eric Leninger, the Superintendent of HR and Risk Management for Respondent, testified that Petitioner never contacted him about medical treatment that was not approved or requested his assistance for obtaining treatment that was not approved. The Arbitrator finds that Petitioner failed to meet his burden of proof and, as such, Petitioner's Petition for Penalties 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 WILL)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANET THOMAS,

Petitioner,

vs. NO: 11 WC 21092

STATE OF ILLINOIS, DEPARTMENT OF HUMAN SERVICES,

Respondent.

20 I W CC0569

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Permanent Disability

The Commission agrees with the Arbitrator that Petitioner failed to prove permanent total disability. However, we view the extent of Petitioner's permanent partial disability differently. The Commission emphasizes Petitioner's injury resulted in significant restrictions. Specifically, Petitioner is permanently limited to the Light to Medium Physical Demand Level with maximum lifting capabilities of 25.8 pounds above shoulder or chair to floor, and 41.2 pounds desk to chair, all on an occasional basis; maximum carrying capacity of 22 pounds occasionally; sitting tolerance of six hours per workday subject to 60 minute maximum duration; and standing tolerance of three to four hours per workday subject to 30 minute maximum duration. These restrictions preclude Petitioner from returning to her pre-injury employment. Further, she is a relatively young person with a long work-life remaining. Having weighed the evidence, the Commission finds Petitioner sustained a 32.5% loss of use of the person as a whole under Section 8(d)2.

20IWCC0569

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 3, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 5 2/7 weeks, representing August 18, 2014 through September 23, 2014, as provided in §8(b) of the Act. Respondent shall have credit for undisputed TTD benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses of $33,986.58 (Hinsdale Orthopedics); $3,637.00 (Allied Anesthesiology); $15,433.00 (Pain and Spine); $3,287.37 (Pain and Spine Institute); $529.00 (Jackson Medical Center); $3,431.03 (St. Joseph's Hospital); and $850.00 (Silver Cross Hospital) pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent shall be given a credit for medical benefits that have already been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 162.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 32.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: SEP 28 2020

LEC/mck

O: 8/5/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

NOTICE OF ARBITRATOR DECISION

THOMAS, JANET
Employee/Petitioner

Case# **11WC021092**

ST OF IL-DEPT OF HUMAN SERVICES
Employer/Respondent

20IWCC0569

On 7/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 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:

3019 LAW OFFICE OF BRIAN MORROW
63 W JEFFERSON ST
SUITE 201
JOLIET, IL 60432

6149 ASSISTANT ATTORNEY GENERAL
DANIELLE CURTISS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

JUL 3 - 2018

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

Janet Thomas
Employee/Petitioner

Case # **11** WC **21092**

v.

State of Illinois- Department of Human Services
Employer/Respondent

20 I W CC0569

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 7, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [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 **May 15, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* 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 $**12,527.82**; the average weekly wage was $**351.92**.

On the date of accident, Petitioner was **44** 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 $**34,152.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**34,152.72**.

Respondent is entitled to a credit of $**91,311.79** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**253.00**/week for **5 2/7 weeks.** weeks, commencing **August 18, 2014** through **September 23, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$33,986.58** to Hinsdale Orthopedics, **$3,637.00** to Allied Anesthesiology, **$15,433.00** to Pain and Spine, **$3,287.37** to Pain and Spine Institute, **$529.00** to Jackson Medical Center, **$3,431.03** to St. Joseph's Hospital, and **$850.00** to Silver Cross Hospital, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**253.00**/week for **125** weeks, because the injuries sustained caused the **25%** 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.

Arbitrator Anthony C. Erbacci

June 29, 2018
Date

JUL 3 - 2018

FACTS:

Petitioner testified that she was employed by the Illinois Department of Human Services ("IDHS") as a personal assistant ("PA"), where she worked between the years of 2007 or 2008 to 2011. In this role, Petitioner was responsible for assisting elderly and/or disabled individuals ("clients") with daily living. Some of her job duties included: bathing, feeding, administering medicine, and changing diapers if needed.

Petitioner testified that she initially heard about the position through a neighbor whose daughter was disabled and required medical assistance. She went into IDHS and applied for the PA position at the front desk with Pat McGowan. Petitioner did not have any education or training prior to getting hired at IDHS.

Upon being hired at IDHS, Petitioner underwent a mandatory certification and training program and was certified by the Respondent. Petitioner found the first client on her own; however, after that, IDHS asked her if she was available to care for additional clients throughout her employment.

When Petitioner received a new client, Petitioner would receive a formal treatment plan from IDHS, which was given to her by her supervisor, Pat McGowan. The formal treatment plan would detail her specific job duties for each client. Each client required an individualized treatment plan, which necessitated a unique set of job duties. Petitioner was initially paid $8.25 per hour, and received regular pay increases, making $11.20 per hour on the date of accident. Petitioner was required to complete bi-monthly timesheets in order to be paid for the hours she worked, and the timesheets were signed by the client, certifying that the information contained on the timesheet was true, accurate, and complete, and that the services described were received by the client. If Petitioner or the client experienced any issues while Petitioner was working for a client, all complaints went through Pat McGowan. Petitioner received regular performance reviews, and if performance was deemed to not be acceptable, Petitioner could be terminated.

Petitioner testified that on May 15, 2011, she was working for two clients, one of whom was mobile and one of whom was not. She testified that she would generally go the non-mobile client's house in the morning, and the mobile client's house in the afternoon. On that day, she was at the non-mobile client's house in the morning. She got him out of bed, changed his diaper, helped him into the shower, and then helped him back into bed. The Petitioner testified that she was moving the client from his bed back into his wheelchair when she turned and her lower back snapped and she experienced pain in her lower back. Petitioner testified that she weighed 156 pounds on the date of injury and the client weighed approximately 200 pounds. Petitioner testified that she finished her shift with that client and then went to work her shift with her other client where all she did was pick up the client's prescriptions. The Petitioner completed an injury report, and that report indicates that she was lifting a client out of bed to place him into wheelchair, and injured her back.

The Petitioner was first treated for her injury at Silver Cross Hospital on May 16, 2011 with complaints of back pain. It was noted that the Petitioner reported that she felt a "pop" when attempting to transfer a 200-pound patient at work. It was also noted that "the patient has not experienced similar symptoms in the past", and the Petitioner testified that she had not previously injured her back nor had she received any prior medical treatment or care for her back.

An x-ray of the Petitioner's lower back was taken which revealed a narrowing of the L5-S1 disc space with mild sclerosis of the posterior elements. The absence of a definite, significant, acute lumbar fracture deformity or gross dislocation was noted and the Petitioner was diagnosed with acute low back pain and muscle spasm. The Petitioner was prescribed Flexeril, Motrin, Norco and Prednisone and was referred to follow-up with her personal physician, Dr. Yatin Shah. Petitioner followed-up with Dr. Shah on two occasions and was referred by him to Dr. Cary Templin, a board certified orthopedic specialist practicing with Hinsdale Orthopedics.

The Petitioner testified that she discontinued caring for the non-mobile client after her injury but she continued to care for her mobile client for several weeks thereafter, as the physical care that client needed was significantly less strenuous.

Petitioner saw Dr. Templin at Hinsdale Orthopedics on July 1, 2011. Dr. Templin noted that Petitioner was experiencing significant pain on examination. X-rays revealed a well-aligned spine in the coronal and sagittal planes and some evidence of degenerative disc change at L5-S1 with loss of disc height. Petitioner was referred to physical therapy and was given a work restriction of no lifting greater than ten pounds, and no overhead activity. An MRI of the Petitioner's lumbar spine on July 28, 2011 revealed L4-5 disc space narrowing and dissection with shallow central protrusion as well as L5-S1 disc space narrowing, disc desiccation, and end palate degenerative changes. Dr. Nudo at Hinsdale Orthopedics noted that there was central disc protrusion present with moderate right and mild left sided neural foraminal narrowing, and no evidence of disc herniation.

Petitioner was next seen by Dr. Templin on July 29, 2011 with continued complaints of low back pain. Petitioner was ordered to continue physical therapy, and given the same work restrictions of no lifting greater than ten pounds, no overhead activities, and no bending, squatting, or kneeling. Petitioner followed up with Dr. Templin on August 1, 2011 and Dr. Templin continued to recommend physical therapy. Petitioner next saw Dr. Templin on September 1, 2011 at which time physical therapy was discontinued due to continued pain.

On September 8, 2011, Petitioner saw Dr. Sharma at the Pain and Spine Institute. Dr. Sharma recommended facet joint injections to alleviate the pain and Petitioner underwent lumbar intra-articular facet joint injections of the L4-L5, L5-S1 joints on January 11, 2012 and January 30, 2012. She followed up with Dr. Templin on February 2, 2012, and noted that she experienced good relief from the first injection, and only moderate relief from the second injection.

On February 2, 2012, Dr. Templin reviewed Petitioner's MRI and diagnosed a left- sided L-4 L-5 annular tear. He continued her restrictions and prescribed a Radio Frequency Ablation. That procedure was performed at Pain and Spine on March 8, 2012. The procedure provided Petitioner with temporary relief and she was referred back to Dr. Templin for follow-up care.

Petitioner continued under Dr. Templin's care and he continued Petitioner's work restrictions and prescribed surgery. Petitioner testified that she wanted to avoid back surgery, if possible. Because of her desire to avoid surgery Dr. Templin placed her at maximum medical improvement and prescribed a Functional Capacity Evaluation.

On May 15, 2012, the Petitioner was examined by Dr. Frank M. Phillips, a board certified orthopedist, at the request of the Respondent. Dr. Phillips diagnosed Petitioner with a disc injury at L5-S1 and he related that injury to the Petitioner's May 15, 2011 work injury. Dr. Phillips opined that fusion surgery was reasonable for the Petitioner if she desired to undergo it but he opined that she was at maximum medical improvement as far as conservative treatment of her back injury was

concerned. He noted that Petitioner was not capable of returning to work full-duty but there were no spinal contraindications to working with a twenty pound lifting restriction and avoiding repetitive bending and twisting. He recommended a functional capacity evaluation to define Petitioner's precise functional limitations, and discography testing as a prelude to fusion surgery.

Petitioner underwent a Functional Capacity Evaluation at the Newsome Work Performance Center on August 13, 2012 and she was found to have demonstrated work tolerance at a light to medium physical level. Petitioner's job was self-rated as requiring a heavy physical demand level.

Petitioner next saw Dr. Templin on August 30, 2012 with complaints of severe pain extending into the buttock. Petitioner declined a diskogram for possible future surgery, and Dr. Templin noted that Petitioner was at maximum medical improvement without surgery. Petitioner was given permission to return to work with restrictions as noted in the FCE.

Petitioner continued to treat at the Pain and Spine Institute in October and November of 2012 and was found to be at maximum medical improvement from a pain management standpoint in November, 2012. She returned to their care in April, 2013 with complaints of increased pain. In May, 2013 Petitioner returned to Dr. Templin who prescribed a repeat lumbar MRI which was noted to be unchanged from the previous examination. In August, 2013, because of Petitioner's continued reluctance to undergo low back surgery, Dr. Templin referred her back to the Pain and Spine Institute where she underwent a transforaminal epidural injection bi-laterally at L5-S1 on August 7, 2013. For the ensuing 3 months Petitioner was treated with a number of pain medications.

Petitioner followed up with Dr. Templin on August 8, 2013 complaining of continued lower back pain, along with pain and tingling into the leg. Petitioner was permitted to return to work with the restrictions of no lifting greater than ten pounds, bending, squatting and kneeling to tolerance, and no overhead activities.

Petitioner continued to follow up with Dr. Sharma in September and November, 2013 and on December 5, 2013 Petitioner saw Dr. Templin with complaints of 9/10 pain on lower back. Dr. Templin recommended the Petitioner undergo lumbar fusion surgery.

On December 11, 2013, Petitioner underwent an L5-S1 anterior lumbar interbody fusion with Dr. Templin at Silver Cross Hospital. Petitioner's post-operative diagnosis was L5-S1 degenerative disc disease and discogenic low back pain. Petitioner followed up with Dr. Templin post-surgically and she underwent a course of physical therapy between January 2014 and April 2014. The Petitioner testified that the surgery and post-surgical physical therapy did not provide any improvement in her pain or her physical capabilities.

On May 27, 2014 Dr. Templin noted that a CT scan of Petitioner's spine showed appropriate fusion five months post-surgery, and that her back appeared to be almost solidly fused through disc space and no loosening or migration of screws. He opined that the SI joints may be causing some pain due to a transfer of stress, and Petitioner was sent for a left SI injection. On July 7, 2014, Petitioner saw Dr. Sharma who administered a lumbar medial nerve branch block. On July 22, 2014, Petitioner saw Dr. Templin and reported that the SI injection only provided one day of relief. Dr. Templin referred Petitioner back to Dr. Sharma for continued pain management.

On September 23, 2014, Petitioner returned to Dr. Templin and he indicated that Petitioner had reached maximum medical improvement and was cleared to work with permanent restrictions as outlined in the Functional Capacity Evaluation.

On September 6, 2016, Petitioner returned to Dr. Templin, reporting 8/10 pain. Dr. Templin noted that the instrumentation was unchanged in alignment, and there was no loosening around screws, and no fracture of instrumentation.

Petitioner underwent another Functional Capacity Evaluation on September 9, 2016. Petitioner's job at IDHS was noted to be at a medium demand level and her physical demand level as determined by the FCE was light to medium. The FCE indicated that Petitioner is capable of working above shoulder for eight hours per day; sitting in a chair for 6 hours, in 60 minute increments; standing for three to four hours, in thirty minute increments; and walking five to six hours per day with occasional long distances.

Petitioner testified that she is unable to return to her PA job and that has not worked since May 15, 2011. Petitioner testified that she moved to Alabama in 2014 because of her lack of job prospects in the Chicagoland area, and she testified that her current residence in Alabama is located in a remote, rural area. Petitioner testified that she has been searching for a job since 2011 after the accident occurred, and has been unable to find a new job. Petitioner testified that she drives, and is proficient at using the Internet. She has a high school diploma, and took some courses in cosmetology after high school. Petitioner testified that she has no specialized training. Prior to working for IDHS, she held jobs with titles such as cook and cashier in various industries.

Petitioner testified that she continues to suffer low back pain, which she rated as 7/10, and she continues to have difficulty sleeping. She testified that she is restricted from bending, stooping and squatting, and she cannot sit, stand or walk for extended periods. She testified that she has been limited in her ability to seek medical treatment because of her lack of insurance and insufficient income and that she is not able to purchase the pain medications prescribed by either Dr. Templin or Dr. Sharma.

Petitioner was paid appropriate Temporary Total Disability benefits up until August 18, 2014, when her benefits were terminated by the Respondent based upon a determination that no employee-employer relation existed between her and the Respondent.

Petitioner testified that during her care and treatment the Respondent utilized two medical case managers who approved all of her treatment. Petitioner testified that some of the bills for her medical treatment remain unpaid and offered Petitioner's Exhibits 8 through 14, and Petitioner's Exhibit 24 into the record as evidence of the unpaid medical bills.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

The Arbitrator finds that, on the date of the Petitioner's accident, the relationship between the Petitioner and the Respondent was that of employer and employee. The Petitioner was hired, trained and supervised by the Respondent. Petitioner underwent training by Department of Human Services personnel at Department of Human Services facilities and was approved/certified by the Department of Human Services as a personal assistant" PA". It performed annual reviews of Petitioner based on its criteria. Petitioner was supervised by a Department of Human Services employee, Pat McGowan

20IWCC0569

who acted as a field case worker and provided assistance to Petitioner in caring for her patients. Pat McGowan evaluated Petitioner annually to determine if she would continue to be employed as a PA. The Department of Human Services obtained patients for Petitioner to care for. It determined a treatment plan for patients and Petitioner had to comply with that plan or be discharged by the Department of Human Services. Petitioner submitted time sheets to the Department of Human Services. The Department of Human Services paid Petitioner directly and withheld from her pay FICA, Medicare and State and Federal taxes. None of Petitioner's patients paid or contributed any money towards Petitioner's wages. Petitioner's wage was determined by the Department of Human Services only as were her hours and days of work.

The Arbitrator notes that the Illinois Appellate Court has acknowledged that the Commission has, for some period of time, rejected the Respondent's argument that personal assistants are not employees of the Department of Human Services and has threatened the Respondent with penalties and fees because denial of the employment relationship with personal assistants is unreasonable and vexatious in light of the numerous decisions finding that such a relationship exists. (See Hoffman v. Madigan, 2017 IL App (4th) 160392)

Based upon the totality of the credible evidence adduced at hearing, as well as the prior Decisions of the Commission and the Appellate Court, the Arbitrator finds that Petitioner has established by a preponderance of the evidence that on May 15, 2011, an employee-employer relationship existed between Petitioner and Respondent-employer.

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

Petitioner testified that she on May 15, 2011, she was moving a client from his wheelchair back into bed when she turned and her lower back snapped and she immediately experienced pain in her lower back. Petitioner testified that she weighed 156 pounds on the date of injury and the client weighed approximately 200 pounds. The description of injury contained in the Petitioner's first report of injury and in the record of her initial medical treatment are consistent with her unrebutted testimony at hearing.

Based upon the unrebutted testimony of the Petitioner and other credible evidence which corroborates that testimony, the Arbitrator finds that the Petitioner has established by a preponderance of the credible evidence that on May 15, 2011, she sustained accidental injuries which arose out of in the course of his employment by Respondent-Employer.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained an accidental injury arising out of and in the course of her employment on May 15, 2011 when she was moving a client from his bed into his wheelchair. Petitioner testified that as she was moving the client, her lower back snapped and she experienced pain in her lower back. The Petitioner sought medical treatment the next day and an x-ray revealed a narrowing of the L5-S1 disc space with mild sclerosis of the posterior elements. Petitioner thereafter commenced a course of conservative medical treatment with Dr. Templin and Dr. Sharma which continued until May 15, 2012, when she was placed at maximum medical improvement with regard to

conservative treatment. Petitioner was then diagnosed with a L5-S1 herniated disc and surgery was prescribed.

On May 15, 2012, the Petitioner was examined by Dr. Frank M. Phillips, a board certified orthopedist, at the request of the Respondent. Dr. Phillips diagnosed Petitioner with a disc injury at L5-S1 and he related that injury to the Petitioner's May 15, 2011 work injury. Dr. Phillips opined that fusion surgery was reasonable for the Petitioner if she desired to undergo it.

Petitioner continued to treat conservatively with Dr. Templin and Dr. Sharma until she underwent an L5-S1 anterior lumbar interbody fusion surgery on December 11, 2013. Petitioner's post-operative diagnosis was L5-S1 degenerative disc disease and discogenic low back pain. Petitioner followed up with Dr. Templin post-surgically and she underwent a course of physical therapy between January 2014 and April 2014, which ended on March 3, 2014. The Petitioner testified that the surgery and post surgical physical therapy did not provide any improvement in her pain or her physical capabilities.

On September 23, 2014, Petitioner returned to Dr. Templin and he indicated that Petitioner had reached maximum medical improvement and could work with permanent light to medium duty work restrictions.

On September 6, 2016, Petitioner returned to Dr. Templin, reporting 8/10 pain. Dr. Templin noted that the instrumentation was unchanged in alignment, and there was no loosening around screws, and no fracture of instrumentation.

Petitioner underwent another Functional Capacity Evaluation on September 9, 2016 and she was again determined to be capable of light to medium duty work.

Petitioner testified that she did not have any back problems prior to her work injury and that she currently continues to suffer low back pain, which she rated as 7/10. She testified that she is restricted from bending, stooping and squatting, and she cannot sit, stand or walk for extended periods.

Based upon the unrebutted testimony of the Petitioner and the medical opinions expressed by her treating physicians, as well as the opinions of Dr. Phillips, the Respondent's examining physician, the Arbitrator finds that the Petitioner's current low back condition of ill-being is causally related to her May 15, 2011 work injury.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Petitioner submitted evidence of unpaid medical expenses as Petitioner's Exhibits 10 through 14 and Petitioner's Exhibit 24. As the Arbitrator has found that the Petitioner's current low back condition of ill-being is causally related to her May 15, 2011 work injury, the Arbitrator finds that all of the medical treatment provided to the Petitioner for her low back condition since the date of her work injury was reasonable, necessary, and causally related to the injury and that the Respondent is obliged to pay for those medical expenses pursuant to Section 8(a) of the Act.

20 I W CC0569

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner acknowledged that she was paid Temporary Total Disability benefits until August 18, 2014, when her benefits were terminated by the Respondent based upon a determination that no employee-employer relation existed between her and the Respondent. The Petitioner claims to be entitled to additional Temporary Total Disability benefits from August 18, 2014 through June 7, 2018.

The Arbitrator first notes that the Petitioner's Temporary Total Disability benefits were terminated by the Respondent, while she was still under active medical treatment for her injury, based upon a determination that there was no employee-employer relationship between the Petitioner and the Respondent. The Arbitrator finds the termination of benefits on that basis to have been objectively unreasonable in light of the numerous Commission and Court decisions finding that such a relationship exists with respect to personal assistants and the Department of Human Services.

The Arbitrator also notes that Petitioner indicated that Vocational Rehabilitation assistance was requested from the Respondent, and was never provided. It appears, however, that that request was made in February of 2013 based upon an August 30, 2012 note of Dr. Templin which returned the Petitioner to light duty work. (See PX 15). There is no evidence of any subsequent request for vocational assistance. Subsequent to that request, the Petitioner resumed medical treatment for her low back condition and then underwent a fusion surgery. Thereafter, the Petitioner continued to receive treatment for her injuries through at least September of 2014. The Petitioner then moved to Alabama.

It is clear from the medical records that on September 23, 2014, Dr. Templin indicated that Petitioner had reached maximum medical improvement and was cleared to return to work with permanent light to medium duty restrictions. While the Petitioner may have received some medical treatment for her pain in Alabama during 2015, she did not return to see Dr. Templin until September 6, 2016, two years later, and Dr. Templin noted that the Petitioner's condition was essentially unchanged.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that she was entitled to Temporary Total Disability benefits after September 23, 2017. The Arbitrator finds that the Petitioner was entitled to Temporary Total Disability benefits from August 18, 2014 through September 23, 2014, a period of 5 2/7 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

Petitioner was diagnosed with L5-S1 degenerative disc disease and discogenic low back pain. and underwent an L5-S1 anterior lumbar interbody fusion with Dr. Templin in December 2013. She continues to complain of low back pain, despite Dr. Templin's finding that the surgery was successful and the instrumentation was properly in place. Petitioner testified that she is unable to return to her employment as a PA due to her restrictions and her pain. Petitioner testified that she is unable to do things around the house, and has trouble sleeping at night due to continued pain. She testified that she gained fifteen to twenty pounds since the accident seven years ago.

No medical evidence was presented which would indicate that the Petitioner is not capable of performing any work. In fact, on September 23, 2014, Dr. Templin indicated that Petitioner had reached maximum medical improvement and was capable of returning to work with permanent light to medium duty restrictions.

The Petitioner testified that, in spite of her efforts to find employment, she has been unable to find a job within her restrictions. While Petitioner introduced into the record what she identified as her job search logs, she offered little or no testimony as to how she actually conducted her job search. The Petitioner testified that she did move to Alabama in 2014 and she acknowledged that she lived in a rural area of that state. The Arbitrator finds that Petitioner's job search evidence to be insufficient to support a conclusion that there is no stable employment available for the Petitioner within her restrictions.

The Arbitrator finds that Petitioner has failed to sustain its burden in proving by a preponderance of the evidence that Petitioner is permanently and totally disabled. Petitioner's work condition does not preclude her from working in any capacity. Petitioner underwent two Functional Capacity Evaluations placing her capabilities at light to medium and indicating that Petitioner is capable of working above shoulder for eight hours per day; sitting in a chair for 6 hours, in 60 minute increments; standing for three to four hours, in thirty minute increments; and walking five to six hours per day with occasional long distances.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, including the medical records and the testimony of the Petitioner, the Arbitrator finds that the Petitioner's May 15, 2011 work injury resulted in permanent partial disability to the Petitioner's whole person to the extent of 25% thereof.

In Support of the Arbitrator's Decision relating to (M.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

At hearing, Petitioner made an oral motion for leave to request Penalties under Sections 19(k) and 19(l), and for Attorneys' Fees under Section 16 of the Illinois Workers' Compensation Act, which was allowed. No written Motion or Petition for Penalties and Fees was submitted.

In the case at bar, Petitioner was paid appropriate Temporary Total Disability benefits up until August 18, 2014, when her benefits were terminated by the Respondent based upon a determination that no employee-employer relation existed between her and the Respondent. Medical expenses totaling $91,311.79 were also paid by Respondent.

The Arbitrator specifically finds that the Respondent's termination of Temporary Total Disability benefits based upon its determination that no employee-employer relation existed was objectively unreasonable in light of the numerous Commission and Court decisions finding that such a relationship exists with respect to personal assistants and the Department of Human Services. However, in light of the lack of a written Motion or Petition for Penalties and Fees served on the Respondent at least 72 hours prior to hearing, the Arbitrator declines to award penalties or fees in the instant matter.

20IWCC0569

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIC RUSSO,

Petitioner,

vs. NO: 14 WC 14476

ILLINOIS DEPARTMENT OF TRANSPORTATION,

Respondent.

20IWCC0570

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 causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

DATED: SEP 28 2020

D. Douglas McCarthy

DDM/tdm

O: 9/9/20
052

Stephen Mathis

DISSENT

I, respectfully, dissent. I would modify the Decision of the Arbitrator and find Petitioner sustained permanent disability of 7% loss use of the person as a whole pursuant to Section 8(d)2 of the Act. I arrive at my decision by utilizing a different analysis of the relevance and weight of the factors contained in Section 8.1b. *820 ILCS 305/8.1b(b)* (West 2014).

Section 8.1b(b)(i) – level of impairment

Neither party submitted a Section 8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), I assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner sustained injury while performing his duties as a sign hanger for Respondent. Following his accident, Petitioner did not return to work, although, there is no testimony as to why Petitioner failed to return to work for Respondent. Instead Petitioner found employment as a laborer and when he was unable to perform this job as a truck driver. T. 8-10. Given the change in occupations, I find this factor weighs in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 50 years old on the date of accident. I observe Petitioner is relatively older, and as such, has a decreased work-life expectation. I find this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner testified he has sustained a loss of earnings in his new occupation as a truck driver, although he failed to provide any documentary evidence of the same. As such, I afford no weight to this factor.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Following his accident, Petitioner underwent limited treatment for cervical/lumbar strains which the Arbitrator found him to be at maximum medical improvement (MMI) as of September 4, 2014. Petitioner underwent right shoulder surgery, and the Arbitrator found him to be at MMI as of July 7, 2016. At trial Petitioner testified to pain and a lack of range of motion in his cervical

20IWCC0570

spine and right arm. T. 11. Petitioner further testified he is tournament fisherman and uses his right arm to cast which he is able to do but such causes pain. T. 19. Petitioner offered no medical records to corroborate these complaints. Petitioner testified he had not sought treatment since 2016. T. 7. As there are no medical records to corroborate his current complaints, I find this factor weighs in favor of a decreased permanence.

I would award benefits of 7% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RUSSO, DOMINIC
Employee/Petitioner

Case# **14WC014476**

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

20[illegible]CC0570

On 10/25/201[illegible], an arbitration decision on this case 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.[illegible]7% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0213 DEPAOLO & ZADEIKIS
DONNA ZADEIKIS
309 W WASHINGTON ST SUITE 600
CHICAGO IL [illegible]

0202 ASSISTANT ATTORNEY GENERAL
PATRICIA [illegible]
100 W RANDOLPH ST 13TH FL
CHICAGO IL 60601

1430 CENTRAL MGMT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX [illegible]
SPRINGFIELD IL 62794-[illegible]

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305/14

DEC -9 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Dominic Russo
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 14 WC 14476

Consolidated cases: D/N/A

20 IWCC0570

The Arbitrator issued a 19(b) decision in this case on October 25, 2016. Petitioner filed a review thereafter. The Commission affirmed the Arbitrator's decision on September 18, 2017. Arb Exh 2. The sole disputed issue now 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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **11/20/2019**. By stipulation, the parties agree:

On the date of accident, **4/14/2014**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current right shoulder and spinal conditions of ill-being are causally related to the accident. [See the Commission's decision of September 18, 2017 for specific causation-related findings that are the law of the case. Arb Exh 2.]

In the year preceding the injury, Petitioner earned **$68,335.28**, and the average weekly wage was **$1,314.14**.

At the time of injury, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $721.66/week for a further period of 75 weeks, as provided in Section 8(d)2 of the Act because Petitioner has sustained permanent injuries to the extent of 15% of a man as a whole.

Respondent shall pay Petitioner compensation that has accrued from 4/14/2014 through 11/20/2019, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

12/9/19

Date

DEC 9 - 2019

Dominic Russo v. Illinois Department of Transportation
14 WC 14476

Procedural History

The Arbitrator conducted a Section 19(b) hearing in this case on September 21, 2016. Petitioner was the sole witness at this hearing. Respondent stipulated to an accident of April 14, 2014, along with timely notice and a substantial period of temporary total disability. Respondent challenged Petitioner's entitlement to temporary total disability benefits during a period in late March 2015, based on its contention that Petitioner was in jail at that time. Respondent also contended that its liability for temporary total disability ended on July 20, 2016, at which point Petitioner entered a plea of guilty to several significant crimes.

The disputed issues at the hearing included causal connection, medical expenses, temporary total disability and penalties/fees.

On October 25, 2016, the Arbitrator issued a decision finding: 1) that Petitioner established causation as to a right shoulder condition that required care, including surgery, with this condition stabilizing as of July 7, 2016; 2) that Petitioner established causation as to cervical spine and lumbar spine conditions that required MRI scanning and relatively short courses of conservative care; 3) that Petitioner failed to establish causation as to a claimed left knee condition; 4) that Petitioner was temporarily totally disabled from April 15, 2014 through July 20, 2016, with Respondent receiving credit for the $94,034.35 in benefits it paid; 5) that Petitioner was entitled to certain medical expenses relating to facet injections performed in 2014 and the right shoulder surgery of July 20, 2015; 6) that Petitioner was not entitled to prospective care; 7) that Respondent was not liable for penalties or fees; and 8) that Petitioner reached maximum medical improvement but that, because the parties proceeded under Section 19(b), the Arbitrator was precluded from addressing permanency. Arb Exh 2.

Petitioner filed a Petition for Review. On September 18, 2017, a unanimous Commission affirmed and adopted the Arbitrator's decision. Arb Exh 2. Because the claim involved the State, no further appeals were possible.

Summary of Disputed Issues at Hearing Held on November 20, 2019

At the hearing of November 20, 2019, the only disputed issue was nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact Relative to Hearing of November 20, 2019

Petitioner testified he worked as a sign hanger for Respondent as of his April 14, 2014 accident. He no longer works for Respondent.

Petitioner recalled testifying at the 19(b) hearing held on September 21, 2016. He denied undergoing any additional care for his work injuries after that hearing.

Petitioner testified he returned to work in April 2017, but not for Respondent. He drove a truck for Rick's Trucking for four months. He then quit to take a better job as a laborer at Hard Rock Concrete Cutters. He started working at Hard Rock Concrete Cutters in July 2017. He was laid off in early December 2017. He testified he was the only employee laid off at that time. He believes he was laid off because he was physically unable to perform the overhead lifting required of him. As a laborer, he was required to lift a maximum of 140 pounds overhead. He testified he could not do this due to his right shoulder condition.

Petitioner testified he currently works as a truck driver for H2 Cartage. He began working for H2 Cartage in April 2018. He now earns about half or less than half of the amount he earned while working for Respondent.

With respect to his cervical spine condition, Petitioner testified he continues to experience pressure in the back of his neck on a daily basis. He also experiences neck pain on some days. The symptoms vary in intensity from day to day. His neck mobility is also limited. He is able to look down but not up. He can tilt his head but only about half as far as he could tilt it before the accident. His neck pain and associated headaches affect his ability to sleep. He has tried about seven kinds of pillows. He denied having headaches or sleep issues before the accident. He experiences bad migraine headaches about two or three times per month. He does not take any medication for his neck symptoms.

Petitioner testified his current job affects his neck. He drives a cement mixer that has detachable chutes. He has to install the chutes on his truck six times per load. He has to wash the chutes and re-install them after making a delivery. He delivers between three and five loads per day. The chute-related activities put stress on his neck.

With respect to his lumbar spine condition, Petitioner testified he experiences low back pain every day but the pain is "not too bad." If he performs an activity requiring bending or twisting, he is sore later on. His low back is the least of his problems.

With respect to his right shoulder, Petitioner testified he experiences "naggy pain" daily. He finds it painful to lift his right arm. His right arm range of motion is limited compared to his left. His right arm is 50% weaker, especially when his right arm is at shoulder level. When he raises his right arm overhead, he experiences tingling in the arm. If he sleeps with his right arm overhead, the arm goes completely numb. His right arm tires faster than his left. He tries to use his left arm and shoulder more than his right. In his current job, he has to use both arms to hold the dump truck chutes. He self-treats his right shoulder complaints by stretching, applying ice and taking hot showers. He avoids taking prescription medication because he does not want to become dependent on it.

Petitioner testified he used to work out five to six times per week. He no longer goes to the gym because he finds it painful to exercise. His weight has dropped from 210 or 214 to 180 because he no longer works out. He continues to participate in fishing tournaments. These tournaments last for two days. Cash prizes are awarded. He has to cast for eight hours each day. His right shoulder feels stiff and painful after he does this. His casting is less accurate than it was before the accident but he continues to participate in the tournaments. He had no problems fishing before the accident.

Under cross-examination, Petitioner denied having neck pain before the accident. His neck, back and right shoulder pain started when the accident occurred. His "naggy" right shoulder pain is constant. The sharper, more intense pain comes and goes, as does the pressure behind his neck. He underwent right shoulder surgery, due to a shoulder separation, when he was 14 or 15 years old. He recalls undergoing an examination by Dr. Belich. He did not review Dr. Belich's report with his attorney. He believes he underwent therapy after seeing Dr. Belich. He never had the opportunity to undergo work conditioning because his medical treatment was cut off. When he returned to work in April 2017, he was not subject to any restrictions. He worked as a laborer at Hard Rock Concrete between July 2017 and his layoff in December 2017. His job at Hard Rock required him to lift heavy equipment all day. His workdays ranged in length from 8 to 20 hours. He was laid off because he had difficulty performing the required lifting. He receives weekly paychecks at his current job. He cannot recall exactly when he last underwent right shoulder care. He knows he did not undergo care for his right shoulder, neck or back in 2018 or 2019.

No witnesses testified on behalf of Respondent. Neither party offered any exhibits.

Arbitrator's Conclusions of Law

<u>What is the nature and extent of the injury?</u>

This is a post-amendatory claim, since the accident occurred after September 1, 2011. Accordingly, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing the nature and extent of Petitioner's injury. That section sets forth five factors to be considered in determining permanency, with no single factor predominating. The Arbitrator assigns no weight to the first factor, any AMA Guides impairment rating, since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's age at the time of the accident and occupation. Petitioner was a 50-year-old sign hanger as of the April 14, 2014 accident. The Arbitrator views him as a middle-aged individual who could reasonably be expected to remain in the workforce for another ten to fifteen years. With respect to the fourth factor, future earning capacity, Petitioner claims some diminution of earnings but offered no wage-related records into evidence. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator initially notes that the only treatment records in evidence are those admitted at the 19(b) hearing held in 2016. The Arbitrator views the previously admitted treatment records as part of the overall record in this case. With respect to the right shoulder, the Arbitrator notes that Petitioner's treating

surgeon, Dr. Freedberg, noted significant pathology, including a very large anterior labral tear and insertional tears of the biceps and subscapularis, in his operative report of July 20, 2015. PX 7, pp. 206-208. The Arbitrator also notes that, while Petitioner reported feeling "great" shortly after the surgery, he complained of right shoulder weakness and radicular right arm symptoms when he saw Dr. Freedberg in November 2015, February 2016 and May 2016. The Arbitrator further notes that, with respect to the right shoulder, Dr. Freedberg found Petitioner capable of full duty as of July 7, 2016. PX 7, p. 356. At the November 20, 2019 hearing, Petitioner testified to significant ongoing right shoulder symptoms but continues to participate in 2-day fishing tournaments that require him to repeatedly use his right arm to cast.

The Commission affirmed the Arbitrator's finding that Petitioner's cervical and lumbar spine conditions required a brief course of conservative treatment. That treatment ended in 2016.

The Arbitrator finds that Petitioner established permanency equivalent to 15% loss of use of the person as a whole (12.5% loss for the right shoulder condition and 2.5% for the spinal condition).

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LISA OSER,

Petitioner,

vs. NO: 17 WC 07455

KOHL'S ILLINOIS, INC.,

Respondent.

20 I W CC0571

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical and prospective medical, and permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2020 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 $35,000.00. 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.

20IWCC0571

DATED: SEP 2 9 2020
KAD/bsd
O080420
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

OSER, LISA
Employee/Petitioner

Case# **17WC007455**

KOHL'S ILLINOIS INC
Employer/Respondent

20 I W C C 0 5 7 1

On 1/8/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1,52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1097 SCHWEICKERT GANASSIN KRZAK
LAURA C HALL
2101 MARQUETTE RD
PERU, IL 61354

0766 HENNESSY & ROACH PC
DANIEL S WELLNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LISA OSER
Employee/Petitioner

Case # **17** WC **7455**

v.

Consolidated cases: **N/A**

KOHL'S ILLINOIS, INC.
Employer/Respondent

20 I W C C 0 5 7 1

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Seal**, Arbitrator of the Commission, in the city of **Kankakee** on **September 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **February 1, 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 $**19,874.40**; the average weekly wage was $**384.1**.

On the date of accident, Petitioner was **46** 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 shall be given a credit of $**1,924.57** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,924.57**.

Respondent is entitled to a credit of $**2,244.73** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $675.00 to OSF Medical Group, $91.51 to OSF Healthcare, $69.35 to Central Illinois Radiology; $14,635.39 to Orland Park Orthopedics, and $1,706.53 to RX Development, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 66 weeks, commencing 10/03/2017 through 10/16/2017 and 06/21/2018 through 09/16/2019, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $1,924.57 for temporary total disability benefits that have been paid.

Pursuant to Section 8(a) of the Act, the Respondent shall provide and pay for, pursuant to the fee schedule, the surgery recommended by Dr. Rhode, including, but not limited to an arthroscopic TFCC repair, and all related necessary ancillary 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

December 31, 2019
Date

JAN 8 - 2020

FINDINGS OF FACTS

On February 1, 2017, the Petitioner, Lisa Oser, was employed by the Respondent, Kohl's Illinois Inc. She was working as a material handler, a position she held for approximately four years prior to the date of the accident. Mrs. Oser explained her day-to-day duties consisted of picking orders and occasionally filling in other departments where assistance was needed.

On February 1, 2017, Mrs. Oser reported to work at 4:00 p.m. to begin her shift. The Petitioner explained between 6:30 and 6:45 p.m., she was holding a Rug Doctor weighing approximately 35 pounds, when it came apart. She was holding the heaver part of the Rug Doctor with her left hand, with the handle in her right hand. The Rug Doctor came apart, and the heavier part of the machine struck the top of the Petitioner's right hand and wrist. Mrs. Oser further explained it was like a sandwich, with her right hand and wrist in the middle of the two pieces of the Rug Doctor. At approximately 8:30 p.m. on February 1, 2017, the Petitioner completed an associate accident report. Rx. 2.

The Petitioner explained her right hand began to swell immediately, and she could see a bruise beginning to form. Mrs. Oser testified she located Dan, a supervisor, who directed her to place an ice pack on her hand and wrist. Despite the pain and swelling, the Petitioner continued to work the remainder of her shift. The next day, February 2, 2017, Lisa Oser spoke with Mike Hayes, a supervisor, and informed him she noticed her wrist was also bruised. Mrs. Oser testified prior to February 1, 2017, she had never experienced any problems with her right hand or wrist, nor any issues with her grip or weakness to her right extremity.

David Oser, the Petitioner's husband, testified on behalf of Lisa Oser. He testified he has been married to Lisa Oser for 20 years, and during that time has not ever heard the Petitioner complain of any problems to her right wrist prior to the February 1, 2017 work accident.

The Petitioner continued to work through her pain until February 6, 2017, when she sought the assistance of Dr. Rhett Miller at OSF in Washington, Illinois. Px.2. Dr. Miller's records reflect Mrs. Oser was at work when a vacuum struck her right hand and wrist, causing pain, swelling and bruising. Id. Dr. Miller recorded Petitioner's pain with palpation over dorsal right wrist, and decreased range of motion at the right wrist due to pain. Id. Following an examination, Dr. Miller ordered x-rays of the right wrist. Id. She next saw Dr. Miller on February 15, 2017, with records from this visit documenting tenderness to the right wrist, weakness with her grip, pain with palpation over dorsal right wrist and pain with palpation metacarpals (3rd and 4th) tendons. Id. Lisa Oser testified she continued to work full duty during this period, pushing through constant pain to her right hand and wrist, which was a 10/10. Dr. Miller referred the Petitioner to see Dr. Rashid, an orthopedic surgeon with OSF, at her next visit, on February 20, 2017, due to the ongoing pain and lack of relief from prescription medications. Id.

Dr. Rashid first examined Mrs. Oser on February 24, 2017. Px. 4. Records from this visit indicate the Petitioner was carrying a rug cleaner at work on February 1, 2017 when the machine came apart, crushing her right hand and wrist. Id. Following an examination, Dr. Rashid prescribed an MRI of the right wrist. Id.

The MRI was performed on March 4, 2017. Px.4. The Petitioner returned to Dr. Rashid on March 10, 2017. Id. At this visit, Dr. Rashid wrote Mrs. Oser had tenderness along the ulnar aspect of the wrist and distal radial ulnar joint. Id. After her examination and a review of the MRI, Dr. Rashid ordered occupational therapy, placed Lisa Oser in a brace, and recommended a follow up in six weeks. Id.

At the request of Dr. Rashid, the Petitioner next visited Athletico in Lacon on April 14, 2017 for physical therapy. Px. 6. Their evaluation reflects the Petitioner took a direct blow to the back of her dominant hand and wrist after a rug doctor fell apart and landed on her right hand. Id. The evaluation reflects the Petitioner experienced decreased range of motion to the right hand and wrist, mild swelling, and presence. Id. Following this evaluation, Mrs. Oser attended physical therapy sessions, continuing to experience pain through her discharge from therapy on July 22, 2017. Id.

On April 21, 2017, the Petitioner was examined by Dr. Rashid. Px. 4. At this visit, Dr. Rashid wrote Mrs. Oser still complains of fairly severe pain in the right wrist, at a 10/10. Id. Dr. Rashid prescribed a 5 lb. right hand restriction, continued the brace and prescribed Meloxicam. Id. Records also note a recommendation for a corticosteroid injection at the next visit, should symptoms not improve. Id.

Dr. Cohen performed an examination under section 12 of the Act for the Respondent on June 15, 2017. Rx. 1. At this visit, Dr. Cohen found the Petitioner's condition to be related to the work injury of February 1, 2017, and he opined that all treatment had been reasonable and necessary. Id.

Over the next several months, the Petitioner continued to treat with Dr. Rashid for her work-related right hand and wrist injury. Px. 4. Records from Dr. Rashid note Mrs. Oser's continued complaints of pain to her right hand and wrist and issues with gripping and lifting. Id. Dr. Rashid kept Mrs. Oser wearing a splint on her wrist right, prescribed medications and diagnosed right wrist tendonitis on July 14, 2017. Id. On July 14, 2017, Dr. Rashid administered a corticosteroid injection to Petitioner's right wrist. Id. The injection only provided relief for a few days. Id.

Dr. Rashid ordered x-rays of the right wrist on August 11, 2017. Id. Dr. Rashid also wrote, "I don't have a specific diagnosis to account for this. We have tried conservative treatment with therapy and corticosteroid injections. I've discussed the next step would be a diagnostic wrist arthroscopy." Id.

After a referral from Dr. Rashid, Dr. Jason Miller, an orthopedic surgeon, examined the Petitioner for a second opinion on September 27, 2017. Px. 4. Records from this visit explain Mrs. Oser sustained a right hand and wrist injury on February 1, 2017, when a Rug Doctor impacted her right hand and wrist. Id. Dr. Jason Miller noted the majority of the Petitioner's pain was to the dorsal aspect of her right wrist. Id. Records also reflect the Petitioner has exquisite tenderness over the TFCC ulnarly. Id. Following this evaluation, Dr. Jason Miller agreed with Dr. Rashid's recommendation for a right wrist arthroscopy. Id.

Dr. Cohen performed another IME for the Respondent on November 29, 2017. Id. Mrs. Oser testified the visit only lasted approximately five minutes. Dr. Cohen performed a third IME for the Respondent on January 16, 2019, which the Petitioner testified again only lasted approximately five minutes.

Lisa Oser continued to work through her pain while treating with Dr. Rashid, as she awaited approval for the right wrist arthroscopy. Dr. Rashid's records from a February 13, 2018, visit indicated an MRI was possible consistent with TFCC tear and ECU tendinopathy. Px. 4. At the recommendation of Dr. Rashid, another injection was administered on March 5, 2018. Id.

As the Petitioner explained, she sought another opinion in June 2018 with Dr. Blair Rhode, an orthopedic surgeon with Orland Park Orthopedics. At the visit on June 21, 2018, the Petitioner explained to Dr. Rhode how she sustained her injury at work on February 1, 2017, and

despite treatment, continued to experience significant pain and decreased function. Px. 5. Records from this visit reflect pain elicited over the radial side and dorsal surface of the right wrist with palpation. Id. After examination, Dr. Rhode prescribed the Petitioner off of work and recommended a diagnostic arthroscopy. Id.

The Petitioner next saw Dr. Rhode on July 19, 2018, where Dr. Rhode administered a steroid injection, and continued to keep Mrs. Oser off of work. Id. When Dr. Rhode next examined Lisa Oser, on August 2, 2018, he noted the only temporary relief experience from the extensor tendon injection. Id. At this visit, Dr. Rhode records the Petitioner continues to experience ulnar sided wrist pain with a positive ulnar grind. Id. He continued to keep Lisa Oser off work, prescribed medications and prescribed an MRI with gadolinium to the wrist. Id. On August 29, 2018, the Petitioner underwent the MRI arthrogram prescribed by Dr. Rhode at Orland Park Orthopedics. Id. This showed a tear triangular fibrocartilage complex at the radial attachment with contrast extending to the distal radioulnar joint to the proximal aspect TFCC. Id. Dr. Rhode prescribed an arthroscopic TFCC repair versus debridement on August 30, 2018. Id.

Mrs. Oser has continued to treat with Dr. Rhode since August 30, 2018, during which period Dr. Rhode has kept the Petitioner off work as she awaits authorization for surgery. Id. The Petitioner, still wearing a brace on her right wrist, testified she wishes to proceed with this surgery because other care has not resolved her issues. While Petitioner awaits surgery, she continues to treat with Dr. Rhode for palliative management, visiting with him monthly. Id. Records from each visit reflect Mrs. Oser continues to experience ulnar sided wrist pain. Id.

At arbitration, the Petitioner testified that she has not worked since June 21, 2018, through the September 16, 2019, hearing in this case. She testified to continually experiencing pain to her right hand and wrist. On a scale of one to ten, her pain can be as high as a 10/10 depending on the day. On the issue of further care, Mrs. Oser wishes to proceed with the surgery recommended by Dr. Rhode in hope of finding some relief and the ability to return to work.

Through the date of the hearing, Mrs. Oser has incurred gross bills of $36,956.92 for this injury. (OSF Medical Group: $2,964.00; OSF Healthcare: $2,038.00; Central Illinois Radiology: $436.00; Athletico Physical Therapy: $15,177.00; Orland Park Orthopedics: $14,635.39; and RX Development: $1,706.53) Px. 1. Of this amount, the Respondent has paid $8,927.17 (OSF Medical Group: $853.01; Athletico Physical Therapy: $8,076.16). Px 1. Discounts of $8,607.24 have been provided (OSF Medical Group: $1,275.87; Central Illinois Radiology: $228.53; and Athletico Physical Therapy: $7,102.84). Id. Respondent's group insurance carrier paid bills in the amount of $2,244.73 (OSF Medical Group: $160.12; OSF Healthcare: $1,946.49; and Central Illinois Radiology: $138.12). Id. Bills of $17,177.78 (OSF Medical Group: $675.00; OSF Healthcare: $91.51; Central Illinois Radiology: $69.35; Orland Park Orthopedics: $14,635.39; and RX Development: $1,706.53) remain unpaid. Id.

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally connected to this injury?

The Arbitrator references the Findings of Facts above. The Petitioner, on February 1, 2017, was injured when a Rug Doctor came apart and struck her right hand and wrist, causing pain, bruising and swelling. It was this pain to her right hand and wrist which caused Lisa Oser to seek treatment from February 6, 2017, consistently to the present.

Respondent's section 12 examiner, Dr. Cohen, testified that Mrs. Oser's issues result from a pre-existing ulnar abutment syndrome and its natural progression. Rx. 1. Although the Petitioner might have such a condition, there is no indication natural progression is the cause of the Petitioner's pain and injury. Simply, the thoughts of Dr. Cohen are not well-founded in fact. The Respondent introduced records from a 2012 ER visit where Mrs. Oser fell while skating and was treating for a contusion to her wrist. Rx. 3. During cross-examination, Mrs. Oser could not even recall this incident. From Dr. Rhett Miller to Dr. Rashid, Dr. Jason Miller, and Dr. Rhode, Px. 2-6, all indicate no prior issues for the Petitioner until suffering a work accident causing her right wrist injury. Id.

Based on a review of the entirety of the record, the Arbitrator finds that Petitioner proved that her current condition of ill-being is causally connected to her February 1, 2017, work 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?

The medical records entered into evidence demonstrate that Mrs. Oser sustained a right hand and wrist injury and ongoing complaints of pain and disability that followed, and which are a result of the injury sustained on February 1, 2017. The Petitioner has submitted treatment records supporting the severity of her injury and the reasonableness and necessity of the medical care and services provided. Px. 2-6. Respondent has offered no evidence to dispute the severity of the injuries or the reasonableness or necessity of the medical services provided to Mrs. Oser. Following consideration of testimony and evidence presented, the Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary.

On the issue of whether the Respondent paid all appropriate charges for all reasonable and necessary medical services, gross bills of $36,956.92 have been incurred for services rendered to the Petitioner for this injury. (OSF Medical Group: $2,964.00; OSF Healthcare: $2,038.00; Central Illinois Radiology: $436.00; Athletico Physical Therapy: $15,177.00; Orland Park Orthopedics: $14,635.39; and RX Development: $1,706.53) Px. 1. Of this amount, the Respondent has paid $8,927.17 (OSF Medical Group: $853.01; Athletico Physical Therapy: $8,076.16). Px 1. Discounts of $8,607.24 have been provided (OSF Medical Group: $1,275.87; Central Illinois Radiology: $228.53; and Athletico Physical Therapy: $7,102.84). Id. Respondent's group insurance carrier paid bills in the amount of $2,244.73 (OSF Medical Group: $160.12; OSF Healthcare: $1,946.49; and Central Illinois Radiology: $138.12). Id. Bills of $17,177.78 (OSF Medical Group: $675.00; OSF Healthcare: $91.51; Central Illinois Radiology: $69.35; Orland Park Orthopedics: $14,635.39; and RX Development: $1,706.53) remain unpaid. Id. It is found that Respondent has not paid all the medical bills for all reasonable and necessary services. Id. Following consideration of testimony and evidence presented, this Arbitrator finds the Respondent shall pay, pursuant to the medical fee schedule, the aforementioned bills which were incurred for reasonable and medical services related to the injury.

Regarding the issue of whether the Petitioner is entitled to any prospective medical care, following consideration of the testimony and evidence presented, the same is incorporated by reference, it is found that Petitioner requires and the Respondent shall provide prospective medical care as recommended by Dr. Rhode, including the arthroscopic TFCC repair and all related necessary ancillary care. Dr. Blair Rhode, an orthopedic surgeon and specialist,

diagnosed a TFCC tear related to the Petitioner's work injury and prescribed an arthroscopic TFCC repair due to conservative measures having failed. Px. 5.

L. What temporary benefits are in dispute? TTD

This Arbitrator incorporates the foregoing Findings of Fact and refers to them by reference herein. The parties agree that the average weekly wage in this matter is $384.11. Arb. 1. Lisa Oser was taken off of work by Dr. Rashid from October 3, 2017 through October 16, 2017. Px. 4. The Petitioner's last day of work was June 20, 2018, and she has been off work since that time, per her physician, Dr. Blair Rhode. Px. 5. The Respondent has paid TTD benefits to the Petitioner in the amount of $1,924.57. A shortfall exists when considering the evidence. Px. 2-6. The Respondent is required to pay TTD benefits to Mrs. Oser for the period she is off work due to her work injury sustained on February 1, 2017, from and including October 3, 2017, through October 16, 2017, and June 21, 2018, to September 16, 2019, the date of hearing in this matter, a period of 301 days equaling 66 weeks at $330.00 or $21,780.00, should have been paid. Following a credit to Respondent for $1,924.57 paid, a shortfall in TTD of $19,855.43 (60.17 weeks) exists and is to be paid by the Respondent.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF KANE	)		

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROSALINDA DIAZ,

Petitioner,

vs. NO: 17 WC 26990

SUNCAST CORPORATION,

20 IWCC0572

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, prospective medical, and temporary total disability (TTD) benefits, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator for the reasons outlined below, and finds that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment by Respondent. The Commission further finds in favor of Petitioner on the issues of notice, causal connection, medical expenses, prospective medical, and TTD benefits. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Indus. Comm'n*, 78 Ill. 2d 327 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission incorporates the Statement of Facts contained in the Decision of the Arbitrator, which is attached hereto and made a part hereof, and makes the following additional findings of fact:

1) As a janitor for Respondent, Petitioner additionally cleaned bathrooms. "Clean the sinks, clean the glass, clean the toilets, sweep, mopping, and clean the walls when they were dirty." (T.14). Petitioner performed these tasks on a daily basis. (T.14).

2) Petitioner testified that she also mopped a large hall, reception area, and five offices that did not have carpet. "I would dust down the desks and I would clean on top of the desks and also wash down, I don't know how you call it, the computers." (T.14-15). Petitioner would clean the office windows and used the vacuum in three areas; she would operate the vacuum with her right hand – her dominant hand. (T.15). Petitioner used both hands to mop. (T.15). She performed these tasks every day. (T.15).

3) On September 12, 2014, Physician Assistant Kristin Engle, of Castle Orthopaedics, evaluated Petitioner and noted that Petitioner worked as a janitor and had had right shoulder complaints that waxed and waned for the past year. Petitioner reported that her shoulder would pop on occasion. Examination revealed mild discomfort with range of motion, tenderness over her AC joint, and pain with crossed arm adduction test; Hawkins and Neer signs were positive. X-rays taken at the examination demonstrated arthritic changes within the AC joint and a Type II acromion. Petitioner was diagnosed with right shoulder impingement and AC joint pain. (T.18; RX12; RX16).

4) Physician Assistant Engle reported that Petitioner's right shoulder symptoms could have been aggravated by her work as a janitor and the repetitive movements of her job duties. Ms. Engle recommended physical therapy and anti-inflammatory medication. (RX12; RX16).

5) On May 30, 2017, Petitioner's job position changed from janitor to cell operator. (T.22; RX4). Petitioner testified that during the first week in her new position, she was required to assemble a deck box that was about her arms' length. (T.23-24). She obtained parts to assemble the box from a machine and then she put parts in a box on a conveyor belt. (T.23-24). The parts weighed approximately seven pounds. (T.26). Petitioner stated that the conveyor belt came up around waist height, and she had to raise her arms completely up so she could put the parts in the box. (T.24). "When I put those parts in the box, I had to go back and do the other parts." (T.25). One cycle took about three minutes to complete; Petitioner would perform this task all day, but she only did it for a week. (T.25-26).

6) Petitioner stated that during that week working as a cell operator, her right shoulder condition worsened. (T.27). She had been taking medication, but at this point, "[t]he medication was not doing any affect anymore." (T.27).

7) Petitioner further testified that she had a different, unrelated accident at work on July 11, 2017. (T.31). "I was working in the line and there was a part that fell down. And I had parts in my hand, and I stepped on it because I didn't see it. And I slipped on the floor and my waist and my knee were hurt." (T.31-32). Petitioner injured her left knee in the incident. (T.32). Petitioner completed an Incident Report on July 11, 2017. (T.32; RX5). Respondent's Exhibit 5 was the Incident Report which was consistent with Petitioner's testimony; the report stated that Petitioner injured her left knee and hip. (RX5).

8) Respondent's Exhibit 6 was Petitioner's statement, handwritten in Spanish and English, regarding the July 11, 2017 incident. (RX6). During cross-examination, Petitioner testified with respect to Respondent's Exhibit 6. She confirmed that she had completed the statement on July 11, 2017. Petitioner acknowledged that she had not reported any right shoulder injury at that time. (T.42-43).

9) Petitioner treated with Dr. Steven Chudik at Hinsdale Orthopaedics on September 29, 2017. (T.36; PX4; PX10, pg. 8; RX12). Dr. Chudik testified at his deposition that he had reviewed the Section 12 Report of Dr. Aaron Bare. (PX10, pg. 18). He disagreed with Dr. Bare's causation opinion:

> But as he highlighted in his notes, she had some earlier pains that were related to her work at that employment, and then progressed. And then as of June 12th of 2017, it got to where she couldn't work anymore. I would agree that that's very strong documentation – and I have those records as well – that shows that her work-related activities is a causative factor in the tear. And that June 12th specifically was the one that created the eventual need for treatment and was probably the most significant contributing factor at that point, changing a condition of her shoulder to requiring surgery. (PX10, pgs. 18-19).

10) Dr. Chudik testified that he could not say whether Petitioner had a rotator cuff tear in 2014.

> [W]hen you're doing repetitive activities like she was doing at that time, washing mirrors, vacuuming, mopping, doing things like that, those are all activities that are very common that I see in my practice all the time that aggravate the shoulder, and particularly the rotator cuff. And I'd have to say the majority of patients that present with that pain do not

actually have a rotator cuff tear, but symptoms of a dysfunctional rotator cuff. (PX10, pgs. 21-22).

Dr. Chudik stated that an irritated or fatigued rotator cuff can hurt in the same fashion as a patient with a rotator cuff tear. (PX10, pg. 22).

11) Dr. Chudik reiterated at his deposition:

> [I]t wasn't really until she started that job in May, which was much more challenging and demanding, not that the other one wasn't, but it was an increase in symptoms. And with that we saw the increase in symptoms and need for treatment, and likely the worsening of the condition in her shoulder. (PX10, pg. 24).

12) Dr. Bare, Respondent's Section 12 examiner, similarly diagnosed Petitioner with a right shoulder full-thickness rotator cuff tear and also recommended arthroscopic repair surgery. (RX1, pg. 12; Deposition Exhibit 2).

13) Dr. Bare opined that Petitioner's right shoulder condition was not causally related to the alleged repetitive trauma injury. (RX1, pgs. 12-13; Deposition Exhibit 2).

> [C]onsidering she had pain in 2013, 2014, 2015, I noted that her pain did not resolve. And the fact – probably most significantly, the fact that she sought medical care six weeks prior to her reported injury, which there actually was no injury reported on her symptoms. And at that time her doctor recommended an MRI. It was highly likely, to a high degree of medical certainty, I could say that her pain was present prior to that and her tear was most likely present; therefore, I did not believe that causation exists linking need for treatment or care as pertains to her right shoulder from a reported work episode that occurred in June of 2017. (RX1, pg. 13; Deposition Exhibit 2).

14) Dr. Bare further opined that Petitioner's right shoulder tear was not causally related to her job as a janitor. (RX1, pg. 13; Deposition Exhibit 2). Although Dr. Bare found that Petitioner's duties required repetitive but varied use of her right arm, he explained:

> The job requires her to use her arms. It doesn't necessarily require to do a lot of heavy reaching and lifting. Therefore, the occupation as a janitor does not predispose somebody to developing a rotator cuff tear. Many janitors out there right now that don't have rotator cuff tears have been doing it for

> 20 or more years. So the occupation itself doesn't cause rotator cuff tears. (RX1, pgs. 14-16).

He added: "[U]sually rotator cuffs fail either because of age or because someone had an injury, a bad fall, things like that. So typical jobs where you're doing most of the work below the chest level – pushing, sweeping, mopping, vacuuming – doesn't typically overload the rotator cuff tendon." (RX1, pg. 17; Deposition Exhibit 2).

15) During cross-examination, Dr. Bare agreed that mopping and using a broom might or could result in development of pain in Petitioner's right upper extremity. (RX1, pgs. 25-26; 28). Notwithstanding this, Dr. Bare did not agree that repetitive movements of the upper extremities could result in tearing of the rotator cuff. (RX1, pg. 31). He further added on cross-examination that the motion of pushing and pulling a mop or the activities of a work cell operator might temporarily aggravate symptoms of a tear, but would not accelerate the condition. (RX1, pgs. 31-32; Deposition Exhibit 2).

16) Dr. Bare did not believe that Petitioner's position in the assembly department contributed to the rotator cuff tear either. (RX1, pg. 17; Deposition Exhibit 2). He testified:

> One, this individual saw a doctor right around the time that she switched positions. So there's – at that time there was not an opportunity for repetitive use of the job because the person just started the job. And, also, the person was seen for shoulder pain right around the time she switched jobs and an MRI was ordered. There was also no injury. (RX1, pg. 18; Deposition Exhibit 2).

He added: "I think we can agree that the MRI was recommended, ordered during that office visit on 5/1/2017. If indeed she switched jobs in May of 2017, it's most likely that she changed positions after the MRI was ordered." (RX1, pgs. 18-19).

17) During cross-examination, Dr. Bare agreed that the work activities of a work cell operator, including performing repetitive movements of lifting up to 50 pounds, assembling, and packing on a regular basis throughout the day, might or could exacerbate Petitioner's right upper extremity condition. (RX1, pg. 29).

18) Dr. Bare had no concerns with respect to the recommended medical care, including the surgery. (RX1, pg. 19; Deposition Exhibit 2). He also opined that Petitioner was capable of working light duty. (RX1, pg. 20; Deposition Exhibit 2). "In my opinion, to back off her full duty demands will be – will lessen the chance of another temporary aggravation of the pain, therefore, backing off would be in her best interest. I still believe she could do it. It's just more likely that she will continue to have pain." (RX1, pgs. 34-35).

19) As of the date of arbitration, Petitioner testified that she wanted to proceed with surgery on her right shoulder. (T.38). Petitioner confirmed that she has not worked anywhere since she quit her job with Respondent on July 13, 2017. (T.38). Petitioner has not sustained any other accidents or injuries to her right shoulder since she stopped working for Respondent. (T.38-39).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator found that Petitioner failed to meet her burden of proof that she sustained an accidental injury that arose out of and in the course of her employment. The Arbitrator further found that Petitioner's current condition of ill-being and right shoulder rotator cuff tear predated the alleged injury date of June 12, 2017 and was unrelated to her employment with Respondent.

In a repetitive trauma claim, the claimant must prove by a preponderance of the evidence all elements necessary to justify an award under the Act. *Quality Wood Prod. Corp. v. Indus. Comm'n*, 97 Ill. 2d 417, 423 (1983). The claimant has the burden of establishing "some causal relation between the employment and the injury." *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill. 2d 52, 63 (1989). A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003).

The evidence herein demonstrates that Petitioner was hired by Respondent as a janitor on October 29, 2010. Petitioner's prior medical records revealed that on June 10, 2013, Petitioner sought treatment for right shoulder pain. She returned for additional treatment for her right shoulder complaints in 2014 and 2015. Petitioner testified and the medical records indicated that Petitioner's right shoulder pain at that time was due to her housekeeping duties for Respondent, specifically mopping and using a broom all day. Petitioner was referred to an orthopedic doctor and underwent therapy.

There was no further treatment until May 1, 2017. The Arbitrator noted that on May 1, 2017, Petitioner visited the office of Dr. Qadir, her primary care physician, with worsening shoulder pain. Dr. Qadir ordered a right shoulder MRI. On May 30, 2017, Petitioner changed from working as a janitor to working as a cell operator for Respondent so that she could have a better work schedule. Petitioner next returned to Dr. Qadir on June 3, 2017. Petitioner had continued right shoulder pain. The recommended MRI had been approved.

The Arbitrator indicated that Petitioner was alleging that her rotator cuff tear occurred on June 12, 2017 after she had stopped working as a janitor, and that her rotator cuff tear was not the result of her janitorial duties. Thus, the Arbitrator focused on Petitioner's job duties as a cell operator and found the opinions of Respondent's Section 12 examiner, Dr. Bare, more persuasive than the opinions of Petitioner's treater, Dr. Chudik. Dr. Bare testified that the time period Petitioner had worked as a cell operator, from May 30, 2017 through June 12, 2017, was insufficient to cause Petitioner's rotator cuff tear.

In reviewing Dr. Bare's deposition transcript, Dr. Bare noted Petitioner's pre-existing right shoulder complaints and treatment in 2013, 2014, and 2015 as a basis for his opinion, and further noted that Petitioner had sought medical care six weeks prior to her reported injury, that an MRI had been ordered at that time, and Petitioner's pain simply had not resolved by June 2017. Dr. Bare therefore opined, "her pain was present prior to that and her tear was most likely present; therefore, I did not believe that causation exists linking need for treatment or care as pertains to her right shoulder from a reported work episode that occurred in June of 2017." (RX1, pg. 13; Deposition Exhibit 2).

Petitioner argues, however, that her cumulative, repetitive duties for Respondent as a janitor and later as a cell operator caused or aggravated the right shoulder rotator cuff condition. The Arbitrator did make findings with respect to Petitioner's job duties as a janitor. The Arbitrator again relied on Dr. Bare's opinion that Petitioner's job duties as a janitor did not cause the rotator cuff tear because there would not be significant strain on the rotator cuff to cause a tear. The Arbitrator noted that Dr. Bare also did not believe that Petitioner's janitorial duties would have actually caused or accelerated the underlying shoulder condition. Notwithstanding this, Dr. Bare's testimony is in fact consistent with Petitioner's position.

Dr. Bare conceded that Petitioner's job duties as a janitor required repetitive but varied use of her right arm, but he found no evidence of heavy reaching or lifting that could contribute to a rotator cuff injury. He further testified that job duties "below the chest level – pushing, sweeping, mopping, vacuuming – doesn't typically overload the rotator cuff tendon." (RX1, pg. 17; Deposition Exhibit 2). However, the job description for a Janitor at Suncast Corporation and Petitioner's testimony demonstrated reaching, lifting, and work above the chest level, including emptying garbage cans, removing garbage bags from the cafeteria and offices, and cleaning bathroom walls and glass and office windows; Petitioner performed these tasks on a daily basis.

During cross-examination, Dr. Bare agreed that mopping and using a broom might or could result in development of pain in Petitioner's right upper extremity; he further agreed that the motion of pushing and pulling a mop or the activities of a work cell operator might temporarily aggravate symptoms of a tear, but would not accelerate the condition. Dr. Bare specifically stated that the work activities of a work cell operator, including performing repetitive movements of lifting up to 50 pounds, assembling, and packing on a regular basis throughout the day, might or could exacerbate Petitioner's right upper extremity condition.

On the one hand, Dr. Bare acknowledged that Petitioner's job duties as a janitor and cell operator could cause or aggravate her upper extremity pain or condition. He also testified that Petitioner's pain and tear were present prior to June 2017. However, Dr. Bare stopped short at opining that Petitioner's job duties could cause a rotator cuff tear.

Nevertheless, the evidence demonstrated that some of Petitioner's janitorial duties involved reaching or lifting that could have contributed to a rotator cuff injury and Petitioner's prior medical records listed her job duties for Respondent as a cause for her right shoulder complaints. Whether Petitioner's work as a janitor or cell operator caused the actual tear is unclear as the MRI confirming the diagnosis was not completed until July 15, 2017. What is clear, however, is that the evidence demonstrated a gradual development of right shoulder complaints and symptoms that eventual led to a right shoulder rotator cuff tear diagnosis. Petitioner's treater, Dr. Chudik, testified along these lines, stating that an irritated or fatigued rotator cuff can hurt in the same fashion as a patient with a rotator cuff tear.

The Commission finds that although Drs. Bare and Chudik provided contrasting causation opinions, they agreed that Petitioner had a right rotator cuff tear and that she required surgery. The preponderance of the evidence, especially the compelling, prior medical records, demonstrated a consistent history of repetitive use of Petitioner's right shoulder to perform her job duties as a janitor and later as a cell operator and a consistent timeline of her subsequent right shoulder complaints and symptoms.

The Commission further notes that even though the manner in which Petitioner reported her injuries and resigned from Respondent's employ appear to cast uncertainty, the actual, documented medical evidence of the timeline of Petitioner's work for Respondent and her subsequent right shoulder complaints and symptoms support her claim. There is sufficient evidence, including the medical testimony, to find that Petitioner's job duties for Respondent were *a* causative factor, if not the causative factor, in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). The Commission therefore reverses the Arbitrator's Decision with respect to accident and causal connection as the evidence demonstrates that Petitioner's work duties either caused or contributed to Petitioner's right shoulder rotator cuff tear.

With respect to the date of accident and timely notice pursuant to the Act, Petitioner alleges that the correct manifestation date was June 3, 2017 – the first time Petitioner returned to her primary care physician, Dr. Qadir, following her job change from janitor to cell operator for Respondent on May 30, 2017.

Our Supreme Court has provided various factors to assist in determining the manifestation date for a repetitive trauma injury. The manifestation date may be the date on which the employee required medical treatment or the date on which the employee can no longer perform his or her work activities. *Durand v. Indus. Comm'n*, 224 Ill. 2d 53, 72 (2006).

> A formal diagnosis, of course, is not required. The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee. [citation omitted] However, because repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. *Id.*

Our Supreme Court held that it was unrealistic and unwarranted to require an employee suffering from a repetitive trauma injury to fix, as the date of accident, the date the employee became aware of the physical condition, presumably through medical consultation, and its clear relationship to the employment. *Id.* at 71.

> By their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. [citation omitted] Similarly, an employee is also clearly prejudiced in the giving of notice to the employer [citation] if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident. *Id.* at 68.

While our Supreme Court has stated that the standard for determining the manifestation date remains flexible, neither of Petitioner's alleged manifestation dates fit the Court's criteria. The June 3, 2017 office visit note indicated that Petitioner was there to address a nail fungal condition on her hands and feet. Petitioner also reported that the prescribed MRI of the right shoulder had been approved. There is also no support for the alleged June 12, 2017 manifestation date. It appears that this initial date was the date Petitioner had reached the 10-day mark working as a cell operator for Respondent and she would undergo an evaluation for this time period. (*See* RX13).

Having already determined the issues of accident and causal connection for Petitioner's right shoulder rotator cuff tear, the Commission finds that the appropriate manifestation date, as supported by the evidence, is July 18, 2017. On this date, Petitioner reviewed the results of the July 15, 2017 MRI with Dr. Qadir and was diagnosed with a right supraspinatus tendon rupture; treatment recommendations followed thereafter. The medical records leading up to the MRI demonstrated a consistent history of Petitioner's job duties for Respondent contributing to her right shoulder pain. It can reasonably be inferred that by July 18, 2017, Petitioner's injury and its causal link to her work became plainly to her. The Commission further finds that Petitioner provided timely notice to Respondent under the Act. Both Petitioner and Respondent provided evidence that Petitioner reported her right shoulder injury to Respondent on July 21, 2017. (*See* PX7; RX11). This date is well within 45 days after the accident date as provided in Section 6(c) of the Act.

With respect to the medical bills incurred as a result of Petitioner's right shoulder injury, Respondent does not dispute the reasonableness or necessity of the treatment rendered or recommended. Respondent disputes its liability based on no accident. Having decided the issues of accident and causal connection for Petitioner's right shoulder rotator cuff tear, the Commission awards the reasonable, necessary, and causally-related medical bills as detailed in Petitioner's Exhibit 6. The Commission further awards the recommended rotator cuff arthroscopic repair surgery and post-surgical treatment. The Commission notes that Respondent's Section 12 examiner, Dr. Bare, did not dispute any of the treatment rendered and had also recommended the right shoulder surgery.

Finally as to TTD benefits, Respondent disputes that it is liable to Petitioner for payment of benefits because she did not sustain a work-related injury, and also argues that Petitioner is not entitled to TTD because she voluntarily quit her job with Respondent. Petitioner requests TTD from September 29, 2017, the date Dr. Chudik took Petitioner off work, through the date of arbitration, June 26, 2019.

The evidence demonstrates that Dr. Chudik had kept Petitioner off work through April 20, 2018. At his deposition, on December 3, 2018, Dr. Chudik testified that he had had Petitioner off work pending surgery. Dr. Bare testified that he believed that Petitioner could have worked light duty because she had been able to do it in the past even though she had had the rotator cuff injury for a long time. "In my opinion, to back off her full duty demands will be – will lessen the chance of another temporary aggravation of the pain, therefore, backing off would be in her best interest. I still believe she could do it. It's just more likely that she will continue to have pain." (*See* RX1, pgs. 34-35).

In light of the foregoing, the Commission awards Petitioner TTD from September 29, 2017 through June 26, 2019. The preponderance of the evidence finds support for the requested TTD as Dr. Chudik had kept Petitioner off work pending surgery and Dr. Bare testified that having Petitioner return to her job duties could cause her continued pain.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on November 8, 2019, a copy of which is attached hereto, is hereby

reversed for the reasons stated above. Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent; Petitioner's injury manifested on July 18, 2017; and Petitioner's current condition of ill-being with respect to the right shoulder is causally related to the July 18, 2017 accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills as contained in Petitioner's Exhibit 6 totaling $56,038.88 pursuant to Sections 8(a), 8.2, and 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to the recommended rotator cuff arthroscopic repair surgery and post-surgical treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $330.00 per week for 90 6/7 weeks, commencing September 29, 2017 through June 26, 2019, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all other amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for 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: SEP 29 2020

D. Douglas McCarthy

DDM/pm
O: 8/5/2020
052

Stephen J. Mathis

DISSENT

I, respectfully, dissent. As the Majority correctly notes, the Commission maintains original jurisdiction, but as the Court noted in *R & D Thiel v. Illinois Workers' Compensation Commission*, 398 Ill. App. 3d 858, 866, 923 N.E.2d 870 (2010), "whether the Commission's credibility findings which are contrary to those of the arbitrator are against the manifest weight of the evidence. A resolution of the question can only rest upon the reasons given by the Commission for the variance." The Majority focuses its analysis on accident and causation and provides one sentence as to the Petitioner's credibility or lack thereof. If Petitioner is not credible, as appropriately indicated by the Arbitrator, then it is incumbent on the Majority to provide an explanation as to why they now find her believable.

The Arbitrator provided a detailed analysis as to why she found Petitioner lacked credibility. For example, Petitioner testified she reported her right shoulder injury to Ms. Aguilar during her June 16, 2017 performance review. T. 30. Ms. Aguilar unequivocally denied such conversation took place. T. 54, 61. These opposing testimonies cannot be reconciled, and the Arbitrator believed Ms. Aguilar and not Petitioner. The Majority's recitation of Petitioner's medical treatment and the discussion of the opposing experts' opinions provides no basis as to why Petitioner is now credible.

More importantly, the Majority misconstrues the competing experts' opinions. As the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." As the Arbitrator found "Dr. Bare's opinions [is] persuasive that even if petitioner were to argue the rotator cuff tear was related to her job duties while working as a janitor, the job duties would be inconsistent with development of a rotator cuff tear as there would not be significant strain on the rotator cuff to cause a tear." *Arbitration Decision*, p. 10, ¶ 4.

Petitioner testified to her job duties as a janitor which required her to clean and mop the bathrooms, the office, and the cafeteria. T. 13-15. Dr. Bare testified Petitioner's job duties as a janitor bore no causal relationship to her resulting condition of ill-being, a torn rotator cuff. RX1, p. 13. As to the basis of this opinion, Dr. Bare explained Petitioner's job duties required her to use her arm in a repetitive manner but the actual tasks she performed were varied throughout the day: "[s]o it does require use of the arm in different fashions, different manners, different mechanisms, which require different use of different muscles; therefore, it's not a repetitive task job. It's a repetitive-use-of-the arm-type job, if that makes sense. It's a little bit hard to discuss this, but we need to. And, my opinion, she uses her arm during the day, but does a lot of different activities with her arm." RX1, p. 16. Dr. Bare went on to explain "[s]o if an individual had a highly repetitive job that required overhead, like hundreds of times a day, maybe like a pipefitter, things like that, it's possible that repetitive action could contribute to the damage of a rotator cuff." RX1, p.17. Simply put, Petitioner's job duties, although repetitive in nature, were not the type

of duties nor did they involve the body mechanics which lead to the development of a rotator cuff tear. See, *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 210-11, 614 N.E.2d 177 (1993) (The Commission is allowed to consider evidence, or the lack thereof, of the repetitive "manner and method" of a claimant's job duties.)

Certainly, Dr. Chudik testified in opposition opining a causal relationship existed between Petitioner's job duties as a janitor and her development of a rotator cuff tear. PX10. What Dr. Chudik failed to provide, though, is the basis for his opinion. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶ 24 ("An expert opinion is only as valid as the reasons for the opinion." (Internal quotation marks omitted)). As the Majority notes Dr. Chudik repeatedly states his conclusion that Petitioner's work duties are a causative factor, (*Supra*, p. 3) but provides no testimony as to why other than Petitioner's history of symptoms which she associated to her work duties. PX10, p. 20-21.

As to a theory of aggravation, Dr. Bare explained Petitioner's work duties would cause pain, an aggravation of her symptoms but did not cause nor aggravate her underlying condition of ill-being. RX1, p. 31-32; 38. For example, many people who suffer from carpal tunnel syndrome experience symptoms while sleeping. Sleeping does not cause nor aggravate the carpal tunnel syndrome but allows the symptoms to become prescient.

For the reasons stated above, I, respectfully, dissent. I would affirm and adopt the decision of the Arbitrator.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

ROSALINDA, DIAZ
Employee/Petitioner

Case# **17WC026990**

SUNCAST CORPORATION
Employer/Respondent

20IWCC0572

On 11/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

5317 CASTANEDA LAW OFFICE
JOHN J CASTANEDA
514 W STATE ST SUITE 210
GENEVA, IL 60134

0560 WIEDNER & McAULIFFE LTD
NICOLE SCHNOOR
ONE N FRANKLIN ST SUITE 1900
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
ARBITRATION DECISION
19(b) 8(a)

Rosalinda Diaz
Employee/Petitioner

v.

Suncast Corporation
Employer/Respondent

Case # 17 WC 26990
Consolidated case:

20IWCC0572

An *Application for Adjustment 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 **Geneva**, on **June 26, 2019.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. **X** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. **X** Was timely notice of the accident given to Respondent?

F. **X** Is Petitioner's current condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. **X** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. **X** Is Petitioner entitled to any prospective medical care?

L. **X** What temporary benefits are in dispute?
☐ TPD ☐ Maintenance **X** TTD

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident **June 12, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was not*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to an accident.

In the year preceding the injury, Petitioner earned **$20,800.00;** the average weekly wage was **$400.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **4** dependent children.

Respondent ***does not owe*** for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0.**

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained accidental injuries to her right shoulder on June 12, 2017, or any other date, that arose out of and in the course of her employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Christine M Ory
Signature of Arbitrator

November 5, 2019
Date

NOV 8 - 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosalinda Diaz)
Petitioner,)
vs.) **No. 17 WC 26990**
Suncast Corporation)
Respondent.)
)

20 IWCC0572

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing under the provisions of §19b/§8a in Geneva on June 26, 2019. The parties agree that on June 12, 2017, the petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner's wages, in the year pre-dating the claimed accident, were $20,800.00; and her average weekly wage, calculated pursuant to §10 was $400.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment;
2. Whether petitioner gave respondent notice of the accident within the time limits set in the Act.
3. Whether respondent is liable for medical bills.
4. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
5. Whether petitioner is entitled to payment for prospective medical treatment.
6. Whether petitioner is due TTD.

STATEMENT OF FACTS

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Rafael Arellano, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Mr. Arellano served as an interpreter for the petitioner.

Rosalinda Diaz, Petitioner, Testimony

Petitioner testified she was 52 years of age, weighed 134 pounds and sstood 4 feet 11 inches tall. She began working for respondent on October 29, 2010. She had found her employment through her husband, who used to work for respondent. She was hired as a janitor to work in the office section of the plant. Her shift was from 5 p.m. to 1 a.m. As a janitor, she did not work in the production area of the plant. She swept and mopped floors, emptied garbage cans and bags from the cafeteria and offices. She cleaned bathrooms, dusted desks and operated a vacuum. She is right-hand dominant. When she started working for respondent, she had no problems with her right arm or right shoulder.

On March 3, 2014, she saw her primary care physician, Dr. Abdul Qadir, and complained of right shoulder pain. She also complained to Dr. Qadir of right shoulder pain on July 23, 2014; X-rays were ordered. Petitioner was referred to Castle Orthopaedics; where she saw an orthopaedic surgeon on September 12, 2014. Additional X-rays were ordered and Meloxicam was prescribed. She returned to Dr. Qadir on December 6, 2014 with continued complaints of right shoulder pain. Dr. Qadir prescribed Celebrex. She did not return to Dr. Qadir until October 5, 2015, and then again not until May 1, 2016 (sic). On May 1, 2017, petitioner continued to work as a janitor. Dr. Qadir ordered a MRI.

On May 30, 2017, respondent moved petitioner from the janitor job to cell operator at her request as she was tired of working nights and wanted to be with her kids. As a cell operator, she assembled parts in a box. She performed this work for one week. She stated as she performed the work, her shoulder got worse. She returned to Dr. Qadir at the end of the week of June 3, 2017.

Around June 12, 2017, petitioner had a meeting with Maria Aguilar regarding performance as a cell operator. Petitioner was advised she was performing her job well, but needed to do it faster. Petitioner advised Maria her shoulder was hurting. Maria advised that it was probably because she wasn't used to doing the work.

Petitioner returned to Dr. Qadir on July 6, 2017. An MRI was recommended and obtained on July 15, 2017 from CDI in Geneva. She saw Dr. Qadir again on July 18, 2017 to discuss the MRI.

On July 11, 2017, petitioner had slipped on a part that had fallen down. She injured her waist and left knee. An accident report was completed that day. On July 13, 2017, petitioner quit her job as she felt a lot of pressure because she was not able to complete her job fast enough due to her right shoulder hurting. Petitioner completed another accident report on July 21, 2017 because her knee and waist were hurting a lot. She testified she was told by security they did not have the accident report she reportedly filled out on July 11, 2017 and needed to complete another one. Petitioner identified Petitioner's Exhibit No. 7 as the report she completed on July 21, 2017. She mentioned her right shoulder as it was still hurting; she was told by Maria and security to write everything in the report.

Petitioner returned to Castle Orthopaedics on August 1, 2017. Petitioner explained how her shoulder started hurting. Surgery was recommended. Petitioner saw Dr. Qadir on September 14, 2017, who referred her to Dr. Chudik. Petitioner saw Dr. Chudik on September 29, 2017. Petitioner explained to Dr. Chudik how it was that her shoulder started hurting. Dr. Chudik recommended she stay off work. Dr. Chudik has not released petitioner to return to work as of the last time she saw him. She also received physical therapy from November 3, 2017 to March 8, 2018. Petitioner continued to see Dr. Chudik through April 20, 2018. Petitioner has not worked anywhere since she quit working for respondent. She wants to have the surgery so she can get better and get back to work.

She confirmed she was examined by Dr. Aaron Bare on May 7, 2017 at respondent's request.

On cross-examination, petitioner could not remember if an MRI of her right shoulder was ordered in 2014. She didn't recall if she told Dr. Qadir if her right shoulder pain worsened after she was working as a cell operator. Petitioner first insisted she told Dr. Qadir about her right shoulder every time she saw the doctor. She then changed her testimony to say she didn't recall if she hadd.

Petitioner identified Respondent's Exhibit No. 6 as the report she completed on July 11, 2017. She agreed she did not mention her right shoulder in that report. She agreed she did not complete a report for the June 11, 2017 injury (sic), but advised Maria during her performance review.

Petitioner identified Respondent's Exhibit No. 13 as petitioner's performance review. Petitioner agreed she had initialed that she understood the proper procedures to report an injury. Petitioner acknowledged she did not provide any written report of her shoulder injury until after she had quit. Petitioner acknowledged Petitioner's Exhibit No. 7 was dictated to her daughter on July 21, 2017.

Maria Aguilar Testimony

Maria Aguilar was called upon to testify in behalf of respondent. She has been employed by respondent for 17 years; presently as a group leader. Her duties as a group leader included training, explaining rules and reporting accidents. Aguilar identified Respondent's Exhibit No. 13 as a report of petitioner's performance that was dated June 16, 2017. It included an acknowledgement that petitioner was aware of reporting an injury. Aguilar denied that petitioner reported anything about an injury to her right shoulder at the time of the performance or at any time when she worked with petitioner. Aguilar was not aware of petitioner's right shoulder injury until she learned through respondent's attorney.

Aguilar was aware petitioner fell while working on the line on July 11, 2017. The only interaction Aguilar had with petitioner was when she resigned. Aguilar completed a sign statement on January 19, 2018, identified as Respondent's Exhibit No. 7. In the statement, Aguilar indicated petitioner fell and was taken security by group leader Eddie Hernandez to report the injury. Petitioner declined to go for treatment. Thereafter, petitioner came to Aguilar and advised she wished to quit as it was a lot of work and the machines ran fast. To her recollection, petitioner never told Aguilar about problems with her right shoulder. If petitioner had problems with her right shoulder, Aguilar would be the one to whom she would have reported the problem.

Rubicelia (Ruby) Ayala Testimony

Ruby Ayala was called upon to testify in behalf of respondent. She was employed by respondent as an HR assistant. She was employed by respondent for 28 years. Her duties include taking care of insurance forms and doing part of the hiring process.

On July 13, 2017, petitioner was brought to Ayala's office as she wanted to resign. Petitioner indicated she wanted to quit as she could not keep up with the job. She further commented to Ayala that respondent treated their employees like f---ing slaves and she wanted to go home. Ayala identified Respondent's Exhibit No. 8 as her statement to which she testified. At no time during her employment did petitioner complain to Ayala that she had any right shoulder pain or injury, or was unable to work because of shoulder problems. This was the only interaction Ayala had with petitioner during her employment.

John Baunach Testimony

John Baunach was called upon to testify in behalf of respondent. He has been employed by respondent for 33 years; presently as the human resources manager. His duties included handling safety, security and human resources for all employees. Baunach would be made aware of any work injuries, unless the employee did not receive treatment. Baunach initially testified he learned of petitioner's June 12, 2017 alleged right shoulder injury after petitioner left her employment; specifically, on July 21, 2017. Later, Baunach testified it was actually in September or October, 2017 when respondent received the Application for Adjustment of Claim.

Baunach confirmed that the procedure that is followed, in the event an employee reports a work injury, is to report the injury to the group leader and then the injured employee is taken to

security to investigate the claim. A statement is then completed by security and the injured employee.

Baunach identified Respondent's Exhibit No. 6 as the report of petitioner's occurrence on July 11, 2017. The security officer who initialed the report was Shirley Farmer. Petitioner's Exhibit No. 7 differs from Respondent's Exhibit No. 6 as it was written in English and not signed by the security officer or petitioner. The content was also different. Baunach testified that he had not seen Petitioner's Exhibit No. 7 until the day of hearing.

Baunach confirmed petitioner requested a change in job duties from janitor to cell operator as she wanted to work first shift. Petitioner never advised that the reason for her request to change jobs was due to right shoulder problems.

Baunach confirmed the most weight petitioner had to lift was eight pounds in the deck box job within the cell operator position. The other position of wicker hose reel job where only one to two pounds. The job of cell operator did not require any overhead lifting.

Baunach confirmed respondent could accommodate any restrictions and would re-employ petitioner. Baunach would see petitioner a couple of times a week when she worked in the janitorial position. Baunach never observed petitioner having difficulty performing her duties as a janitor. Petitioner never complained of right shoulder problems to him.

Dr. Abdul Qadir Records (PX.1)

The records begin with the visit on June 3, 2017. At that time, petitioner complained of right shoulder pain. She was approved for a MRI. Petitioner was seen again on July 6, 2017 for an order for the right shoulder MRI. She returned on July 18, 2017 after completing the MRI which showed a complete tear of the supraspinatus distal tendon with retraction of the muscle and some degree of atrophy. Petitioner returned on September 14, 2017 needing a referral to see Dr. Chudik with Hinsdale Orthopaedics.

On February 7, 2018, she was seen for a routine physical. She had complaints of pain in the right shoulder which was reportedly due to a work injury.

CDI Geneva Records (PX.2)

The July 15, 2017 right shoulder MRI showed a full-thickness rotator cuff tear with mild supraspinatus muscle atrophy an intrasubstance degenerative change in the infraspinatus tendon.

Castle Orthopaedics & Sports Medicine Records (PX.3)

Petitioner was seen by Kristin Engle PA on July 26, 2017. Petitioner reported she was having pain in the right shoulder for a month or two. She also reported she had shoulder pain in 2014, but was doing fairly well until the last month or so. She denied sudden injury. Petitioner reported she changed jobs from janitor to machine operator; which was reported as very repetitive. She denied any sudden injury. Surgery was proposed, but was put off due to insurance issues.

Hinsdale Orthopaedics Records (PX.4)

Petitioner was seen by Dr. Steven Chudik on September 29, 2017 for right shoulder pain. Petitioner reported it began on June 12, 2017 from an injury at work without direct trauma. She reported she had worked as a housekeeper for 6.5 years and the pain began in May, 2017 from repetitive mopping and cleaning. On May 29, 2017, petitioner moved to the machine operator position and the pain increased. She reported the position required her to do a lot of repetitive

movement, some overhead lifting and putting parts together. The diagnosis was rotator cuff supraspinatus tear on the right. Arthroscopic rotator cuff repair was recommended.

Petitioner returned on December 15, 2017. Physical therapy was helping, but surgery was still required. She was seen again on January 26, 2018, March 9, 2018 and April 20, 2018.

Petitioner was kept off work by Dr. Chudik as of September 29, 2017 through the period he treated her.

ATI Physical Therapy Records (PX.5)

At the direction of Dr. Joshua Alpert, petitioner was initially evaluated for physical therapy for her lumbar spine and left knee on September 25, 2017 for an injury that occurred on July 11, 2017. Lower back and left knee physical therapy concluded on November 17, 2017.

On November 3, 2017, petitioner was initially evaluated for physical therapy to her right shoulder as a referral by Dr. Chudik. According to these records, therapy to the right shoulder concluded on December 29, 2017.

Medical Bills (PX.6)

Petitioner claims the following are for treatment of the claimed work accident:

$1,833.00 Center for Diagnostic Imaging (07/15/2017)
$909.00 Dr. Steven Chudik/Hinsdale Orthopaedics (09/29/2017-04/08/2018)
$50,533.88 ATI (11/03/2017-06/21/2018)
$830.00 Dr. Abdul Qadir (06/03/2017, 07/06/2017, 07/18/2017, 02/07/2018)
$183.00 Castle Orthopaedics (07/26/2017)

Suncast Corporation Security Department Security Statement (PX.7)

Petitioner's July 21, 2017 statement regarding an incident of July 11, 2017 indicated she accidently tripped over a piece of material and fell hurting her left hip and left knee.

In a separate paragraph, petitioner stated she had been working in the plant for a week and a half when she was called in for a review by her supervisor, Maria Aguilar, who advised petitioner she was not doing her job good and fast enough. Petitioner reported that she told her she was doing the best she could, but her shoulder was hurting. Aguilar advised that it was because petitioner was not used to doing the work.

Work Cell Operator Job Description (PX.8 & RX.2)

The job description includes the qualifications and physical requirements of the work cell operator job which includes standing, walking, bending, lifting, stopping, assembling and packing. The weight of parts is from two ounces to twenty pounds.

Janitor Job Description of (PX.9 & RX.3)

The job description of the janitor is typical job duties of a janitor at various locations within respondent's plant. The job description includes cleaning of the production plant, which petitioner confirmed she did not perform.

Dr. Steven Chudik December 3, 2018 Deposition (PX.10)

Dr. Steven Chudik, board certified orthopaedic and orthopaedic sports medicine surgeon, testified in behalf of petitioner. He concentrates his practice in the treatment of upper and lower extremities. Dr. Chudik testified consistent with the histories and findings contained in his records.

He reviewed Dr. Qadir's records from 2014 and concluded it was more likely petitioner did not have a rotator cuff tear at that time. However, he further stated there was something definitely that happened in [June, 2017] that caused her inability to perform her job; up to that point she had good function.

On cross-examination, Dr. Chudik did not find petitioner's claim that she had no prior injury to her right shoulder, despite having treatment in 2014, was inconsistent with her history to him in 2017.

Northwestern Medicine Orthopaedics Records (PX.11)

Petitioner subpoenaed these records used by Dr. Bare for his exam of the petitioner.

These records include the June 10, 2013 record of Dr. Qadir, wherein petitioner reported right arm pain when mopping and denies trauma or injury during a routine physical. She was diagnosed with right arm sprain.

Petitioner returned to Dr. Qadir on July 23, 2014 with complaints of extensive right shoulder pain for almost a year. She reportedly worked in housekeeping and used a mop and broom all day. She was referred to an orthopaedic surgeon.

On December 6, 2014 she returned to Dr. Qadir with chronic right shoulder pain. She was diagnosed with right shoulder sprain and prescribed Celebrex.

She was seen on May 22, 2015 and May 26, 2015 after falling and hurting her second and third toe on the right side. On July 6, 2015, during a routine physical, petitioner reported right shoulder pain. On June 29, 2016, her routine physical with Dr. Qadir, petitioner had no complaints relative to her right shoulder. Petitioner was seen on September 26, 2016 for right foot puncture wound caused by a knife falling on her right foot. On November 29, 2016, petitioner was seen for fungal infection of her toes and hands. She was seen on January 19, 2017 for unrelated problems.

On May 1, 2017, petitioner was seen for right shoulder pain. She stated the shoulder pain had worsened since 2014; she now has developed right hand weakness. She also had complaints of left shoulder pain. The petitioner reported it started in 2014. Dr. Qadir reported she was supposed to follow up back in 2014 and get an MRI and never did. Dr. Qadir indicated as the pain has worsened [the MRI] now needs to be done. An MRI, without contrast, was ordered.

Petitioner returned on June 3, 2017 with right shoulder pain. She advised the MRI had been approved and was to be done soon. She was seen again on July 6, 2017; again Dr. Qadir reported an MRI was needed. Petitioner returned on July 18, 2017 after obtaining an MRI showing a tear of the supraspinatus distal tendon with retraction of the muscle and some degree of atrophy. Petitioner was referred to Dr. Saleem. On September 14, 2017, Dr. Qadir reported petitioner needed to see an orthopaedic surgeon due to the right full-thickness rotator cuff tear and petitioner had an appointment set with Dr. Chudik.

The records also included a report from December 10, 2012. Petitioner complained of lack of energy. She was diagnosed with malaise and fatigue and possible chronic sleep deprivation.

Dr. Aaron Bare February 20, 2019 Deposition (RX.1)

Dr. Aaron Bare, board certified orthopaedic surgeon, testified in behalf of respondent. He specializes in treatment of the lower and upper extremities. He examined petitioner on May 7, 2018. According to Dr. Bare's testimony, petitioner reported she was doing her normal job in the assembly department on June 12, 2017 when she developed pain when lifting and reaching with her right arm. Based upon the fact that petitioner had complaints dating back to 2014; and, more significantly, six weeks prior to the claimed June 12, 2017 accident, at which time an MRI of

petitioner's right shoulder was ordered, Dr. Bare determined the need for the rotator cuff surgery was not necessitated by the claimed June 12, 2017 work accident.

Dr. Bare testified that work of janitor, although repetitive, was done at below chest level, such as pushing, sweeping, mopping and vacuuming and did not typically overload the rotator cuff tendon. Dr. Bare also did into find petitioner's work as a work cell operator done at chest level caused the rotator cuff tear and the need for surgery.

Dr. Bare believed rotator cuff tears were the result of direct trauma; but more often, from degenerative changes over time.

Employee Status Change (RX.4)

The change showed petitioner changed from janitor on second shift to cell operator on first shift as of May 30, 2017.

Suncast Security Department Incident Report (RX. 5)

Petitioner reported to security that on July 11, 2017 that she slipped and fell on a piece she had previously dropped and landed on her left knee and hip. She applied an ice pack to her knee and returned to work.

Suncast Corporation Security Department Statement (RX.6)

The petitioner completed a report in Spanish, but was translated in English, on July 11, 2017. She reported she fell over a piece and hit her hip and left knee.

Maria Aguilar Statement (RX.7)

Aguilar's statement, regarding petitioner's work accident when the petitioner slipped and fell on the part and hurt her left hip and left knee, was in Spanish and translated into English. Aguilar stated petitioner never complained of right shoulder problems. Petitioner advised Aguilar that she wanted to quit because it was too much work and the machines were too fast.

Ruby Ayala July 13, 2017 Statement (RX.8)

Ayala statement reflected her testimony.

Employee Status Change (RX.9)

Petitioner's resignation was effective July 13, 2017; reason stated was that she could not keep up with production.

Receipt of Property & Safety Equipment Returned (RX.10)

Petitioner returned badge and safety glasses on July 13, 2017 after her resignation; stating she could not keep up with production.

Employee Accident Investigation Report (RX.11)

The report signed by Rosalinda Diaz on July 21, 2017 indicated she hurt her left knee and left hip on July 11, 2017 and added that her right shoulder got really swollen.

Dr. Abdul Qadir Records (RX.12)

All of these records were included and discussed in PX.1, PX.3, PX.4, PX.11.

Union Employee Performance Review (RX.13)

Petitioner's reviewed of June 16, 2017 was completed by Marie Aguilar.

Application for Adjustment of Claim (RX.14)

The Application for Adjustment of Claim was signed by petitioner on September 13, 2017 and alleges a repetitive injury to her right arm and shoulder.

Photos (RX.15)

Photos identified as pictures of the waste basket petitioner emptied, and the mirrors petitioner cleaned, in her performance of her job as a janitor.

Castle Orthopedics & Sports Medicine Records (RX.16)

Petitioner was seen on September 18, 2014 by Kristin Engle PA with complaints of right shoulder pain for the past year or so that waxed and waned. Petitioner denied any injury that started her pain. Diagnosis was right shoulder impingement and AC joint pain. PA Engle reported petitioner worked as a janitor and had to do frequent repetitive movements with her shoulder so her symptoms could be possibly exacerbated by this. Meloxicam and therapy was ordered. Petitioner was to return in six weeks and an injection or MRI would be considered.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator finds petitioner had a credibility issue as she testified inconsistently with the medical records, had convenient loss of memory on cross-examination and a questionable explanation for the appearance of the statement admitted as Petitioner's Exhibit No. 7.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, the Arbitrator makes the following conclusions of law:

It is fundamental that the petitioner has the burden of proving by a preponderance of credible evidence the elements of his or her claim. Vestal v. Indust. Comm'n, 84 Ill. 2d 469 (1981); Republic Steel Corp. v. Indust. Comm'n, 82 Ill. 2d 76, 85 (1980). The employee must show that he or she suffered an injury that arose out of and in the course of her employment. Sisbro, Inc. v. Indust. Comm'n, 207 Ill. 2d 193 (2003). The Arbitrator finds petitioner failed to meet her burden of proof that she sustained an accidental injury that arose out of and in the course of her employment.

In so finding, the Arbitrator finds Petitioner's condition of ill-being and right shoulder rotator cuff tear predated the alleged injury of June 12, 2017 and is unrelated to her employment at Suncast Corporation. In support thereof, the Arbitrator finds it significant that Petitioner had a long standing history of right shoulder complaints that while may have waxed and waned, never resolved. She even sought treatment with Dr. Qadir on May 1, 2017, six weeks before the alleged June 12, 2017 incident, and complained of worsening right shoulder pain. Petitioner's symptoms were significant enough at that visit that Dr. Qadir prescribed a right shoulder MRI. She also began complaining of left shoulder symptoms.

Additionally, the medical records of Dr. Qadir after June 12, 2017 do not reflect any change in petitioner's subjective complaints and there is no indication she reported a sudden worsening of her right shoulder condition after she began working in the assembly department to support an acute injury or that the job duties in the assembly department caused the rotator cuff tear.

The Arbitrator also finds Dr. Bare's opinions as to causation to be more persuasive than Dr. Chudik. Dr. Bare testified that the job duties from petitioner's short time working as a cell operator would have been insufficient to cause petitioner's rotator cuff tear. Petitioner would have had to work as a cell operator for an extended period of time, rather than less than two weeks. Further, he found it significant petitioner complained of increased pain on May 1, 2017 and Dr. Qadir prescribed an MRI. Dr. Bare also testified these types of rotator cuff tears are usually due to an acute injury or normal wear and tear and there was no evidence here of an acute injury.

In support of this finding, the Arbitrator further notes petitioner only worked in the deck box assembly position for approximately one week and the wicker hose reel position for approximately one week before the alleged June 12, 2017 incident. Per the testimony of both petitioner and Mr. Baunach, the deck box assembly position only required lifting up to 7-8 lbs. Mr. Baunach also testified that the wicker hose reel position required lifting less than 2 lbs. and that neither position would be considered strenuous. While the job description for a janitor mentions lifting up to 50 lbs., Mr. Baunach testified that it was a general job description for all positions within the plant and the positions in which petitioner worked would have never required lifting up to 50 lbs.

Dr. Chudik opined petitioner's job duties as a cell operator caused the rotator cuff tear on June 12, 2017. However, the Arbitrator finds it significant that Dr. Chudik appeared unaware that a right shoulder MRI had been recommended before petitioner even began working as a cell operator. He also did not explain how the rotator cuff tear could have occurred given the short duration petitioner worked as a cell operator. Dr. Chudik also failed to account for the lack of change in petitioner's subjective complaints in Dr. Qadir's records after June 12, 2017.

The Arbitrator further finds petitioner's testimony that she reported the right shoulder injury on June 16, 2017 during her performance review not credible. Petitioner testified she told Maria Aguilar she injured her right shoulder during the performance review. Ms. Aguilar denied ever having a conversation with petitioner in which she complained of right shoulder pain or an injury. During the performance review, petitioner even initialed a statement that she was aware of the procedure to report a workplace injury. Despite this, petitioner never requested to complete an incident report after she allegedly experienced a worsening of her right shoulder pain while working as a cell operator. Mr. Baunach and Ms. Ayala also testified petitioner never reported a right shoulder injury.

The Arbitrator also finds it significant that petitioner proved she knew the process for reporting a work place injury when she completed a statement following the unrelated July 11, 2017 incident as evidenced by Respondent's Exhibits 5 and 6. Petitioner admitted on cross-examination that she could have completed a statement related to the June 12, 2017 incident when she completed the statement for the July 11, 2017 incident but did not do so.

The Arbitrator further finds the second statement completed on July 21, 2017 that now references a right shoulder injury questionable. Petitioner testified she returned to the security office after her resignation, as Suncast no longer had a copy of her initial statement completed on July 11, 2017. However, respondent presented the initial statement at trial and submitted it into evidence as Respondent's Exhibit 6 proving this was inaccurate. Further, Mr. Baunach testified he did not receive a copy of the July 21, 2017 statement until the time of trial and it was different than

the July 11, 2017 statement as it was not signed or initialed by a security officer per protocol and it did not have a report number.

Comparing Respondent's Exhibit 6 and Petitioner's Exhibit 7, it is also apparent that the statement completed on July 21, 2017 differs from the July 11, 2017 incident and does not include all necessary information. It lists the location of incident as "Plant # 1 Suncast Corporation" and the statement completed on July 11, 2017 lists the location of incident as "D-3". The second statement does not list the time of incident, I.D. number or title. Petitioner did not explain why the second statement differed than the first statement and why it did not include all necessary information. The Arbitrator finds the authenticity of Petitioner's Exhibit 7 questionable.

Although petitioner prepared an Employee Accident Investigation Report of the July 11, 2017 accident on July 21, 2017 that stated petitioner had hurt her left knee and left hip, there was a line added that her right shoulder got really swollen. There was no evidence that petitioner claimed that she injured her right shoulder in the July 11, 2017 fall.

Regardless as to whether the second set of statements were actually completed on July 21, 2017, the Arbitrator finds the timing of the statements questionable. It was not until after petitioner resigned and appeared to be disgruntled with her employment at Suncast using expletives during her departure did she ever report the alleged right shoulder injury.

The Arbitrator further finds Dr. Bare's opinions regarding lack of causation between the rotator cuff tear and the janitorial job duties persuasive. Before addressing the janitorial job duties, the Arbitrator notes petitioner is alleging the rotator cuff tear occurred on June 12, 2017 after she stopped working as a janitor and is not the result of her janitorial duties. Nevertheless, the Arbitrator finds it necessary to address the testimony regarding the janitorial duties. The Arbitrator finds Dr. Bare's opinion persuasive that even if petitioner were to argue the rotator cuff tear was related to her job duties while working as a janitor, the job duties would be inconsistent with development of a rotator cuff tear as there would not be significant strain on the rotator cuff to cause a tear. Dr. Bare testified even if she experienced some discomfort while performing her job as a janitor, the janitorial duties would not have actually caused or accelerated the underlying condition. The Arbitrator finds it significant petitioner's own treating doctor even testified that while the job duties while working as a janitor could have irritated the rotator cuff, they did not cause the tear. Further, although petitioner requested a change from her position as a janitor to a work cell operator, she testified she made the request as she wanted to work a different shift. This is supported by Respondent's Exhibit No. 4. There is no indication petitioner requested the change because of her right shoulder pain and the janitorial duties.

Based upon the evidence taken as a whole, the Arbitrator finds petitioner failed to prove by a preponderance of the evidence that she suffered an injury to her right shoulder in a work accident that arose out of and in the course of her employment with respondent on June 12, 2017, or any other date.

As the Arbitrator determined petitioner did not sustain accidental injuries to her right arm from a work related accident, her case is dismissed and all other issues are moot.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edmund Terrance,

Petitioner,

vs. NO: 13 WC 30960

Paige Bus Enterprises,

Respondent.

20 I W CC0573

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, temporary total disability, medical expenses, prospective medical care, permanent partial disability and penalties and fees, and being advised of the facts and law, reverses in part the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

I. FINDINGS OF FACT

A. Background

Petitioner had been employed by Respondent as a Mechanic for one year prior to the date of his undisputed accident on September 16, 2013. In this position, Petitioner's duties included diagnosing and repairing school buses, preparing them for safety inspections and going on road calls. He lifted items such as gas tanks, starters, alternators and batteries. These items weighed 40 pounds and up. Petitioner testified that he was on his feet all day, but occasionally worked on his knees for twenty minutes to an hour, depending on the repair.

Prior to the accident, Petitioner had no left knee issues or arthritis and had never undergone a left knee MRI. He was also able to complete all of his work duties. As of the date

of accident, Petitioner stood approximately 6'1" and weighed approximately 300 pounds. Petitioner's primary care physician ("PCP") at the time was Dr. Daniels. His pre-accident treatment records confirm the lack of left knee treatment prior to September 16, 2013.

B. Accident and Medical Treatment

On September 16, 2013, Petitioner was working on a bus outside of the garage. He was walking in and out of the garage retrieving tools as needed. At that time, his supervisor was working on a sewer but had left the hole uncovered. On one trip back outside, Petitioner was concentrating on his work and his right leg fell into the hole. The hole measured two-and-a-half by three feet. As he fell, Petitioner's left knee slammed to the concrete and stopped him from falling completely into the hole. He immediately had excruciating left knee pain and was helped out of the hole by his supervisor. The supervisor immediately drove Petitioner to Advocate Occupational Health.

At Advocate, Petitioner complained of moderate throbbing pain in his left knee and the back of his right leg. X-rays revealed no acute findings. He had swelling in patellar area and pain to palpation over the medial joint line of his left knee. Petitioner was diagnosed with internal derangement of the left knee and was released to work with restrictions, but he did not report to work, testifying that he was unable to walk without pain.

On September 18, 2013, Petitioner followed up at Advocate for left knee pain. His pain was 6/10 and made worse by squatting. The diagnosis remained the same and Petitioner was released to regular duty beginning September 20, 2013. Petitioner testified that his knee was not better, however.

On September 20, 2013, Petitioner sought treatment with Dr. Pye in Chicago. Petitioner complained of left knee pain rating 4/10 as well as left thigh pain. An examination revealed limited range of motion ("ROM") and tenderness to palpation on the medial joint line. Dr. Pye diagnosed unspecified internal derangement of the left knee and a sprain and strain of other specified sites of the hip and thigh. He initially prescribed a muscle relaxer and recommended an MRI and x-rays of the left knee and thigh, followed by physical therapy. Dr. Pye placed Petitioner off work.

Petitioner testified that he handed the off work note to his supervisor and was not paid while he was off work undergoing therapy. He testified that he did not return to work for Respondent but sought out work elsewhere and he was hired by Estes Trucking on September 30, 2013. Petitioner explained that he was still in pain at that time, but testified that he lives alone and thus needed income to support his livelihood. Initially, Petitioner was performing general maintenance such as oil and fluid changes. He was also tasked with driving the trucks in and out of the garage, which involved pushing the clutch and driving eight, ten and eighteen speeds. Petitioner experienced knee pain while engaged in these tasks, and has been working ever since.

On October 22, 2013, a left knee MRI read by Dr. Bosman revealed: 1) a complex medial meniscus tear, probably complete, at the junction of the body and posterior horn with extrusion;

2) secondary high grade osteoarthritis of the medial compartment with bone on bone contact and reactive bone marrow edema in a periarticular distribution; and 3) low grade patellar chondromalacia. A bilateral knee x-ray on the same day was reviewed by Dr. Shahrooz and revealed mild to moderate degenerative osteoarthritis of both knees, left worse than right.

On October 28, 2013, physical therapist, Ellen O'Donnell, noted that the MRI revealed a large medial, posterior meniscal tear on the left with significant loss of cartilage. Petitioner also complained of left calf and ankle pain, intermittent elbow pain and lumbar pain. As of October 31, 2013, physical therapist Jim Holway noted Petitioner with displacement of lumbar intervertebral disc without myelopathy.

On November 4, 2013, Petitioner returned to Dr. Pye's clinic complaining of left calf pain and reporting that bending and getting up/down bothered his knee the most. Dr. Pye diagnosed: 1) displacement of lumbar intervertebral disc without myelopathy; 2) unspecified internal derangement of knee; 3) sprain and strain of other specified sites of hip and thigh; and 4) an elbow contusion.

On November 13, 2013, while working for Estes, Petitioner testified to having another incident where he was pushing a rolling tool cart and bent down to lift a heavy rotor that was in his way. After lifting it, his right his knee gave out. He visited physical therapist Jim Holway the following day and reported right knee pain and swelling, but no left knee pain. Petitioner indicated he could barely walk, felt like his right knee wanted to give out, and that the swelling was from wearing a right knee brace. He also stated it was difficult to put pressure on his right knee and that he felt a strain in his back the day before when he bent down to lift an object. Petitioner was diagnosed with a sprain and strain of the hip and thigh, internal derangement of the knee and displacement of the lumbar intervertebral disc without myelopathy.

On November 15, 2013, Petitioner presented to the Advocate Christ Medical Center emergency room ("ER") complaining of right knee pain after walking the day before when his right knee suddenly gave out. He had prior occasional clicking and catching in his right knee. It was noted at the time that he was supposed to schedule surgery for a left knee meniscal tear. Petitioner was diagnosed with a right knee strain. On November 20, 2013, Petitioner complained of pain in his low back, left knee, and right knee to physical therapist Ellen O'Donnell.

C. Respondent's Section 12 Examination – Dr. Mash

Petitioner then underwent a Section 12 examination at Respondent's request with Dr. Mash on November 21, 2013. The exam was difficult due to Petitioner's difficulty ambulating with his right knee brace. Dr. Mash noted no left knee effusion with full extension to approximately 120 degrees. Petitioner's left knee reflexes were normal. Dr. Mash reviewed medical records from Dr. Pye, Advocate Occupational Health, and diagnostic studies, but did not review pre-accident medical records.

Dr. Mash opined that the meniscal tear shown in the MRI was likely degenerative and not accident-related. He noted x-rays revealed significant osteoarthritic change in the left knee joint with joint space narrowing in all three compartments. Dr. Mash also opined that the MRI

20 I W CC0573

revealed a degenerative medial meniscal tear with high grade osteoarthritis of the medial compartment. He opined both diagnostic studies reveal chronic conditions. Dr. Mash opined that Petitioner had reached maximum medical improvement as of September 20, 2013 and that any work restrictions would be due to his preexisting problems, not the accident in question.

Dr. Mash diagnosed Petitioner with preexisting osteoarthritis in both knees and opined that his symptoms were related to an aggravation of this preexisting condition for which Petitioner should have recovered from by this time. He further opined that Dr. Pye's treatment had been excessive, as Petitioner had indicators of symptom magnification and was exaggerating his complaint. He had no further treatment recommendations and stated that further treatment should be provided with great care. Dr. Mash summarized his report by stating that, at best, Petitioner suffered a temporary aggravation of a preexisting condition which he should now be recovered from.

D. Additional Treatment

On November 21, 2013, Petitioner returned to Dr. Pye who performed a corticosteroid injection in Petitioner's left knee which provided relief for one week. The following week, on November 27, 2013, Petitioner reported low back and hamstring pain to Dr. Pye. There is no mention of knee pain in the record, but left knee ROM was improved, although the internal derangement diagnosis remained. Petitioner's left knee complaints continued and, on December 11, 2013, Petitioner complained of 8/10 pain in both knees. Dr. Pye noted that Petitioner's job would not let him off of work for left knee surgery.

Petitioner visited Dr. Pye's clinic for the last time on January 2, 2014. He complained of 4/10 pain in his left knee. An exam revealed bilateral knee valgus deformity with identical ROM. The left knee had generalized soft tissue swelling and tenderness in the medial joint line.

Petitioner subsequently sought another opinion from Illinois Orthopedic Network. On January 15, 2014, Petitioner presented to Dr. Levi offering a consistent mechanism of injury and stating he had no pre-accident left knee issues. His relevant complaint was left knee pain. Dr. Levi noted moderate left knee effusion, medial/lateral joint line tenderness and severe left knee pain. He reviewed the MRI and found a left medial meniscus tear with extrusion in the body and the posterior horn with arthritic changes on the medial compartment as well as chondromalacia of the patella. Dr. Levi opined that the meniscus tear was directly related to the work accident. He recommended a left knee arthroscopy.

During the same period of time, Petitioner treated with Dr. Primus at Chicago Sports Orthopedics for his unrelated right knee condition. On February 7, 2014, Petitioner received no left knee treatment from Dr. Primus because he did not want any confusion between injuries. A right knee injection helped his symptomatology. Thereafter, Petitioner decided to transfer his left knee care to Dr. Primus as well, and he received a referral from Dr. Levi to Dr. Primus.

As of March 7, 2014, Dr. Primus noted that Petitioner was presenting for a left knee injury that occurred at work. He reviewed Petitioner's left knee MRI and diagnosed a complex tear of the medial meniscus and advanced degenerative joint disease. A left knee x-ray indicated

near bone-on-bone joint space narrowing indicative of medial and lateral patellofemoral degenerative changes. Dr. Primus performed a left knee injection and recommended physical therapy.

On March 21, 2014, Petitioner followed up with Dr. Primus for his left knee pain. He indicated that he did not go to physical therapy, as the available times interfered with his work schedule. It was noted that another injection had been performed March 14, 2014. Petitioner was diagnosed with knee pain, localized osteoarthritis, chondromalacia and a meniscus tear.

On April 25, 2014, Petitioner presented to Dr. DeBartolo at Chicago Sports Orthopedics for knee pain. He indicated he was taking double doses of Tramadol and had run out and was now taking Hydrocodone. A bilateral knee exam was unchanged since the previous visit. Petitioner's symptoms were stable and consistent with localized osteoarthritis of the knee (primary or secondary) and patellofemoral chondromalacia. Therapy, injections and a left knee brace were prescribed. Petitioner underwent the recommended left knee injection on May 13, 2014, along with a knee drain to remedy swelling and clicking.

On November 30, 2015, Respondent's Section 12 examiner, Dr. Mash, authored an addendum report after reviewing additional diagnostics and records. He stated that his opinions from his initial IME remained unchanged. Dr. Mash did indicate, however that any additional medical care required by Petitioner was unrelated to the work accident.

In the interim Petitioner's unrelated low back pain increased and eventually led to lumbar surgery. With regard to his left knee, on November 9, 2016, Petitioner presented to Dr. DeBartolo who prescribed bilateral knee steroid injections and a left knee drainage. The recommended treatment was performed on December 7, 2016. Petitioner followed up the next year and underwent additional recommended injections and knee drainage on November 10, 2017.

Petitioner last saw Dr. DeBartolo on March 26, 2018 reporting that he was experiencing bilateral knee swelling, popping and increased left knee pain. Petitioner received a left knee steroid injection and knee drainage. He was scheduled to return for repeat left knee gel injections after May 10, 2018. As of the arbitration date of June 13, 2018 Petitioner had not returned to Dr. DeBartolo.

E. Deposition Testimony – Dr. Mash

Dr. Mash was called as a witness by Respondent and gave deposition testimony on March 3, 2016 relating to his Section 12 examination report and his opinions regarding Petitioner's condition of ill-being and its relatedness, if any, to the accident at work. He testified consistent with the contents of his report. However, Dr. Mash added that Petitioner would likely need conservative care of medication, physical therapy and injections en route to a total knee replacement which is unrelated to the work accident. He testified that, irrespective of causation, restrictions would be reasonable for Petitioner's knee condition. Dr. Mash also testified that, due to the advanced stage of degeneration in Petitioner's knee, he believed Petitioner's knee had been symptomatic prior to the accident.

On cross-examination, Dr. Mash agreed that Petitioner had a preexisting condition that had been aggravated by an acute injury, but that he had since recovered. He acknowledged that without reviewing prior medical records it was difficult to determine which symptoms were present pre-accident. He also acknowledged he had no way of knowing if Petitioner ever returned to his pre-accident baseline level of health.

F. Surveillance Evidence

Between September 27, 2013 and December 3, 2013 Petitioner was observed via surveillance by David Smart, a private investigator, who has been in the business for 30 years. Throughout this surveillance period, Petitioner was seen shopping at a grocery store, visiting a bank, a Dunkin Donuts, a restaurant and a small corner store, as well as briefly helping a neighbor with a mechanical issue under the hood of a vehicle. Mr. Smart noted that Petitioner did move with some difficulty and in a labored fashion.

Petitioner is seen on September 27, 2013 driving to a grocery store, shopping, loading and unloading his SUV. Petitioner favors his right leg while ambulating. He was also observed going to a bank. Petitioner testified that the gait he walks with that was observed on September 27, 2013 is not the gait he walked with prior to the instant accident. He testified that he is not aware of his gait while walking but stated that he is in constant pain.

On November 21, 2013 Petitioner was observed exiting the passenger side of an SUV to enter Dr. Mash's office for his examination. He was seen limping severely with a brace on his right leg. Upon exiting the doctor's office, Petitioner entered the passenger side of the SUV. The video then cuts to one hour later where a female exits the passenger side of the SUV and Petitioner drives away. Petitioner acknowledged that after leaving Dr. Mash's office, he and the driver switched positions and Petitioner took over driving. This transition is not shown in the video but was corroborated by Petitioner. The video then cuts to Petitioner briefly and laboriously ambulating without the leg brace and entering his SUV again before driving off. A few minutes later Petitioner arrived home and gingerly stepped up on a stoop to enter his home after tending to a dog. Petitioner testified that the surveillance video on this date shows him without a leg brace after the IME exam because he was unable to drive with the brace on, so he removed it so he could drive himself home. He further testified that he switched to the driver's seat shortly after leaving the IME exam because he wanted to see if he would be able to drive.

On November 27, 2013, Petitioner is seen ambulating laboriously without a right leg brace. He then meets with another gentleman and laboriously walks to a vehicle, briefly looking under the hood. In a final video on December 3, 2013, Petitioner is seen again ambulating laboriously without a brace into and out of an establishment. He appears to be holding a coffee cup and another small bag. He then enters his SUV and drives away. Later, he enters his SUV again holding a small plastic grocery bag.

G. Additional Information

Petitioner is now the Lead Mechanic at Estes Trucking, a company with six employees.

He testified he now labors when he walks and walks side to side. He has left knee pain and takes Hydrocodone prescribed by Dr. Sebastian, his current PCP. Petitioner notices left knee pain when it rains and when he walks a lot on the job (approximately 4 miles some days). Occasionally he has left knee pain just waking up in the morning. His pain occasionally rates an 8-9/10.

Petitioner used to walk and run one to two miles daily. He still attempts to bike, but noticed knee swelling after his last attempt, which was one month prior to the arbitration hearing. Petitioner testified that he was afraid to undergo the surgery recommended by Dr. Pye, as he was worried it would affect his ability to provide for himself. He is still in pain and now regrets not having the surgery.

II. CONCLUSIONS OF LAW

A. Causal Connection

The Arbitrator ruled that Petitioner's current condition of ill-being was not causally connected to his injury at work. He noted that there was no doubt that Petitioner sustained a left knee injury on the date in question but found no causal connection between said injury and Petitioner's current left knee condition. In so doing, the Arbitrator relied on the opinions of Respondent's Section 12 examiner, Dr. Mash, and found that Petitioner's current left knee condition was not causally related to the instant accident. The Commission is not similarly persuaded.

In order to obtain compensation under the Act, a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injuries. *Land & Lakes Co. v. Industrial Comm'n*, 359 Ill. App. 3d 582, 592 (2005). Recovery will depend on the employee's ability to show that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 204-05 (2003). "Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." (Emphasis in original.) *Id.* at 205.

Our supreme court has held that "medical evidence is not an essential ingredient to support the conclusion of the [Commission] that an industrial accident has caused the disability," but rather, "[a] chain of events which demonstrates a previous condition of good health, an accident, and subsequent injury resulting in a disability" may be sufficient to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64 (1982). It is well established that proof of prior good health and change immediately following after an injury may establish that an impaired condition was due to the injury. *Navistar International Transportation Corp.*, 315 Ill. App. 3d 1197, 1206 (2000). A causal connection between work duties and a condition may be established by a chain of events, including a claimant's ability to perform duties prior to the accident and inability to do the same following the accident. *Id.*

In this case, the Commission concludes that the evidence supports a finding that Petitioner has met his burden of proving causal connection to his current condition by a preponderance of evidence. On the date in question, Petitioner suffered an undisputed left knee injury. The record is devoid of any pre-accident knee treatment suggesting prior symptomatology, and it is only after the accident that Petitioner's left knee became symptomatic.

Petitioner had worked for Respondent as a Mechanic for one year without seeking treatment for knee pain, even working on his knees for up to an hour when necessary. After the accident Petitioner exhibited immediate knee pain which deteriorated to a state of disability.

The Arbitrator relied on Dr. Mash's belief that Petitioner was symptomatic prior to the accident, despite his testimony that "it's difficult to quantify what the symptoms were that may have been present before the injury." While Petitioner does not deny his preexisting condition, he does deny that it was symptomatic prior to the accident. This testimony is corroborated by the absence of prior medical treatment to Petitioner's knee. The record reflects pre-accident treatment records with Petitioner's PCP at the time, Dr. Daniels, spanning from May 15, 2009 through the date of accident. There are eleven treatment records during this period, none of which contain a single mention of knee pain in either of Petitioner's knees. This directly contradicts Dr. Mash's assumption. Further, Dr. Mash himself acknowledged that the acute injury aggravated Petitioner's preexisting condition.

The Commission also diverges from the Arbitrator's reliance on the fact that Petitioner's knees[1] were bilaterally symptomatic to conclude that Petitioner's left knee condition could not be accident related. As to his right knee, the records reveal that Petitioner did not complain of pain until after a separate, unrelated injury to his right knee while working for his new employer approximately two months after his left knee injury. This supports a finding that neither of Petitioner's knees were symptomatic prior to their respective acute accidents, which undermines a finding that Petitioner's current conditions (both related and unrelated to this accident at work) were degenerative in nature. The important metric is that Petitioner was asymptomatic in the left knee prior to the accident and consistently symptomatic in the left knee requiring medical treatment after the accident.

Next, the Commission finds that the Arbitrator's reliance on Dr. Mash's September 20, 2013 MMI designation belies the medical records. On that date, Petitioner presented to Dr. Pye with left knee pain of 4/10, limited ROM, and tenderness to palpation. Petitioner was taken off work when just four days prior, and for the entire preceding year, he was able to work and kneel with no apparent need for medical care.

Lastly, the Commission places more weight on the causation opinions of Dr. Levi and Dr. Primus than did the Arbitrator. These opinions were reached after examining Petitioner, reviewing diagnostics and learning of the mechanism of injury.

In total, the Commission finds that the chain of events regarding Petitioner's left knee

---

1 The Commission further notes that, although medical records relating to other body parts were entered into evidence, Petitioner is not seeking compensation for any injury beyond that to his left knee condition.

injury are well documented. Petitioner had no prior left knee treatment before suffering an undisputed work accident, which was followed by consistent left knee complaints and treatment through the most recent medical record of March 26, 2018. Thus, the record belies the opinions of Dr. Mash, rendering them unpersuasive. Based on the above, the Commission reverses the Arbitrator's ruling and finds that Petitioner has established a causal connection between his accident and current left knee condition.

B. Temporary Total Disability

Petitioner claims temporary total disability ("TTD") benefits from September 20, 2013 through September 29, 2013. The Arbitrator found that no temporary total disability benefits were due and owing based on the opinions of Dr. Mash, which the Commission has found are unpersuasive.

The dispositive test for awarding TTD benefits is "whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). Petitioner was placed off work for his left knee condition by Dr. Pye on September 20, 2013. He returned to work with a new employer on September 30, 2013.

On the date of accident, Petitioner was released to restricted duty work, although he did not attempt to return to work at that time. On September 18, 2013, Petitioner was released to full duty work at the occupational health clinic effective September 20, 2013. Petitioner then saw Dr. Pye on that date at which point he was taken off work completely. Petitioner returned to work with a new employer on September 30, 2013. Thus, the evidence establishes that Petitioner was not yet at maximum medical improvement during the claimed TTD benefits period.

Accordingly, the Commission reverses the Arbitrator's ruling and awards TTD benefits of $458.45 per week for a period of 1 and 3/7ths week, from September 20, 2013 through September 29, 2013.

C. Medical Expenses[2]

The Arbitrator found that all medical expenses related to Petitioner's left knee had been paid. Further, the Arbitrator denied left knee medical treatment after September 18, 2013 based on Dr. Mash's opinions.

Under the provisions of section 8(a) of the Act, an employer is required to pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of her employment. 820 ILCS 305/8(a) (West 2006). An employer's liability under this section

---

[2] The Commission notes that Petitioner did not pursue prospective medical care in the form of a total left knee replacement and elected to proceed on permanency. It would be inappropriate to issue a permanency award as it does below, and also suggest that Petitioner has not reached maximum medical improvement in this part of the award. Awarding both would be inconsistent and the Commission declines to do so.

of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury. *Second Judicial District Elmhurst Memorial Hospital v. Industrial Comm'n*, 323 Ill. App. 3d 758, 764 (2001) (citing *Efengee Electrical Supply Co. v. Industrial Comm'n*, 36 Ill. 2d 450, 453 (1967)).

The Commission has found that Petitioner has established causal connection between his left knee condition and accident at work as noted above. The record reflects that Petitioner's claimed medical expenses were reasonable and necessary to alleviate him from the effects of his accident at work. With regard to Petitioner's left knee MRI of October 22, 2013, it is notable that Dr. Mash relied on the diagnostic in rendering his opinions. He agreed that the MRI was reasonable and necessary and was related to the accident as it provided him with some baseline information needed to develop his causation opinion. RX 4 at 31. Thus, the Commission finds no basis to deny this MRI or the claimed outstanding left knee medical expenses.

Accordingly, the Commission herein reverses the Arbitrator's ruling on medical expenses, concluding that the weight of the evidence supports finding these charges were reasonable and necessary, and awards Petitioner's claimed medical expenses pursuant to §8(a) and 8.2 of the Act.

D. Permanent Partial Disability

As it pertains to permanent disability ("PPD"), the record reflects that Petitioner suffered a work-related accident on September 16, 2013. Accordingly, a determination of permanent disability under §8.1b of the Act must follow. 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. Specifically, §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 addressed the factors delineated in the Act for determining permanent partial disability. The Commission modifies the findings with regard to these factors as indicated below.

With regard to subsection (i) of §8.1b(b), the Arbitrator noted that no impairment report was offered by either party. Accordingly, no weight was given to this factor.

With regard to subsection (ii) of §8.1b(b), the Arbitrator noted that Petitioner was and still is employed as a Diesel Truck Mechanic, a physically demanding job. He was released to full duty four days after the accident and returned to work in essentially the same capacity for another employer two weeks after the accident. The Arbitrator found no credibility in Petitioner's testimony that he now works with left knee pain. The Arbitrator assigned substantial weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator noted Petitioner was 49 years old at the time of accident. The Arbitrator noted that Petitioner was obese, but that his left knee had stabilized. The Arbitrator assigned little weight to this factor.

With regard to subsection (iv) of §8.1b(b), the Arbitrator found that Petitioner returned to work earning the same or a slightly higher rate of pay as he was making pre-accident, and that there was no evidence of impaired earnings. Little weight was given to this factor.

With regard to subsection (v) of §8.1b(b), the Arbitrator noted that Petitioner continued working in essentially the same occupation with no restrictions. His left knee was essentially in the same shape as his right knee and his left knee reached MMI four days after the accident. The Arbitrator gave great weight to this factor.

Based on the above analysis, the Arbitrator found that the injuries sustained caused Petitioner a 1% loss of use of his left leg. While the Commission agrees with the Arbitrator's analysis of subsections (i) and (iv) of §8.1b(b) of the Act, we view the evidence differently regarding the remaining factors.

With respect to subsection (ii) of §8.1b(b) of the Act, the employee's occupation, the Commission notes that even Dr. Mash admitted that restrictions would be reasonable due to Petitioner's left knee condition. Petitioner's ongoing complaints are corroborated by diagnostic testing and the opinions of medical providers, lending credibility to Petitioner's testimony that he is now working with pain. The Commission gives this factor substantial weight, but views it as supporting evidence for an increase in the PPD award as opposed to it being a mitigating factor.

20IWCC0573

With respect to subsection (iii) of §8.1b(b) of the Act, the Commission notes that Petitioner was 49 at the time of accident and 54 at arbitration. Petitioner potentially will have to work for another 13 years with his left knee pain and/or undergo a total knee replacement. The Commission gives this factor great weight.

With regard to subsection (v) of §8.1b(b) of the Act, the Arbitrator was not persuaded by Petitioner's consistent left knee complaints post-accident. The last record prior to arbitration revealed Petitioner had left knee pain, swelling and popping, and was taking oxycontin with no positive results. Respondent's own expert witness agreed with the need for restrictions and a future total knee replacement. The Commission notes that Petitioner was diagnosed with a complex medial meniscus tear and was prescribed surgery by his treating physician. However, the record reflects that Petitioner has declined the surgery thus far as it would interfere with his ability to provide for his own livelihood. He testified that he now labors when he ambulates and ambulates side to side. He has left knee pain and takes Hydrocodone prescribed by Dr. Sebastian, his current PCP. He notices left knee pain when it rains and when he walks a lot on the job (approximately four miles some days). Occasionally he has left knee pain just waking up in the morning. His pain occasionally rates an 8-9/10. He still attempts to bike, but noticed knee swelling after his last attempt, which was one month prior to the arbitration hearing. The Commission gives great weight to this factor, but again views it as supporting evidence for an increase in the PPD award as opposed to it being a mitigating factor.

Accordingly, having not undergone surgery, the Commission's analysis above supports a modification of the Arbitrator's PPD award up to a 15% loss of use of Petitioner's left leg.

E. Penalties and Fees

In denying penalties and fees, the Arbitrator relied on his analysis of the record to find that Respondent's actions were neither unreasonable nor vexatious. Petitioner argued that Respondent refused to pay TTD and medical benefits for a period in excess of 14 days, thus there exists a rebuttable presumption of bad faith. He further argued that Respondent did not rely on a qualified medical opinion or Utilization Review in denying compensation and argued that said denial was vexatious within the meaning of sections 19(k) and 16 of the Act. Accordingly, Petitioner sought section 16, 19(k) and 19(l) penalties and fees for TTD benefits as well as accrued and prospective medical care that was denied in bad faith. On April 1, 2015 Petitioner's Counsel made written demand for outstanding medical bills in the amount of $36,989.86.

Despite reversing the Arbitrator's rulings on the above issues, the Commission nevertheless affirms the Arbitrator's denial of penalties and fees. Approximately two months after the instant accident, Petitioner underwent an IME with Dr. Mash, who found that he had reached MMI as of September 20, 2013 and that any ongoing care was unrelated to any work accident. Respondent could reasonably rely on this medical opinion to deny outstanding medical bills and TTD benefits subsequent to that date.

The Commission finds that Respondent's actions do not meet the threshold required for imposition of penalties. Respondent reasonably relied on the opinions of Dr. Mash as a basis to

deny benefits. Accordingly, the Commission affirms the Arbitrator's denial of penalties and fees.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner has met his burden of proof by a preponderance of evidence that a causal connection exists between his accident and his current condition of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses related to his left knee condition to be paid pursuant to the fee schedule and §8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $458.45 per week for the period of September 20, 2013 through the September 29, 2013, a period of 1 and 3/7ths weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to permanent partial disability benefits of $412.60 per week for 32.25 weeks, as Petitioner sustained a 15% loss of use of his left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for penalties and fees is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond is required for removal of this cause to the Circuit Court by Respondent is hereby fixed at $39,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 29 2020
o: 8/6/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TERRANCE, EDMUND
Employee/Petitioner

Case# **13WC030960**

PAIGE BUS ENTERPRISES
Employer/Respondent

20IWCC0573

On 3/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1922 SALK, STEVEN B & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1739 STONE & JOHNSON CHARTERED
BONNIE B BIJAK
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

460-12589

STATE OF ILLINOIS)
)SS.
COUNTY OF **C O O K**)

- [ ] 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

Edmund Terrance
Employee/Petitioner
v.
Paige Bus Enterprises
Employer/Respondent

Case # **13** WC **30960**

Consolidated cases: **N/A**

20 IWCC0573

An *Application for Adjustment 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 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. [ ] 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 **September 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 **$35,758.88**; the average weekly wage was $**687.67**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable related and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable related and necessary medical services.

ORDER

There is no TTD due and owed to the Petitioner as a result of the September 16, 2013 incident.

Respondent shall pay the Petitioner permanent partial disability benefits of $412.60/week for 2.15 weeks because the injury sustained caused a 1% (five percent) loss of the left leg, as provided in section 8(d-2) of the Act.

The Arbitrator finds that the Respondent's actions were neither vexatious nor unreasonable in this case and that penalties and fees should not be imposed upon the Respondent.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 1, 2019
Date

MAR 4 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

Edmund Terrance	)	
	)	
Employee/Petitioner	)	
	)	
-vs-	)	No. 13 WC 30960
	)	
Paige Bus Enterprises	)	Arbitrator Charles Watts
	)	
Employer/Respondent	)	

MEMORANDUM OF DECISION OF ARBITRATOR

The matter was heard by an Arbitrator designated by the Commission in the City of Chicago, County of Cook and State of Illinois.

The Arbitrator renders findings on the following disputed issues:
(F) Whether Petitioner's current condition of ill-being causally related to the injury;
(J) Were the medical services provided to Petitioner reasonable and necessary; has Respondent paid all appropriate charges for all reasonable and necessary medical services;
(K) Whether Petitioner is entitled to temporary total disability;
(L) The nature and extent of the injury; and
(M) Whether Petitioner is entitled to penalties and fees.

Per stipulation, this matter is only concerned with Petitioner's claims of injury to his left knee.

FINDINGS OF FACT

On September 16, 2013, the 49 year-old single Petitioner, with zero dependents under the age of 18, was employed as a mechanic for Paige Bus Enterprises. (Transcript hereinafter "T"). Petitioner testified that his job required him to constantly be on his feet, kneel, and lift objects weighing 40 pounds. (T). He had worked for them for approximately one year. (T).

Petitioner testified that on the morning of September 16, 2013, he was walking back and forth in the garage and saw a co-worker, working on an open sewer on the floor of the bus garage. (T). The Petitioner testified that he saw the open hole as he walked through the garage. (T). Later, not realizing the manhole remained uncovered, when Petitioner walked back through the area, his right foot went into the hole and he landed on concrete on his left knee. (T). Petitioner testified that he felt immediate pain in his left knee and had to be helped getting up from the ground by his supervisor, Keith Paige.

Petitioner, a man who regularly weighed in excess of 300 pounds, testified that he ran 1-2 miles, rode his bicycle more than 10 miles, and was otherwise active. (T; PX 2, 4) Treating

physician Dr. Patricia Lewis indicated in a January 2, 2014 progress note that Petitioner reported that he did not exercise. (PX 4 at 2 of 43) Petitioner testified that prior to this accident he had never sought treatment for left knee pain nor had felt symptoms of pain in that knee. (T) Petitioner testified that he had been treated for several ailments with his primary care physician, Dr. Freddie Daniels, between May 2009 and March 2013, but never for his left knee. (T) Petitioner testified that on the morning of the accident he was pain free and able to perform tasks such as lifting gas tanks and other objects weighing up to 40 pounds and was able to squat and bend without issue. (T)

The Petitioner testified that he never had any prior problems with his left knee. (T). On March 14, 2013, approximately six months before the work incident which is the subject matter of this claim, he had treated with his family physician for left ankle and elbow pain, which the Petitioner attributed to arthritis. (T; PX 1). He was prescribed hydrocodone by Dr. Daniels in June, July and August of 2013. (T; PX 1). On redirect examination he indicated that the pain medication was for something with his hands. (T) The records of Dr. Daniels indicate that Petitioner's had carpal tunnel release surgery on July 21, 2009. (T; PX 1).

Within two hours of the fall, Keith Paige drove Petitioner to Advocate Occupational Health in Hazel Crest. (T; PX 2). Petitioner advised them that he had pain in the left knee and the back side of his right leg, and described the pain as throbbing and considered it to be moderate. (PX 2). The record also indicates that Petitioner's pain level was 10 out of 10. (PX 2) Upon examination Dr. Veldman documented swelling over the patellar area and pain to palpation over the medial joint line. (PX 2). The diagnosis was left knee sprain. (PX 2) Dr. Veldman recommended that Petitioner return to work on restricted duty. (PX 2). Petitioner had x-rays taken of the left knee at Advocate South Suburban Hospital that same afternoon and the report indicates that he had moderate osteophytes, and a sharpening of the tibia spines with no fractures or joint effusion found. (PX 2).

Petitioner testified he did not return to work on September 16 or 17, 2013 because of pain in his left knee. (T) Petitioner returned to Advocate on September 18, 2013 at 8:00 a.m. (PX 2). Petitioner testified that the pain in his left knee had not changed and that he could not walk without pain. (T) The medical record indicates that Petitioner's primary problem was his left knee and that the pain level was medium or 6 out of 10. (PX 2). The medical record indicates that Petitioner reported the pain was made worse by squatting. (PX 2) Petitioner reported both that he was doing his prescribed home exercises and wearing a knee immobilizer. (PX 2). Examination indicated that Petitioner's left knee strength was normal and stability was intact. (PX 2) Petitioner was told to be on restricted duty, no crawling, climbing, squatting and he could return to regular duty on September 20, 2013. (PX 2) The diagnosis was left knee sprain. (PX 2)

Petitioner never returned to work at Paige Bus Enterprises, but began a job at Estes on September 30, 2013, where he is still employed, as the lead mechanic. (T)

The Petitioner testified that he was referred to Dr. Harold Pye of HTP Associates by his first attorney, Michael McCready. (T). Petitioner's testified that his first visit with Dr. Harold Pye was on September 20, 2013, the same date that his application was filed at the Commission. (PX 2; PX 4; PX 15). The records indicate that Petitioner was examined by Dr. Carlos Crudup because Dr. Crudup electronically signed the record on September 23, 2013 (PX 4 at 43 or 43) and Dr. Crudup signed a "Disability Certificate" keeping Petitioner off-work on September 20, 2013. (PX 4). The history contained in Dr. Crudup's first note was that Petitioner "was doing normal duties as a mechanic walking from the bus inside and was talking unaware the foreman

was working in an open sewer" when he fell in with his right foot. (PX 4 at 41). Dr. Crudup's initial assessment at that visit was unspecified internal derangement of the knee and a sprain and strain of other specified sites of the hip and thigh. (PX 4 at 42). Dr. Crudup recommended that Petitioner be off work, have an x-ray and MRI of the left knee, and return to be examined in a week. (PX 4 at 42). An October 7, 2013 "Disability Certificate" signed by Dr. Harold Pye indicated that Petitioner remained at full duty work status and noted that Petitioner had been under his professional care between September 20, 2013 and December 30, 2013. (PX 4; the Arbitrator notes that Dr. Pye prospectively indicated that Petitioner was under his care for almost an additional entire two months after this document was dated. The Arbitrator also notes for context that the last note from anyone associated with Dr. Pye is dated January 2, 2014).

On October 23, 2013 the Petitioner returned to see Dr. Crudup complaining of left knee and foot pain that had improved with pain medications. (PX 4 at 39). The plan was to continue full duty. (PX 4 at 40). The October 23, 2013 progress note was electronically signed by Dr. Carlos Crudup on November 19, 2014, and page 38 of 43 of PX 4 is missing, so the evidence indicates that Petitioner was examined by Dr. Crudup. (PX 4 at 39). There is a "Disability Certificate" signed by Dr. Crudup dated October 23, 2013, indicating that Petitioner's work status remained full duty. (PX 4). It was noted that imaging results had not yet been received. (PX 4 at 39).

Petitioner underwent an MRI on October 22, 2013 which consisted of "multiple examinations including bilateral knees; Right elbow; Bilateral anchors and lumbosacral spine" with a listed indication that Petitioner "[f]ell in the sewer last month with continued pain of the lower back, bilateral elbows, bilateral anles and knees." (PX4). Regarding the knees, the findings were: "There is moderate narrowing of the medial knee joint compartment as well as patellofemoral joints, left knee worse than the right. Small osteochondral fragment is adjacent to the right tibial tubercle, likely related to old injury. There is no evidence of acute fracture-dislocation. Soft tissues are unremarkable." (PX 4 – AMC document)The impression regarding the knees is "Mild-to-moderate degenerative osteoarthritis of both knees, left worse than the right." (PX 4 – AMC document). This note was signed by Dr. Shahrooz Sepahdari. (PX 4 – AMC document). Another MRI image, taken the same day, of the left knee without contrast was interpreted by Dr. Suzanne Bosman whose impression was: "Complex tear at the junction of the body and posterior horn of the medial meniscus, probably complete, with medial meniscal extrusion" and " Secondary high-grade osteoarthritis of the medial compartment with bone-on-bone contact and reactive bone marrow edema in a periarticular distribution that is probably a source of pain." Her findings indicate that examination Petitioner's left knee medial meniscus was that it was "diffusely degenerated" and there was a "complex complete tear through the posterior horn" and the lateral meniscus "demonstrates only degenerative type signal alteration without a focal well-defined tear." (PX 4 – AMC document). Dr. Bosman also found "high-grade osteoarthritis of the medial compartment with full thickness cartilage loss from the weight-bearing surfaces" such that "bone-on-bone contact noted." (PX 4 – AMC document).

Petitioner attended an initial therapy evaluation on October 28, 2013 at Dr. Pye's affiliated therapy facility, where he reported pain in his left knee, calf and lower back. (PX 4 at 37). The Arbitrator notes that page 38 of PX 4 is missing. Petitioner returned to Dr. Pye's affiliated therapy facility on October 29, 2013, and complained of left knee and low back pain and he was prescribed therapeutic modalities. (PX 4 at 36). On October 31, Petitioner reported that he did not have burning or numbness in his leg anymore and was getting more sleep. (PX4 at 34). The primary diagnosis on that date was "[d]isplacement of lumbar intervertebral disc

without myelopathy" and the plan was to continue physical therapy for that ailment. (PX 4 at 34).

The Petitioner had six more visits at Dr. Pye's practice between November 4 and November 20, 2013, while working full-time with his new employer, and those visits covered more than the left knee. (PX 4 at 18-32).

On November 4, 2013, Petitioner was seen Ellen O' Donnnell and complained of pain in his left calf and that bending and getting up and down from the ground bothered his back and knee. (Px 4 at 32). Petitioner's had full passive extension in his left knee. (PX 4 at 32). The primary assessment was displacement of lumbar intervertebral disc without myelopathy. (PX 4 at 32).

On November 5, 2013, Petitioner presented to Dr. Pye's practice (provider was Jim Holway, PT and note was electronically signed by Nicole White) and reported that his back was getting better and his knee still was in pain with walking though less severe. (PX 4 at 30). The primary assessment was unspecified internal derangement of the knee, with no indication whether it was the right or left knee. (PX 4 at 30).

On November 7, 2013, Petitioner presented to Dr. Pye's practice (provider was Jim Holway, PT and note was electronically signed by Nicole White) and his chief complaint was pain with burning at 7-8/10 on the back of both legs. (PX 4 at 28). The primary assessment was displacement of lumbar intervertebral disc without myelopathy. (PX 4 at 28).

On November 12, 2013, Petitioner presented to Dr. Pye's practice (provider was Jim Holway, PT and note was electronically signed by Nicole White) and reported that his back felt better. (PX 4 at 26). There is no mention of anything related to either Petitioner's left or right knee. (PX 4 at 26-27).

On November 14, 2013, Petitioner presented to Dr. Pye's practice (provider was Jim Holway, PT and note was electronically signed by Nicole White) with a chief complaint that he could barely walk because it felt like his right knee was going to give out on him and that his right knee was swollen from wearing a brace. (PX4 at 24). Petitioner testified that he had lifted an object at work and that his right knee had given out but that his left knee was not aggravated during this incident at all. (T). Petitioner also reported strain in his low back related to lifting an object the day before. (PX 4 at 24). The primary assessment was sprain and strain of other specified sites of hip and back. (PX 4 at 24).

On November 15, 2013, Petitioner presented to the emergency department at Advocate Christ Medical Center and was examined by Dr. Joan Coghlan at Advocate Christ Medical Center with a complaint of right knee pain which he reported began the day before when he was walking and the right knee suddenly gave out. (PX 5 at 10). Petitioner reported that he had prior occasional clicking and catching in his right knee, and that he was supposed to schedule surgery for his left knee to repair a meniscal tear. (PX 5 at 10). Dr. Coghlan found tenderness on the medial joint line and diagnosed Petitioner with a right knee strain. (PX 5 at 10-11). An x-ray taken that same day revealed mild arthritic changes to the right knee. (PX 5 at 22). The Emergency Department clinical summary indicated an acuity of 3 for Petitioner's right knee pain. (PX 5 at 2). Petitioner was instructed to see his orthopedic physician (Dr. Pye) for follow up. (PX 5 at 3).

On November 18, 2013, Petitioner presented to Dr. Pye's office (Natalie Koteles, NK electronically signed the note) with a chief complaint of low back pain. (PX 4 at 21). The assessment was displacement of lumbar intervertebral disc without myelopathy and compressions to Petitioner's "gluteals tpt to lumbosacral spine and piriformis." (PX 4 at 21).

That same visit, Jim Holoway, PT, was listed as provider of care (although Nicole White electronically signed the note) and Petitioner's chief complaint as that he could not stand and put pressure on his right leg. (PX 4 at 22). The assessment was that Petitioner had difficulty ambulating with erect posture due to increase in pain and antalgic sequence on the right side.

Petitioner presented for a Section 12 exam on November 21, 2013 with Dr. Mash and the doctor had a difficult time examining the Petitioner because he was wearing a brace on his right leg. (RX 4 at11). The Petitioner told Dr. Mash that his right knee problem was not related to the incident of September 16, 2013 (RX 4 at 10). Dr. Mash's examination yielded a finding that Petitioner's range of motion in his left knee was 120 degrees. (RX 4 at 11). Dr. Mash testified that Petitioner complained of pain to palpation at the medial and lateral joint lines as well as near the patella femoral articulation. (RX 4 at 11). He reviewed the MRI and testified that it showed evidence of a meniscal tear which was likely related to the degenerative changes and probably not to the accident. (RX 4 at 24-25). Dr. Mash also testified that the MRI results supported his opinion that Petitioner was at maximum medical improvement as of September 20, 2013 and that the accident was not a causal factor of Petitioner's current condition of his left knee. (RX 4 at 31). Dr. Mash explained that a meniscal tear is really part of the osteoarthritic degenerative process in the case of Petitioner. (RX 4 at 25). Dr. Mash opined that the Petitioner had sustained an aggravation of preexisting osteoarthritis of both knees, contusions of the low back, left ankle and elbows, all of which were resolved. (RX 4 at 13-14). Dr. Mash opined that the Petitioner was at maximum medical improvement for the condition to his left knee. (RX 4 at 15-16). Dr. Mash further opined that Dr. Pye's care of the Petitioner had been excessive. (RX 4 at 14-15). Finally, Dr. Mash testified that Petitioner would likely need a total knee replacement in the future and that conservative treatment would include limitation of physical activity, physical therapy, cortisone injections, and the like on route to the knee replacement. (RX 4 at 29).

The Petitioner continued to treat with Dr. Pye's office until January 2, 2014. (See PX 4, PP 1-17 of 43). On November 27, 2013, Petitioner was examined (Dr. Pye is listed as provider and Natalie Koteles, NK electronically signed the note) and reported low back pain and hamstring pain. (Px 4 at 9). There is no mention of knee pain in this record. (PX 4 at 9). On that same visit, Petitioner was examined by Ellen O'Donnell, PT, and reported to her that his low back pain was a 2-7/10. (PX 4 at 10). Petitioner's gait was less antalgic and his left knee had improved since Dr. Mash's section 12 exam. (PX 4 at 10). The primary assessment was sprain and strain of other specified sites of hip and thigh, with secondary conditions being displacement of lumbar discs without myelopathy and "unspecified derangement of knee." (PX 4 at 10). On December 3, 2013 Petitioner was examined by at least two providers at Dr. Pye's practice. (PX 4 at 6). In a note that listed Dr. Pye as the provider but was electronically signed by Natalie Koteles, NK, Petitioner presented with complaints of low back and leg pain. (PX 4 at 6). This note also assessed Petitioner with primarily sprain and strain of other specified sites of hip and thigh, and displacement of lumbar discs without myelopathy. (PX 4 at 6). Massage therapy was prescribed. (PX 4 at 6). On that same visit, Ellen O'Donnell (provider and signatory of the note) indicated that Petitioner reported intermittent burning in his left calf, low back pain at 0-7/10, and left knee pain at 0-5/10. (PX 4 at 7). Ms. O'Donnell indicated that the left knee had improved but that Petitioner's low back remained functionally limiting while standing and walking. (PX 4 at 7) On December 11, 2013, Dr. Crudup examined Petitioner who complained of pain of 8/10 in both knees. (PX 4 at 4). Dr. Crudup reported that Petitioner's left knee had full passive extension and assisted range of motion of 5-120 flex which was noted to be an improvement since Dr. Mash's section 12 exam. (PX 4 at 4).

On December 27, 2013, an Amended Application for Adjustment of Claim was filed on which the part of the body affected was changed to "Left leg and right leg" by adding to the original application the handwritten phrase "and right leg."

On January 2, 2014, Petitioner was examined by Dr. Patricia Lewis for follow-up on bilateral knee pain. (PX4 at 1). The history was that Petitioner "fell while working in their garage, injuring both knees and low back after getting caught in a loose sewer grate. His R leg was caught in the grate and he twisted and bent the L leg during the incident." (PX4 at 1). The reported pain was 10/10 in the right knee and 4/10 in the left knee. (PX4 at 1). Examination of both knees yielded a finding of bilateral valgus deformity with identical findings of 0-120 range of motion, no laxity with maneuvers, and negative McMurray's, Drawer's, and Lachman's; the left knee was more swollen than the right. (PX 4 at 2).

On January 15, 2014, Petitioner was examined by Dr. Gabriel Levi and complained of left knee and low back pain, with a date of onset of September 15, 2013. (PX 6 at 6-7). Dr. Levi's assessment was that both the low back and the left knee conditions were related to the accident. (PX 6 at 6). He recommended a left knee arthroscopy. (PX 6 at 6).

Petitioner was examined on February 7, 2014 by Dr. Gregory Primus, at Chicago Center for Sports Medicine & Orthopedic Surgery for an evaluation of his right knee pain from an onset date of November 10, 2013 and was referred by Dr. Joseph. (T; RX 6 at 63- 64). Petitioner testified that he was referred to Dr. Gregory Primus by Dr. Pye. (T) Dr. Primus recorded that Petitioner gave a history of a pattern of joint symptoms of episodic flare-ups with symptom-free periods in between with progressive worsening. (RX 6 at 64). The symptoms included dull ache, pain with stairs, pain with walking, popping, clicking, locking, giving away of the knee, and joint stiffness and swelling. (RX 6 at 64). The diagnosis was knee pain, localized osteoarthritis that was either primary or secondary, and patellofemoral chondromalacia. (RX 6 at 66). Dr. Primus also noted there was a worker's compensation claim for the left knee. (RX 6 at 64).

A visit with a Dr. Gregory Primus on March 7, 2014 indicates that the meniscal examination of Petitioner's left knee showed that the Petitioner had no tenderness to palpation along the medial or lateral joint line with a negative McMurray test both medially and laterally. (RX 6 at 57). Range of motion was 0-135 degrees without pain. (RX 6 at 57). Dr. Primus noted that the MRI scan report revealed a complex tear of the medial meniscus and advanced degenerative joint disease. (RX 6 at 57). An x-ray of the left knee indicated near bone on bone joint space narrowing indicative of medial and lateral patellofemoral degenerative changes. (RX 6 at 58). Dr. Primus also examined Petitioner's right knee and noted that the meniscal exam was identical to that of the left knee. (RX 6 at 57). Petitioner underwent an aspiration injection of the left knee. (RX 6 at 57-58).

In a March 14, 2014 visit with Dr. Primus it is unclear which of Petitioner's knees was examined because the note indicates that the injury date was November 10, 2013, and the objective section of the note only describes an examination of the right knee, while under the chief complain and history portions of the subjective part of the note indicate left knee complaints. (RX 6 at 49-50). The Petitioner advised the doctor that he has not been able to get to physical therapy because he was working full-time. (RX 6 at 49).

There are two recorded visits with Dr. Primus for March 21, 2014. (RX 6 at 37-42). The first is at 11:11 a.m. and is for a follow up for the left knee although they the right knee and low back pain was discussed. (RX 6 at 40). The note records a date of onset of injury of November 10, 2013 for both visits in a paragraph that is identical except for the first sentence for the earlier

visit that day which indicates that the mechanism of injury is unknown. (RX 6 at 37 and 40). Dr. Primus' diagnosis for the first visit (left knee) was localized osteoarthritis and chondromalacia. (RX 6 at 42). The second visit to Dr. Primus on that same date was at 3:00 p.m. and was for right knee pain. (RX 6 at 37). The objective section describing the examination of the knee for both notes is identical except for the first word in the section which is either "RIGHT" or "LEFT" and the assessment section is identical with knee pain, secondary localized osteoarthritis-knee, chondromalacia, and meniscus tear listed in that order. (RX 6 at 38 and 41).

On March 27, 2014, the Petitioner called Dr. Primus and indicated that he was out of medication, although he had received 60 tablets of Tramadol on Friday, March 21, 2013. (RX 6 at 36).

On April 25, 2014, the Petitioner saw Dr. Dore DeBartolo for his left knee pain and mentioned that he was taking double doses of tramadol and hydrocodone. (PX 6 at 21). The Secondary Insurance listed is the name of the Petitioner's second attorney, Donald W. Fohrman & Associates. (PX 6 at 24). This particular entry containing that information is not part of the Respondent's Exhibit 6 from the Chicago Center for Medicine and Sports Medicine. (compare to RX 6 at 32-34). Dr. DeBartolo performed a bilateral knee examination which indicated that both knees had identical findings and that the physical exam was unchanged from the prior visit. (PX 6 at 22). Dr. DeBartolo noted that Petitioner's symptoms were stable and the plan was for bilateral injections but did not include potential surgery. (PX 6 at 22).

Petitioner saw Dr. DeBartolo on May 13, 2014 for a follow up of for left knee pain with a note that he was present for bilateral Synvisc injections into bilateral knees. (RX 6 at 26-29). Addendum notes of May 15, 2014 indicate that the Petitioner received a prescription for Tramadol ER 150 mg and that the Walgreens did not carry that formulation. (RX 6, P 25). The nurse changed the Prescription to Tramadol 50, and spoke with the pharmacist. (RX 6, P 25). The pharmacist indicated that she was holding the prescription as the patient has the potential for abuse and ultimately Dr. DeBartolo cancelled the prescription as the patient had received four prescription for narcotics within the month of April alone. (RX 6 at 25).

The next two listed visits with Dr. DeBartolo on July 10, 2014 and July 24, 2014 appear to be for right knee pain, with a mention of the left knee. (PX 6 at 2-4 and 6-8; RX 6 at 18-24).

The Petitioner submitted the records of Seby Medical Center, located at 10830 S. Halsted Street in Chicago, Illinois for care for various maladies from February 6, 2014 through January 10, 2015, including but not limited to pink eye, lumbar problems, need for prescriptions and left and right knee. (PX 7) It is unclear from the record and the testimony how the Petitioner found his way to this medical center, although the clinic is down the street from the Petitioner's first Attorney who sent him to Dr. Pye. (PX 7).

Dr. Mash generated a second report dated November 30, 2015 after reviewing additional diagnostic reports, CD scans, records of Illinois Orthopedic Network, Suburban Pain, Care, and Chicago Center for Sports Medicine and was asked if any of those records altered his opinions from his November 21, 2013 examination of the Petitioner and he responded that they did not. (RX 4 at 17-19). He testified that Petitioner was at MMI for the left knee as of September 2013 (RX 4 at 19). Dr. Mash further opined that the work incident of September 16, 2013 would not have caused the osteoarthritis that was noted in the Petitioner's diagnostic tests. (RX 4 at 19). Dr. Mash testified that the Petitioner's knee was in such bad shape that he is probably going to need a knee replacement in the future but it would not be related to the incident that occurred on September 16, 2013. (RX 4 at 33).

Respondent submitted subpoenaed records from Chicago Center for Sports Medicine and Orthopedic Surgery as one of their Exhibits, and the December 7, 2016 note indicates that they had been treating the Petitioner for bilateral primary osteoarthritis of the knees, and the treatment included gel injections. (RX 6 at 2). The November 9, 2016 note indicates that the petitioner was present for follow up of his right knee pain, and had a history of back surgery in 2014, neither event of which was related to the work incident of September 16, 2013. (RX 6 at 4).

The Respondent called Mr. David Smart, of Investigative Resource Group, Inc. to testify as to his retention for conducting surveillance of the Petitioner and the report that he generated. (T). Mr. Smart testified that he was retained by Gallagher Bassett and conducted surveillance from September 24, 2013 – December 11, 2013 and generated a report in the ordinary course of business. (T; RX 3A). The Petitioner's counsel objected to the report as being hearsay; however, the Arbitrator determines that the report was generated in the ordinary course of business and the witness authenticated the document, along with the surveillance DVD (T; RX 3A and RX 3B). On cross examination, Petitioner's counsel asked Mr. Smart if he had ever observed the Petitioner ambulate prior to the incident of September 16, 2013, to which the witness responded no since he was not retained until after the incident. (T). The witness did testify that Petitioner was a larger man and did appear to walk with an odd gait. (T).

The surveillance began on September 27, 2013 and showed Petitioner driving his Black Chevrolet Tahoe to a grocery store, shopping, unloading and loading his vehicle and returning the shopping cart to the parking lot. (RX 3B). It further showed him going to a bank. (RX 3B). The Arbitrator notes that this was during the time frame that the Petitioner had been cleared to returned to work at Paige and before he started his job with Estes.

The investigator testified that on November 21, 2013, the date of the Petitioner's IME with Dr. Mash, he noticed the black Tahoe enter the parking lot of Dr. Mash's office, driven by a female subject, with the Claimant/Petitioner seated in the passenger seat. (RX 3A and 3B). The claimant exited the vehicle to enter the office and was observed to be limping severely wearing a full leg brace on his right leg. (RX 3A and B). When the Claimant/Petitioner exited the doctor's office he got into the passenger side of the SUV and the vehicle proceeded into an adjoining residential area where they turned left onto a dead end road. (RX 3A). Shortly thereafter the SUV with the Claimant/Petitioner and female pulled out of the area, proceeded east on Ogden to I-294, where they proceeded south to 127th Street to Western Avenue. (RX 3A and B; T). The Claimant/Petitioner was driving. (RX 3A and B; T) When they arrived at the female's home, the Claimant/Petitioner exited the vehicle and he was no longer wearing the brace on his right leg. (RX 3A and B). The Claimant/Petitioner then reentered his vehicle and proceeded to his home where he let a dog out into the rear yard, and no longer wore the leg brace and stepped up on the stoop entering the home. (RX 3A and B; T).

During rebuttal, Petitioner testified that the reason his friend was with him to drive to the Dr. Mash appointment was because he had to determine if he would be able to drive without the leg brace on his right leg. (T).

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 the accidental injury both arose out of and

occurred in the course of his employment (*Horvath v. Industiral Commission,* 96 Ill.2d. 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission, I29 Ill. 2d 52, 63 (1998).* An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board,* 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission,* 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission,* 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

The Arbitrator finds Petitioner to have some credibility issues arising out of inconsistent medical histories, Petitioner's performance at section 12 physician Dr. Mash's examination combined with his actions after that exam as evidenced on video, testimony regarding his alleged level of physical activity, and his inability to clearly answer many questions during trial. The Arbitrator, upon review of all of the above, finds that Petitioner is prone to exaggeration and is not a reliable historian regarding the medical care he received after the accident. The Arbitrator is troubled by Petitioner's actions at the section 12 examination and subsequent to that examination. Petitioner's general credibility problems weigh against finding in his favor on the disputed issues.

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). The workplace injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n,* 207 Ill. 2d 193, 205 (2003). 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).

There is no doubt that Petitioner sustained an injury to his left knee. The issue is whether or not Petitioner's left knee healed or the degree to which it healed. The Arbitrator, in accord with the opinion of the section 12 examining physician, does not believe that prior to the accident Petitioner was physically active with a left knee that did not ever bother him because the medical records indicate that his left knee (and right knee) had advanced osteoarthritis and he consistently weighed 300 pounds. Thus, the baseline for a comparison of Petitioner's left knee pre and post-accident begins with a knee that was in poor shape. The medical records indicate that Petitioner was cleared to return to work full-duty on September 20, 2013. Dr. Mash was of the opinion that Petitioner was at maximum medical improvement as of that date. Petitioner also returned to work, albeit with a new employer, within two weeks of the accident at a full-duty capacity without restrictions to the exact same type of job. During the weeks after the accident, the condition of Petitioner's left knee improved substantially according the medical records, so much so that the chief complaint in those records from Dr. Pye's clinic changes from left knee to low back to calf muscle and to right knee over a span of about two months.

While true that the MRI of Petitioner's left knee showed a meniscus tear, Dr. Mash credibly explained that such a tear is evidence of degenerative joint disease and not trauma. Dr. Levi assessed that both Petitioner's back (for which he had surgery) and his left knee meniscal tear were causally related to the September 16, 2013 accident but there was no explanation beyond the conclusory statement. Care for Petitioner's left knee and right knee passed on to Dr. Primus and Dr. DeBartolo who merely memorialized that Petitioner reported an accident at work that injured his left knee, did not offer any definitive statements regarding causation of Petitioner's left knee condition as being linked to the accident at issue in this case. Much of the treatment of Petitioner and later all of the treatment of Petitioner was for bilateral knee conditions with osteoarthritis of both knees being the primary assessment. The fact that both of Petitioner's knees have significant osteoarthritis and essentially function the same supports a finding that the accident did not cause the current medical condition of Petitioner's left knee.

After weighing all the evidence, the testimony and the records presented by both Parties, the Arbitrator grants greater weight to the testimony of Dr. Mash and finds that the Petitioner's current condition of ill-being as to his left knee is not related to the incident of September 16, 2013.

J. Were the medical services that were provided to the Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

After weighing all of the evidence, and after finding Dr. Mash' testimony credible, the Arbitrator finds that the treatment provided to the Petitioner by Dr. Pye, and subsequent physicians was not related to the incident of September 16, 2013. The Arbitrator further finds that the Respondent is not responsible for any of the bills incurred for care for the right knee, lumbar spine, hip, thigh or elbows.

The Arbitrator finds that the Respondent has paid all reasonable and necessary medical expenses, as they relate to the Petitioner's left knee.

K. What temporary benefits are in dispute?

The Petitioner was released to return to work on September 20, 2013 and chose not to return. He started a new job doing substantially the same thing with the same physical demands on September 30, 2013 with a different employer. No TTD benefits are due and owed.

L. What is the nature and extent of the injury?

Pursuant to §8.lb of the Act, the following criteria and facts must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent impairment 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 Section 8.l (b), the Arbitrator notes no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator gives this factor no weight in determining permanent partial disability.

With regard to subsection (ii) of Section 8.1b (b), the occupation of the employee, Petitioner worked and currently still works as a diesel truck mechanic which is a physically demanding job. Petitioner was released full duty four days after the accident and in fact returned to work in substantially the same capacity in about two weeks-time for another employer. Petitioner testified that he was able to perform his job duties at the new employer although he testified that he now does so with pain in his left knee and other parts of the body. Petitioner's credibility on reporting his medical condition is wanting. The Arbitrator gives substantial weight to this factor.

With regard to subsection (iii) of Section 8.1b (b), the age of the employee, Petitioner was 49 years old at the time of his accident. Noting that Petitioner has credibility problems, Petitioner continues to complain of left knee pain and pain in other parts of his body including his right knee. Petitioner is obese. Petitioner continues to see physicians for a variety of ailments. Per recent

medical records, the condition of Petitioner's left knee has stabilized. The Arbitrator gives little weight to this factor.

With regard to subsection (iv) of Section 8.1b (b), the employee's future earning capacity, Petitioner returned to work earning the same or slightly higher rate of pay as he was making prior to his injuries. Petitioner did not offer evidence of impaired earnings as a result of his work injuries. The Arbitrator gives little weight to this factor.

With regard to subsection (v) of Section 8.1b (b), evidence of disability corroborated by the treating medical records, Petitioner continues to work substantially the same job as he did on the day of the injury without restrictions, the condition of his left knee has stabilized and is practically identical to his right knee which is not claimed per stipulation and amended application, and, as discussed above, the Arbitrator has found Petitioner to be at MMI as of four days after the injury. The Arbitrator give great weight to this factor

Based on the above factors, the Arbitrator finds that the Petitioner's resolved strain/sprain injury to his left knee amounts to a 1 % loss of the left leg which results in an award of $824.30 (2.15 weeks x $412.60 = $824.30).

M. Should penalties or fees be imposed upon Respondent?

After weighing all of the evidence, the Arbitrator finds that the Respondent's actions were neither vexatious nor unreasonable in this case because Petitioner was returned to work as of September 20, 2013, started a new job on September 30, 2013 doing substantially the same mechanic job, and a timely section 12 examination yielded an opinion that Petitioner was at MMI as of September 20, 2013, just four days after the injury. Therefore, penalties and fees should not be imposed upon the Respondent.

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

Deborah Riley,

Petitioner,

vs. NO: 17 WC 9169

Speedway,

Respondent.

20 I W C C 0 5 7 4

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, permanent partial disability and fraud pursuant to section 25.5 of the Act, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below, but otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With respect to permanency, the Commission adjusts the Arbitrator's award. The record reflects that Petitioner's stipulated average weekly wage is $368.00. The Arbitrator used the minimum permanency rate of $220.00. However, the parties stipulated in the Request for Hearing form that Petitioner was a single provider with three dependents. Accordingly, the Commission increases the permanency award to reflect the minimum permanent partial disability rate for a claimant in Petitioner's position, which is $319.00 per week.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2019, is hereby affirmed and adopted with respect to accident, causal connection, medical expenses, temporary total disability and fraud, but changed with respect to permanent partial disability.

20IWCC0574

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to permanent partial disability benefits of $319.00 per week for 25 weeks, as Petitioner suffered injuries causing a 5% loss of use of her person as a whole, as provided in section 8(d)(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 29 2020
o: 8/20/20
BNF/wde
45

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RILEY, DEBORAH
Employee/Petitioner

Case# **17WC009169**

SPEEDWAY
Employer/Respondent

20IWCC0574

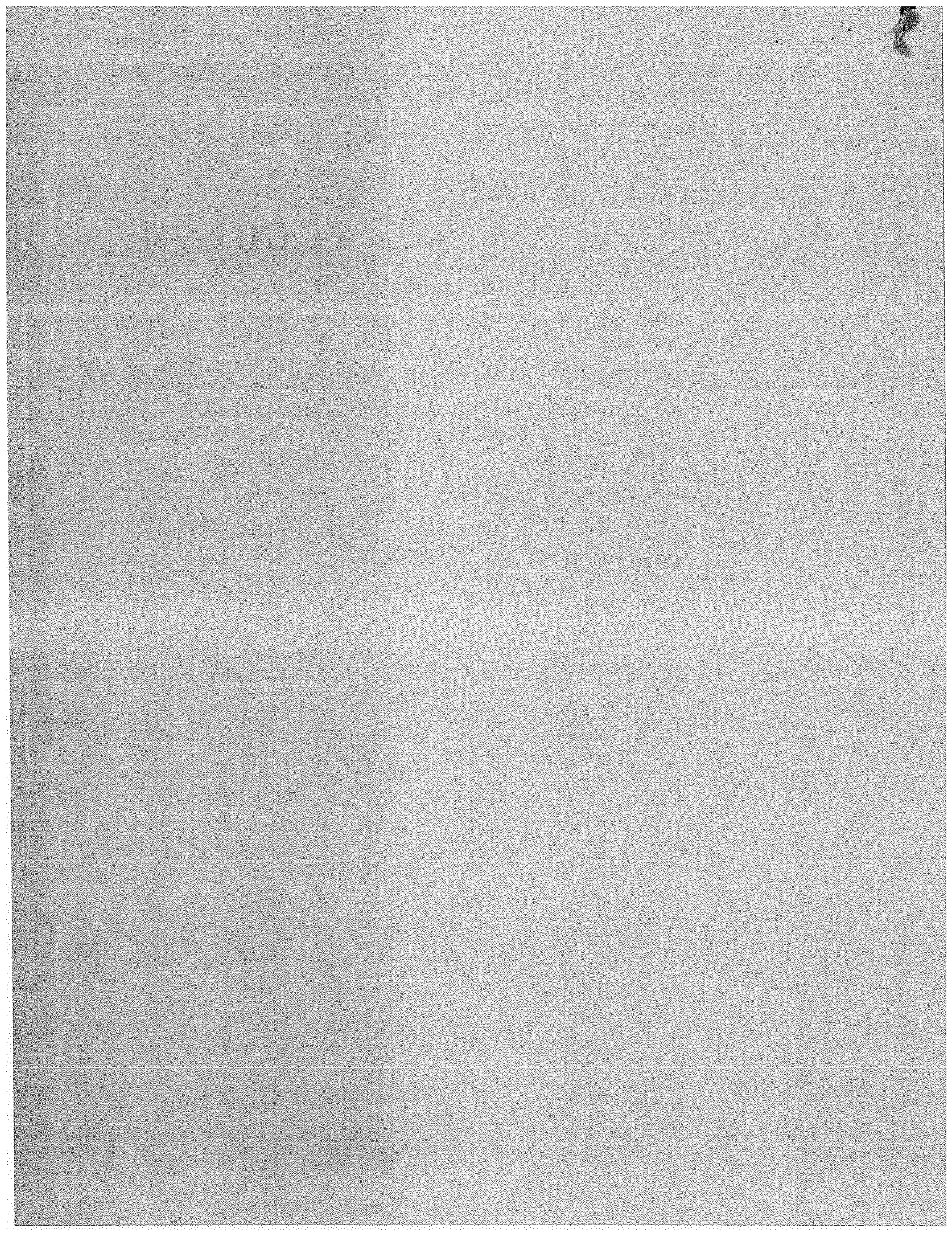
On 3/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

1315 DWORKIN AND MACIARIELLO
CASSANDRA SHASHATY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661



STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Deborah Riley
Employee/Petitioner

Case # **17** WC **9169**

v.

Consolidated cases: **n/a**

Speedway
Employer/Respondent

20IWCC0574

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **February 8, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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: Determination of fraud under Section 25.5 of the Act.

FINDINGS

On **3/17/17**, 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 as it relates to her head, neck, back, right shoulder and right elbow ***is*** causally related to the accident at work and reached MMI as of May 20, 2017, when she sustained an intervening unrelated altercation.

In the year preceding the injury, Petitioner earned $**n/a**; the average weekly wage was **$368.00**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **3** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$220.00/weeks** for **25 weeks**, because the injuries sustained caused the **5%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act.

Respondent shall pay reasonable and necessary medical expenses pursuant to the Illinois medical fee schedule to AMCI, EQMD, and Preferred Open MRI, as provided in sections 8(a) and 8.2 of the Act through May 19, 2017. All other medical expenses after this date are denied as unrelated.

Respondent shall pay Petitioner Temporary Total Disability benefits for **7-6/7th** weeks commencing **March 18, 2017** through **April 25, 2017** and from **May 4, 2017** through **May 19, 2017**, as provided in 8(b) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

3-22-19
Date

MAR 22 2019

FINDINGS OF FACT

Deborah Riley ("Petitioner") was an employee of Speedway ("Respondent") on March 17, 2017. On this date, Petitioner alleges accidental injuries to her head, neck, back, right shoulder, and right elbow. Petitioner was performing her normal job duties for Respondent. In her regular course of employment with Respondent, Petitioner serves as a customer service representative during the overnight shift. Her job duties entail tending to the store, ringing up purchases for customers, and cleaning the gas station lot. On the date of accident, Petitioner testified she was cleaning the gas station lot near gas pump number seven (7) when she slipped on a patch of ice, fell backwards and landed on her back and right side, striking her head on the ground. Petitioner testified that she injured her head, neck, back, right shoulder, and right elbow as a result of this slip and fall accident. Petitioner testified that she reported her injury to her supervisor, Angel Collins. Petitioner testified that although Ms. Collins was not present at the time the accident occurred, she left a handwritten note for Ms. Collins stating she fell during her shift, and she also stayed at work until Ms. Collins arrived, to verbally report the injury. Petitioner was not asked to complete an incident report at that time. Ms. Collins did, however, complete an incident report regarding this injury, which is date-stamped as March 27, 2017, which indicated that petitioner reported her injury to Ms. Collins at 6:45a.m. on March 17, 2017. (Rx. 1). Petitioner testified that this was the first time she has been hurt at work and this is the first workers' compensation claim she has filed.

Petitioner testified that after she fell, she laid on the ground for approximately one minute before being able to get up. After her shift, she went home and then reported to the emergency room because she was in pain. Petitioner presented to Ingalls Memorial Hospital on March 17, 2017 at 9:25a.m. Notes from Petitioner's emergency room admittance state that Petitioner slipped and fell on ice while at work that morning at 3:00am. (Px. 1). Emergency room records from this date state that Petitioner reported pain to her entire right side of her body but her primary complaints were pain to her neck, upper back, lower back, right shoulder and right elbow. (Px. 1). The record further states that Petitioner hit her right elbow and right shoulder on the ground during the fall. (Px. 1). On exam, tenderness of the cervical spine, lumbar spine, and right shoulder were noted. (Px. 1). The emergency room discharge notes states that Petitioner's diagnoses were lumbar strain, cervical strain, right elbow contusion, and right shoulder contusion. (Px. 1). Petitioner was instructed to follow up with Ingalls Occupational Medicine, which she did on March 21, 2017 and on March 22, 2017. (Px. 1). Upon discharge, Petitioner was prescribed cyclobenzaprine for spasms and acetaminophen for pain. (Px. 1). On March 21, 2017, Petitioner presented to Ingalls Occupational Medicine and again provided a description of her injury that she was cleaning the lot at work when she slipped and fell backwards, landing on her right side. (Px. 1). Petitioner denied previous injuries. (Px. 1). Petitioner described her neck pain as a 7/10, her back pain as 8/10, her right shoulder pain as 8/10 and her right elbow pain as 8/10. (Px. 1). A physical examination from this date revealed contusions of the right elbow and right shoulder, cervicalgia, and lumbago with right radiculopathy. (Px. 1). Records from this date further state that due to Petitioner's positive radicular symptoms, a complete steroid burst and a five-day prednisone trial was recommended; along with physical therapy three (3) times a week for the next two (2) weeks. (Px. 1). Petitioner was placed on light duty job restrictions, of no lifting or carrying of more than five (5) pounds, no pushing or pulling more than ten (10) pounds, no overhead work, and no use of the right arm. (Px. 1). Petitioner presented to Ingalls Occupational Medicine again on March 22, 2017 with similar complaints. (Px. 1). On this date, Petitioner underwent a strength test that concluded her left-hand grip with both her elbow flexed and extended was capable of handling fifty (50) pounds. (Px. 1). In contrast to her injured arm, on exam, Petitioner's right-hand grip with elbow flexed was only capable of handling 21 pounds, and 16 pounds with her right elbow extended. (Px. 1).

Petitioner presented to AMCI South Holland Medical Center on March 27, 2017 for a consultation with Dr. Dale Hooten. (Px. 2). Records from this date reflect a description of the accident that the Petitioner was sweeping her work parking lot when she slipped and fell on a patch of ice, falling backwards and landing on her

right side. (Px. 2). Medical records from this appointment note Petitioner's primary complaints of headache, pain to the neck, mid-back, low back, right shoulder, and right elbow. (Px. 2). Dr. Hooten noted that he observed general discomfort in Petitioner, and further stated that he observed tenderness in her cervical spine, thoracic spine, lumbar spine, right elbow, and right shoulder. (Px. 2). Dr. Hooten noted that Petitioner tested positive on exam for Spurling's, Kemps, Bechterews, and Cousins. (Px. 2). Dr. Hooten diagnosed Petitioner with a cervical sprain, thoracic sprain, lumbar sprain, right shoulder sprain, right elbow sprain, and lumbar radiculitis. (Px. 2). In his treatment note from this date, Dr. Hooten opined that Petitioner's diagnoses were causally related to her work-injury as she described. (Px. 2). Dr. Hooten stated Petitioner had been on light duty restrictions but her employer had been unable to accommodate her. (Px. 2). Dr. Hooten placed Petitioner in an off-work status and instructed her to follow up the next day with physiatrist, Dr. Divya Agrawal. (Px. 2).

Petitioner presented to AMCI on March 28, 2017 for consultation with Dr. Agrawal. (Px. 2). Dr. Agrawal stated in his records from this date that Petitioner presented with a headache, neck pain that worsens with bending and turning head, mid and low back pain that worsens with standing, bending, twisting, and lifting; radiating pain into her right thigh that worsens with weight bearing; right shoulder pain that worsens with lifting and raising arm above shoulder level; and right elbow pain that worsens with lifting and straightening the arm. (Px. 2). Dr. Agrawal noted that Petitioner completed a course of steroids the day before the visit, but has poor pain control and a decreased tolerance for activities of daily living. (Px. 2). Dr. Agrawal opined that Petitioner's diagnoses were casually related to her work-injury as she described it. (Px. 2). Dr. Agrawal recommended that Petitioner participate in physical therapy three (3) times a week and placed Petitioner in an off-work status through April 25, 2017. (Px. 2). Petitioner presented to AMCI for physical therapy on March 3, April 5, April 10, April 14, April 17, April 19, and April 21. (Px. 2).

Petitioner presented for a follow-up appointment with Dr. Agrawal on April 25, 2017. (Px. 2). At this time, medical records reflect that Petitioner's headaches were improving, her neck pain continued but with some improvement, her mid-back and low back pain continued with some improvement but she was experiencing daily stiffness and aching with prolonged standing and lifting. (Px. 2). Petitioner's right shoulder pain also continued but with some improvement; but stated that the right shoulder remained painful with repeated activity. (Px. 2). Dr. Agrawal noted that by this date, Petitioner's right elbow pain had subsided. (Px. 2). Dr. Agrawal recommended Petitioner participate in therapeutic exercises two (2) to three (3) times a week for strengthening and a therapeutic massage trial to help with tolerance to activities. (Px. 2). He cleared Petitioner to return to work with regular duties and to follow up with him in a month. (Px. 2). Petitioner reported for routine physical therapy sessions with Dr. Hooten on April 26, 2017 and May 1, 2017. Petitioner began massage therapy at AMCI on May 3, 2017. On this date, Petitioner presented with complaints of neck pain, mid-back pain, low back pain, and stiffness. (Px. 2). On May 4, 2017, Petitioner presented for physical therapy with Dr. Hooten as usual, but reported she was poorly tolerating full-duty work due to prolonged standing. (Px. 2). As such, Dr. Hooten placed Petitioner back in an off-work status. (Px. 2). Petitioner presented to AMCI for massage therapy again on May 9 and May 15. (Px. 2). Petitioner attended physical therapy appointments on May 10, May 12, May 15, May 16, and May 25. (Px. 2).

Petitioner presented to the emergency room at Ingalls Memorial Hospital on May 20, 2017. (Rx. 7). Petitioner stated she was involved in an altercation with someone she knows, who hit her on the head with a heavy object. (Rx. 7). Petitioner denied loss of consciousness. (Rx. 7). Swelling and an abrasion over Petitioner's left forehead were documented in triage notes. (Rx. 7). Petitioner underwent a CT scan of her head, the diagnostic impression of which was a "scalp hematoma." (Rx. 7). Petitioner was discharged as stable. (Rx. 7). On cross, she admitted that perhaps her head and or neck problems began with this incident. Petitioner did not tell her providers about this altercation.

Petitioner presented for another follow-up appointment with Dr. Agrawal on May 30, 2017. (Px. 2). Treatment notes from this date state Petitioner's headaches have improved, her neck pain was improving, her mid and low back pain was minimally improved as she was still experiencing stiffness and aching with prolonged standing, and her right shoulder pain had improved but still bothered her with repeated lifting. (Px. 2). Notes from this date further state that Petitioner's return to work was difficult due to prolonged standing, but she wanted to work, so she spoke with her employer who agreed to let her sit in a chair as needed. (Px. 2). On physical exam on this date, Dr. Agrawal observed cervical spine tenderness, thoracic spine muscles spasms, lumbar spine tenderness with muscle spasms, and right shoulder tenderness with painful impingement testing. (Px. 2). Dr. Agrawal noted that Petitioner was having slow progress with conservative care and ordered a lumbar spine MRI to address Petitioner's persistent lumbar pain with radicular symptoms and a right shoulder MRI. (Px. 2). Dr. Agrawal returned Petitioner to work full duty with the allowance to sit. (Px. 2). Petitioner attended a physical therapy appointment on May 31, 2017.

Petitioner presented to Preferred Open MRI on June 21, 2017 for MRIs of the lumbar spine and right shoulder. (Px. 4). The radiology report from Petitioner's lumbar spine MRI stated Petitioner has spondylosis with disc bulging from L3-S1, most severe at L3-4 bilaterally, with moderate neural foraminal stenosis. (Px. 4). The radiology impression from Petitioner's right shoulder MRI was suspicious for a low-grade partial tear at the junction of the posterior supraspinatus and anterior infraspinatus tendons. (Px. 4).

Petitioner attended a physical therapy appointment on June 22, 2017. (Px. 2). Petitioner attended another follow-up appointment on June 27, 2017 with Dr. Agrawal. (Px. 2). Medical records from this visit reflect that Petitioner was experiencing headaches and neck pain that were mild in nature but manageable and ongoing mid and low back pain with stiffness and aching with prolonged standing. (Px. 2). Dr. Agrawal opined that Petitioner's MRI findings as indicated above, were casually related to her work incident that took place on March 17, 2017. (Px. 2). At this time, Dr. Agrawal opined that Petitioner may be a surgical candidate for her shoulder, and gave her a referral for an orthopedic consultation. (Px. 2). Dr. Agrawal did not amend Petitioner's work status, but stated that her employer was accommodating her need to sit in a chair as needed. (Px. 2).

Petitioner attended a physical therapy appointment on July 3, 2017. (Px. 2). Petitioner attended an orthopedic consultation for her shoulder treatment with Dr. Thomas Bilko from AMCI on July 6, 2017. (Px. 2). In his treatment notes, Dr. Bilko relayed Petitioner's injury description as sweeping her work parking lot when she slipped and fell on a patch of ice, falling backwards landing on her back and her right side, striking her head on the ground. (Px. 2). Dr. Bilko stated that Petitioner denied prior injury to her shoulder. (Px. 2). Dr. Bilko stated that Petitioner presented with continued right shoulder pain, which worsens with lifting and raising her arm above shoulder level. (Px. 2). Dr. Bilko noted that physical therapy and medications have helped Petitioner manage the pain. (Px. 2). On physical examination, Dr. Bilko noted tenderness over Petitioner's acromioclavicular joint and stated Petitioner tested positive for Hawkin's. (Px. 2). Dr. Bilko stated Petitioner's low-grade shoulder tear was causally related to her work injury as she described. (Px. 2). Dr. Bilko recommended Petitioner undergo a corticosteroid injection to the right shoulder, which he performed on Petitioner the same day. (Px. 2).

Petitioner attended physical therapy appointments at AMCI on July 12, July 13, July 17, and July 21. (Px. 2).

Petitioner attended a follow-up appointment with Dr. Agrawal on July 25, 2017. Medical records from this appointment reflect that after undergoing the shoulder injection, Petitioner's right shoulder pain was minimally improved. (Px. 2). Dr. Agrawal stated that Petitioner's headaches and neck pain were mild and manageable but she presented with ongoing mid and low back pain with stiffness and aching with prolonged

standing. (Px. 2). At this time, Dr. Agrawal stated Petitioner had plateaued with conservative care and therapy. (Px. 2). Dr. Agrawal again opined that Petitioner may be a candidate for shoulder surgery. (Px. 2). Dr. Agrawal stated Petitioner had reached maximum medical improvement if more aggressive care was not pursued. (Px. 2). Petitioner did not pursue more aggressive treatment and did not follow up with any doctors for her work-related injuries after this date.

June 29, 2017 Independent Medical Examination & Evidence Deposition of Dr. Michael Bryan Neal

Petitioner attended a Section 12 Examination with Dr. Michael Bryan Neal on June 29, 2017. Dr. Neal testified to his findings and opinions during Respondent's evidentiary deposition on October 9, 2018. (Rx. 6). Dr. Neal testified that Petitioner reported she had only been injured at work on one occasion, which was on March 17, 2017. (Rx. 6). Dr. Neal testified that Petitioner stated she was injured at work when she fell in a parking lot while sweeping when her feet slipped out in front of her causing her to fall backwards. (Rx. 6). Body parts reported as injured were Petitioner's head, neck, back, right shoulder, right elbow, right hip, and right thigh. (Rx. 6). Dr. Neal testified that he diagnosed Petitioner with a normal right shoulder, a normal right elbow, intermittent neck pain originating from the thoracolumbar spine, and low back pain. (Rx. 6). Dr. Neal did not opine that his diagnoses were causally related to Petitioner's work-injury on March 17, 2017. (Rx. 6). Instead, Dr. Neal testified that her complaints were not related to her work injury. (Rx. 6). Dr. Neal conceded it was possible to sustain the types of injuries Petitioner sustained by slipping and falling on ice, as Petitioner had described. (Rx. 6). Dr. Neal testified that it is possible to sustain disc bulges and a shoulder tear from slipping and falling on ice. (Rx. 6). Dr. Neal stated that Petitioner did not indicate that he was asked to evaluate her right elbow. (Rx. 6).

Video Evidence

The Respondent entered into Evidence one disc containing two separate videos depicting Petitioner walking around the gas pumps at her job, picking up trash and changing garbage cans. These were viewed in court and shown to the Arbitrator. The first video, titled "Video Pumps 3-6" shows Petitioner walking in and out of the video frame while picking up trash. Petitioner appears on screen in this video from approximately 3:16:20am through 3:19:14am, or for 2 minutes and 54 seconds. The second video, titled "Video Pumps 11-14" shows Petitioner walking around the same parking lot, cleaning. Petitioner appears on screen in this video from 3:17:22am through 3:17:39am, or for 17 seconds. (Rx. 3).

Testimony of Angel Collins

Respondent called to testify Petitioner's general manager, Angel Collins. Ms. Collins testified that she had worked for the Respondent for seventeen years and that she currently serves as a general manager for the Respondent. Ms. Collins testified that she knows Petitioner and she was the individual who hired her. Ms. Collins testified that Petitioner performs well, has no history of poor performance, and that she oftentimes helps to train new employees. Ms. Collins testified that on March 17, 2017, she received the hand-written note that Petitioner left on her desk stating Petitioner had fallen outside during her shift around 3:00am in the morning. Ms. Collins further testified that she saw Petitioner getting ready to leave work the morning of March 17, 2017 as well, when she arrived for her shift. Ms. Collins testified that she completed an Occupational Injury and Illness report with regard to Petitioner's work-injury on the same day. (Rx. 1). In the report, Ms. Collins stated Petitioner was cleaning the parking lot when she fell on a patch of ice near pump seven (7) at 3:17am. (Rx. 1). When asked by the Arbitrator, Ms. Collins testified that she wrote down 3:17am as the time the injury took place because that is when she first time that she saw Petitioner in the video frame near pump seven. Collins further testified that she viewed this video alone. Collins stated that Petitioner did not tell her 3:17am.

Testimony of Allen Turray

Counsel for Respondent called to testify Petitioner's district manager, Allen Turray. Mr. Turray testified that he was notified by Ms. Collins by telephone that Petitioner fell and sustained injuries on March 17, 2017. Mr. Turray viewed Respondent's videos titled Video Pumps 3-6 and Video Pumps 11-14. Mr. Turray testified that he did not see Petitioner fall in either one of these videos. Mr. Turray testified that it is possible for an employee to be outside and not be within the surveillance video scope.

CONCLUSIONS OF LAW

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner has met her burden of proof by a preponderance of the credible evidence that an injury occurred on March 17, 2017 that arose out of and in the course of her employment with Respondent. Here, there was no doubt she was in the course of her employment. Further, if believed, Petitioner's slip and fall occurred while performing employment related duties, namely that of gathering trash in the gas station outside. The issue of accident, however, is one of credibility.

Having considered all evidence, the Arbitrator finds Petitioner has credibly established she slipped and fell at work while cleaning the gas pump area outside. Petitioner's recollection of events was corroborated by Collins, who testified that Petitioner reported her incident immediately as soon as Collins arrived. Collins took appropriate steps to create an incident report, report up the chain and investigate. Respondent's accident dispute and fraud dispute, rests on the fact that the accident report stated the incident occurred at 3:17am and that petitioner is not visualized near pump 7 at 3:17am on video. However, Petitioner never stated that her accident occurred specifically at 3:17am. In fact, she admitted she did not know the exact time but gave an estimate that it occurred sometime at the 3 o'clock hour. Further, Collins admitted she obtained the time solely based on when Collins first visualized Petitioner in the surveillance video. Turray conceded that its possible a slip and fall at that location could have occurred outside the view of the video or cameras. Thus, because the time issue on the report was reconciled and explained by Collins, Petitioner's credible version of her accident remains unrebutted and otherwise corroborated by the timeline of events and the histories in her medical reports. The Arbitrator notes that Petitioner stated she usually spent about 20 minutes outside but the video only captured a few minutes of total video. Further, only parts of pump 7 are visualized and all witnesses agreed pump 7 is not entirely shown in the videos submitted. Also, of note, Arbitrator takes notice that a video titled "Video Pumps 7-11" exists, the title of which is visible in Respondent's Exhibit 3 disc. Respondent did not introduce a video titled "Video Pumps 7-11" into evidence. The Arbitrator makes the adverse inference that this missing video was omitted and which may have shown Petitioner's fall and which otherwise may have aided the trier of fact in resolving the issues in dispute, especially accident and fraud.

Therefore, the Arbitrator finds Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent.

ISSUE (F) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner has met her burden of proof by a preponderance of the evidence that the current condition as it relates to her head, neck, back, right shoulder and right elbow is causally related to the accident at work but that she reached MMI for this as of May 20, 2017, when she sustained an intervening unrelated altercation which she failed to disclose to all providers.

By failing to disclose, not only does petitioner's credibility become an issue which cannot be ignored but Petitioner's providers were not provided the full benefit of assessing her condition of ill-being. Therefore, petitioner's conditions are causally related but reached MMI as of May 20, 2017.

ISSUE (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues as detailed, supra, the Arbitrator awards bills through May 19, 2017, which is the day prior to Petitioner's unrelated intervening altercation. All other bills after this date are not causally related to the work accident.

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 as detailed, supra, the Arbitrator awards TTD through May 19, 2017, which is the day prior to Petitioner's unrelated intervening altercation. All other claims for TTD after this date are not causally related to the work accident.

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 as detailed, supra, the Arbitrator finds that Petitioner reached MMI as of May 19, 2017 for her work-related injuries and any claim for PPD is ripe for adjudication. The Arbitrator has considered the enumerated factors of Section 8.1(b) as follows:

The first enumerated factor, an AMA impairment rating, is not applicable as neither party offered an AMA rating into evidence. However, nothing in the Act precludes a permanent partial disability award when no AMA impairment report is submitted by either party.

With respect to the second factor, the occupation of the employee, the Arbitrator notes that Petitioner was employed as a customer service representative at the time of the accident. Petitioner is still employed as a customer service representative for the Respondent. However, Petitioner testified that she still works full-duty but with the allowance to sit as needed. No weight is given to this factor.

As for the third factor Petitioner was 44 years old at the time of injury. The Arbitrator assigns weight to the fact that Petitioner will remain in the workforce for the extended future. The Arbitrator gives little weight to this factor.

As to the fourth factor, Petitioner's future earnings capacity, the Arbitrator notes no impairment of earnings was shown. The Arbitrator therefore gives no weight to this factor.

As for the fifth factor, the Arbitrator considered the evidence of Petitioner's disability corroborated by her treating physicians' medical records but only through May 19, 2017. Petitioner's medical records support that the March 17, 2017 work injury represented Petitioner's first injury of this nature to her head, neck, back, right shoulder, and right elbow. All of her records further support a causal connection between her diagnoses and the March 17, 2017 work injury. The Arbitrator notes that Petitioner has not sought additional medical treatment, but does experience intermittent pain from the incident, and does take pain relievers, per her testimony.

Considering Petitioner's credible testimony, Petitioner's medical treatment records, and after considering the factors enumerated in Section 8.1(b) of the act, the Arbitrator awards permanency equivalent of 5% man-as-a-whole under Section 8(d)(2), which most appropriately considers all of Petitioner's multiple injuries.

ISSUE (O) ***Other: <u>Determination of fraud under Section 25.5 of the Act.</u>***

The Arbitrator declines to address this issue as this Arbitrator does not have jurisdiction to determine any allegations of fraud.

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

Mary E. Root,

Petitioner,

vs. NO: 15 WC 18151

Eyler Auto Sales,

Respondent.

20 IWCC0575

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator, as noted herein, and otherwise affirms and adopts, said decision being attached hereto and made a part hereof.

The Commission modifies the decision of the Arbitrator, wherein she awarded 30% loss of use of the right leg, to find that as a result of the injury Petitioner sustained the loss of use of 40% of her right leg pursuant to §8(e)12 of the Act.

In support of this holding, the Commission provides the following analysis pursuant to §8.1b of the Act.

With respect to factor (i), the report level of impairment, the Commission notes that neither party submitted an AMA impairment rating. As such, the Commission accords no weight to this factor.

With respect to factor (ii), the occupation of the injured employee, the Commission notes that Petitioner worked as a driver for Respondent, traveling to different auctions and dealerships, oftentimes out of state, in order to pick up and deliver vehicles on behalf of her employer. This required that she would have to sit for extended periods of time which, given the nature of her lower extremity injury and advanced age, the Commission views as warranting greater weight.

With respect to factor (iii), the age of the employee at the time of the injury, the Commission notes that Petitioner was 79 years old on the date of the accident. The Commission disagrees with the Arbitrator's determination that this factor is to be accorded lesser weight, given that Petitioner was released to full duty work by her treating physician. While true, this fact does not take into account the added difficulties associated with an individual of such advanced age returning to the work force, as well as the more likely and deleterious effect on her everyday life given the serious nature of the injury. As a result, the Commission accords greater weight to this factor.

With respect to factor (iv), the employee's future earning capacity, Petitioner testified that she is not currently working and that the injury has adversely affected her future earnings capacity. (T.32). The Commission notes it is obvious, given Petitioner's advanced age (currently 86 years old), that Ms. Root has in all likelihood reached the end of her work life expectancy. However, Petitioner was not suffering from any serious underlying conditions and was working full duty up to the date of accident, despite her age, and presumably would have continued to do so but for her work-related injury. That being the case, and in light the fact that Petitioner would be seriously disadvantaged in terms of finding employment because of her injury, in the unlikely event that she attempts a return to work, the Commission accords moderate weight to this factor

Finally, with respect to factor (v), evidence of disability corroborated by the treating medical records, the Commission notes that as a result of the accident Petitioner suffered an intertrochanteric comminuted fracture of the right proximal femur. (PX2). She underwent surgery at the hands of Dr. Driessnack on 1/24/14 in the form of closed reduction with right hip gamma nail insertion. (PX3). Petitioner followed up with Dr. Driessnack and was released to return to work without restrictions on 4/10/14. (PX4). Petitioner returned to Dr. Driessnack on 5/22/14 at which time he noted that Petitioner was "... doing well. She had a little bit of pain when she does a lot of walking, but is actually able to be up and about quite well. She notes that she has some pain on the sides of both right and left hips and is unable to lie on her side for very long." (PX4). On examination, Dr. Driessnack noted that the right left was about 2 cm shorter than the left and that she had no pain with gentle passive range of motion. (PX4). X-rays of the right femur and hip revealed that a long gamma nail was well-placed and stable within the confines of the right femur and that there was abundant heterotopic ossification adjacent to the lateral hip from a subtrochanteric oblique fracture with abundant callus seen. (PX4). Dr. Driessnack released Petitioner from his care at that time. (PX8).

Petitioner testified that still has a rod in her right leg. (T.32). Nowadays she notices pain in her leg, noting that she "... can't get up [if she sits too long] without having Don [her husband] help me because it don't do [*sic*] like me [*sic*] regular leg." (T.32-33). She described the pain as like a pinched nerve or a bee sting, and that she has to rub her whole leg. (T.33). She noted that she can't sit, walk or lay a long time. (T.33). She indicated that her pain was probably a five on a scale of 1 to 10. (T.33). She stated that every day she has to rub her leg because of the pain and that sometimes it's not as bad as others, depending on how long she's walked or sat. (T.34). It hurts worse when she does a lot of walking. (T.34). She claims she can't go on long trips to see her kids out of state because she can't sit for long. (T.34). She noted she goes to Sunday school at church and is rubbing her leg all the time because she is sitting. (T.34-35). She stated that her right side goes to sleep and it hurts if she lays too long, so she does not get a lot of

sleep like she used to. (T.35). She also noted that she can't wear the same shoes because she has a riser in her right shoe and her foot falls asleep and hurts. (T.35). She noted that the injury has changed her life completely. (T.36).

Petitioner denied ever having any right leg pain before this accident. (T.34). She noted that she doesn't like medicine and tries not to take over-the-counter pain medication. (T.36). She stated that she misses traveling and driving for Mr. Eyler [Respondent's owner]. (T.36). The longest trip she has taken since the accident was to Springfield and Peoria. (T.36). She noted she doesn't go much further – "... 80 miles, then I have to get out." (T.36).

Based on the above, and the record taken as a whole, the Commission modifies the Arbitrator's decision to find that Petitioner suffered the loss of use of 40% of the right leg pursuant to §8(e)12 of the Act

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/25/19 is modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $49.50 per week for a period of 11 weeks, from 1/23/14 through 4/9/14, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses set forth in PX11, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for reimbursement for home repair-related expenses is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $49.50 per week for a period of 86 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the loss of use of 40% of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

20IWCC0575

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 30 2020
o: 8/4/20
TJT: pmo
51

Thomas J. Tyrrell

Kathryn A. Doerries

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROOT, MARY E
Employee/Petitioner

Case# **15WC018151**

EYLER AUTO SALES
Employer/Respondent

20 IWCC0575

On 3/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0445 RODDY LAW LTD
FRANCIS O'BYRNE
303 W MADISON ST 19TH FL
CHICAGO, IL 60606

20 IWCC0575

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

Mary E. Root
Employee/Petitioner

v.

Eyler Auto Sales
Employer/Respondent

Case # **15** WC **18151**

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 **Peoria**, on **February 13, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [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. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Home Repairs Reimbursement**

FINDINGS

On **January 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$2,574.00**; the average weekly wage was **$49.50**.

On the date of accident, Petitioner was **79** 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, **$0** in non-occupational indemnity disability benefits and **$0**in other benefits, for a total credit of **$0.**

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS 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 **$49.50**/week for **11 weeks**, commencing **January 23, 2014 through April 9, 2014,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$49.50**/week for a further period of **64.5 weeks,** as provided in Section 8(e) of the Act, because the injuries sustained caused **30% loss of use of the right leg.**

Respondent shall pay the reasonable and necessary medical services as included in **Petitioner's Exhibit 11** 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.

Petitioner is not entitled to reimbursement of home repair-related expenses under 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.

20IWCC0575

Statement of Interest rate If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

3/20/19
Date

ICArbDec p. 2

MAR 25 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mary E. Root
Employee/Petitioner

Case # **15** WC **18151**

v.

Consolidated cases: **N/A**

Eyler Auto Sales
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she is currently 84 years of age and is not currently working. She testified that back in 2014, she was working for Dave Eyler, the owner of Respondent Eyler Auto Sales, a car dealership located in Rushville. She testified that she worked for Respondent for 14 years before her accident on January 23, 2014.

When asked what she generally did for Respondent, Petitioner testified that she went out to different auctions and dealerships and picked up vehicles. She testified that her job duties for Respondent included driving cars to and from auction sites, and that the auction sites were located in places such as Morton, Quincy and Peoria, as well as St. Louis, Missouri and Little Rock, Arkansas. She testified that she would often drive to these places with her husband, and that other times she drove without him. She testified that when she got to the auction site, she would look for the car that Mr. Eyler told her to get. She testified that if Mr. Eyler was not present with her, he gave her a paper that identified the car. She testified that Mr. Eyler would give her the paper about which car to pick up when she went to the office before making a trip to the auction site. She testified that she did not tell Mr. Eyler which cars to buy, as that was his decision.

Petitioner testified that she took Mr. Eyler's car when she traveled to the auction sites and that she did not take her personal vehicle. She testified that she would pick up Mr. Eyler's vehicle before the auction. She testified that Mr. Eyler paid for the gas. She testified that she would put gas in the cars at the auction sites with Mr. Eyler's credit card. She testified that she would occasionally have to get a hotel room, and that she used Mr. Eyler's credit card to pay for it.

Petitioner testified that she was not given set times to pick up the cars. She testified that she was not required to be back by a certain date if she picked a car up at an auction, but that she was to come straight back to his dealership with the car as soon as possible. She testified that she considered Mr. Eyler to be her boss. Petitioner testified that she considered herself to be an independent contractor; she also testified that she considered herself to be an employee of Respondent. She further testified that she thought they were the same thing.

Petitioner testified that when she went to auction sites and picked up cars, she expected to be paid for her services and that she did not do it for free. She testified that Mr. Eyler paid her for her services and that it depended on the trip as to how much she was paid. She testified that she was paid a flat price for a trip and that if she drove to the auction site with her husband, they would receive one check issued by Mr. Eyler.

Petitioner testified that she was not required to have any kind of a specialized license. She testified that she was not required to possess any specialized skills other than those of general driving. She testified that there were times that she would pick up a car and that it would not start. She testified that sometimes the dealer that she went to would give her jumper cables, and that Mr. Eyler also gave her jumper cables to use at times as well.

Petitioner testified that on the date of the accident at issue, she went to a Morton area auto dealer and was to pick up two trucks. She testified that one of the trucks would not start. She testified that there was a charger made available to her and that when she pulled on the handle it hit her and tripped her, causing her to land and fall on her right side. She testified that an ambulance was called and that she was taken by ambulance to OSF St. Francis Medical Center. She testified that she was admitted to the hospital for a few days, and that Dr. Driessnack performed surgery on her right hip.

Petitioner testified that she was released from St. Francis Medical Center on January 27, 2014 and that the next day, she called an ambulance to take her to Sarah Culbertson Memorial Hospital as she could not walk on her right leg and had fallen twice. She testified that she was admitted to the hospital and that she did therapy until she got enough strength to go home. She testified that when she went home she was in a wheelchair, and that she used a wheelchair for a while as well as having walked with a cane for a period of time.

Petitioner testified that Dr. Driessnack kept her off work and that she was released from his care as of May 22, 2014. She testified that following that, she saw Dr. Mitchell due to soreness in her back due to her having been walking with a limp. She testified that Dr. Mitchell worked with her on her shoes and leg. She further testified that she was required to have different repairs made to her house including the installation of a ramp, having to have a door put in and having to have a walk-in shower installed. She testified that she also had to have a stackable washer and dryer unit installed, as her other units were in the basement and she was unable to get down the stairs.

Petitioner testified that she was never referred for an impairment rating. She testified that she was not currently working. She testified that she was 79 at the time of the accident and that she had not been able to work since the accident. She testified that she believed that the accident adversely affected her future earnings capacity.

Petitioner testified that she has a rod in her leg from her knee to the hip. She testified that she has pain in her hip and that she sometimes needs help getting up after having sat for too long. She testified that she has to rub her whole leg and that she rubs the area from her right knee up to her right hip. She testified that she has to rub her leg every day, but that some days were not as bad as others. She testified that her leg hurts worse if she does a lot of walking. She denied having had any right leg pain before this accident. She testified that she is now unable to see her children that live out-of-state, that she does not sleep as much now and that she has a riser in her right shoe. She testified that the accident has changed her life completely.

Petitioner testified that she tries not to take any over-the-counter medications as she does not like medication. She testified that she misses traveling and driving, both personally and for work. She testified that the longest trip she can take now sitting in a car is typically to either Springfield or Peoria. She testified that she lives in Rushville.

On cross examination, Petitioner testified that she tried to work after her release from Great Plains Orthopaedics but that it hurt so she quit. She testified that she did one or two trips for Mr. Eyler in April 2014 after she was released. She agreed that there were no medical records since that date stating that she was not able to work.

On cross examination, Petitioner testified that before the accident at issue she had had a hip replacement on her left side. She testified that she had the left hip replacement performed long before she fell. She testified that before the accident at issue, she had had a right knee replacement and a left hip replacement performed.

On cross examination, Petitioner agreed that she was paid a flat fee depending on where she went. She testified that she would get a check for a flat fee from Mr. Eyler and that it was fair to state that the checks were often made out to her and her husband. She agreed that she was typically paid $25.00-$40.00 per trip and that no taxes were taken out of the checks. She testified that she turned in a list of the trips that she had made and that after she turned in the list, she got paid.

On cross examination, Petitioner testified that she would often endorse the checks that were issued. She testified that she believed that she went on two trips to St. Louis and Morton after the fall, and that she quit thereafter.

On cross examination, Petitioner testified that after her surgery she was not able to go down to the basement of her house. She agreed that she did not have a written restriction from her doctor about not going into the basement. She agreed that she did not have a note from her doctor that recommended a stand-up shower. She testified that she was unable to get into the tub and that she decided to get it on her own. She testified that she needed the ramp for her wheelchair. She agreed that she eventually did not need the wheelchair. She agreed that the ramp was not installed at the direction of her doctor, but that she felt that she had to. She further agreed that her doctor did not direct that she have the stackable washer/dryer unit installed.

On cross examination, Petitioner agreed that Mr. Eyler did not care when she left to go get a vehicle. She agreed that Mr. Eyler did not care which route she took on her return. She testified that she would leave when she wanted and that she would take the route she was most comfortable with, but that sometimes Mr. Eyler sent her a map. She agreed that she was able to leave when she wanted to pick up a vehicle and that she often dropped it off by the end of the day, depending on where she went.

On cross examination, Petitioner agreed that she testified that she never used her own vehicle to drive to an auction or dealership. She agreed that there was no rule against using her own vehicle, but that she would only use Mr. Eyler's vehicles. She testified that when she was driving for Mr. Eyler, there were 4 or 5 other drivers that were there as well that she knew of. She testified that there were times that they would travel with the other drivers if they were going to get multiple cars. She agreed that she was not required to go pick up a vehicle and that it was whenever she was available to do so. She testified that she did not have to drive a car every day, and that it was whenever Mr. Eyler called.

On cross examination, Petitioner agreed that she chose to stop driving and further testified that it hurt if she sat too long. She agreed that she had no driving restrictions from her doctor.

On cross examination, Petitioner testified that there were times when she would have to get a hotel room for trips to places like St. Louis or Indianapolis. She testified that she would find her own hotel room, but that Mr. Eyler would pay the bill. She testified that Mr. Eyler did not make the hotel arrangements, but that she used his credit card.

On redirect, Petitioner testified that Mr. Eyler had her check the cars for things such as gas, oil and scratches on the vehicle body.

On redirect, Petitioner testified that she did not understand the legal difference between an independent contractor and an employee.

On redirect, Petitioner testified that she was at Sarah Culbertson Memorial Hospital from the end of January through February 11th and that she had had the repairs done at the house while she was in the hospital. She testified that she did not have a doctor's note for the shower, but that she needed it because she was unable to get into the tub as she could not lift her leg and would lose her balance. She testified that she could not put weight on her leg when she went home. She testified that she was using a wheelchair when the ramp and door were installed. She testified that in February and March of 2014, she had not yet been released to full duty work by her doctor.

On further cross examination, Petitioner testified that she used the ramp for a long time because she had a walker and a cane, that the ramp was much easier to use, and that she still used it.

On further cross examination, Petitioner agreed that when she would pick up a vehicle, Mr. Eyler would ask her to check to see if there was gas and oil in the vehicle. She testified that she would call Mr. Eyler if the mileage on the vehicle was too high. She testified that if the vehicle was low on gas, she would put gas in the car with Mr. Eyler's credit card. She testified that she would use the closest service station. She testified that she would sometimes add air to the tires. She testified that she would select which service station to use.

David Eyler was called as a witness by Respondent at the time of arbitration. He testified that he was employed by Eyler Auto Center in Rushville and that he was the corporation's president. He testified that he had been the president since the corporation was founded in 1990. He testified that he knew Petitioner, as she was one of the drivers that he employed to pick up vehicles.

Mr. Eyler testified that he had a list of drivers to choose from for a particular outing, and that in a given month he had about 6 or 7 people on his list. He testified that all the people on his list were independent contractors. He testified that Petitioner would be given a flat fee depending on the distance.

Mr. Eyler testified that Petitioner's Exhibits 17 and 18 were similar to the lists that Petitioner would provide him and that they looked familiar. He testified that if the driver did not go frequently he would pay them by the trip, and that not all the drivers used the list method. He testified that on occasion Petitioner would drive on her own vehicle and that her husband would also drive on his own. He testified that once her husband started driving Petitioner and her husband drove the majority of the time together, and that the trip would typically only require one person so they could choose who drove.

Mr. Eyler agreed that all the checks written stated that they were made payable to Don and Mary Root and that there may have been occasions when just Don drove, but that he included Petitioner on the check. He testified that Petitioner talked to him predominantly on the phone and that there were times when he left a voice mail for her. He testified that if he did not get a call-back, he would move down the list and assume Petitioner was unable to go. He testified that there were times when a driver declined a trip.

Mr. Eyler testified that when he gave them a location, it was fair to state that the vehicle was ready to be picked up. He testified that Petitioner could leave whenever she liked. He testified that he had no rule about travel routes and that the drivers chose their own routes and determined when to pick up the vehicle, after which they would return it to him. He testified that he believed that there might have been a time or two when Petitioner had used her personal vehicle and that there was no rule that they had to use Respondent's vehicle. He testified that there were other times when Petitioner would be with the other drivers, and that there were no rules that she had to go with the others.

Mr. Eyler testified that it was his practice with Petitioner that she was to write down the trips and give him a list. He testified that there were pay periods where if Petitioner made $25.00 she probably made a single trip, whereas other checks were higher for multiple vehicles. He testified that he did not take any taxes out of the checks and that each driver was on their own for tax purposes.

Mr. Eyler testified that Petitioner voluntarily stopped driving and that it was her decision. He testified that Petitioner's husband, Don, did the same thing as well. He testified that on some trips he would give Petitioner a credit card to use and that it was typically an overnight stay where a hotel was required. He testified that if the vehicle needed gas, Petitioner could use the credit card to get gas. He testified that there was no requirement where to get gas or oil for the vehicle. He testified that it was up to the driver as to when they would leave, what route was taken, or where to go for services that were needed.

Mr. Eyler testified that he did not receive any requests from Petitioner for lost wages or her medical bills while she was receiving medical treatment. He testified that he asked Petitioner to let him know when she was released and that after she got a full duty release, he believed that she drove about three more times and then chose to stop driving.

On cross examination, Mr. Eyler agreed that he was aware after the accident that Petitioner had retained an attorney and had filed a claim. He testified that he did not have anyone sign an independent contractor agreement. He testified that he was unable to speak for the other drivers as to whether they thought they were employees or independent contractors.

On cross examination, Mr. Eyler agreed that there were times when Petitioner drove by herself. He agreed that he paid Petitioner for her services. He agreed that he provided Petitioner with a car to drive to the auctions and that he gave her a credit card to use for gas or a hotel room.

On cross examination, Mr. Eyler agreed that no CDL license was required for the drivers. He agreed that as to the cars that were purchased, he decided that and not the drivers. He agreed that he required the drivers, including Petitioner, at auction sites to check the vehicle's mileage. He agreed that he required Petitioner to give a him call and let him know if the mileage was different. He agreed that he required Petitioner to check the vehicle's oil. He agreed that he expected Petitioner to look for scratches on the cars.

On redirect, Mr. Eyler testified that it would not be every time that Petitioner may need to put oil in a car, and that it occurred maybe a dozen times per year.

The records of Morton Fire Department Ambulance Service were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Incident Location was noted to be that of Morton Auto Auction for a fall with hip pain. It was noted that Petitioner fell onto her right hip while walking on snow and ice in a parking lot. (PX1).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen in the emergency room on January 23, 2014, at which time it was noted that she was at an auto shop, that she went outside to charge a car, that she tried to pull a piece of equipment and that she tripped on the equipment and fell. It was noted that since then Petitioner's right hip was externally rotated and that she was having pain with any movement. It was noted that Petitioner noted a past medical history of a left hip replacement and right knee reconstructive surgery. It was noted that x-rays were interpreted as revealing intertrochanteric comminuted fracture of the right proximal femur. The Orthopedic Discharge Summary dated January 27, 2014 noted that Petitioner underwent closed reduction with right hip gamma nail insertion, and that the procedure was performed without complications. It was noted that Petitioner's current assistive devices required were that of a walker. (PX2).

The Operative Report dated January 24, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent right hip gamma nail insertion on January 24, 2014 by Dr. Driessnack for a pre- and post-operative diagnosis of right hip intertrochanteric hip fracture. (PX3).

The medical records of Great Plains Orthopaedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on May 22, 2014, at which time it was noted that she was doing well, that she had a little bit of pain when she did a lot of walking but was actually able to be up and about quite well, that she noted that she had some pain on the sides of both the right and left hips, and that she was unable to lie on her side for very long. It was noted that Petitioner was released for her right hip fracture and that she would return for ongoing follow-up of her left hip replacement with her operating surgeon at the appropriate timeframes. (PX4).

The records of Great Plains Orthopaedics reflect that Petitioner was seen on February 10, 2014, at which time it was noted that she was taken to the OR by Dr. Driessnack on January 23rd for closed reduction and internal fixation with a long flocked Gamma nail, that she was subsequently transferred to a local skilled care facility where she had been ever since, and that she was scheduled to be released home the next day. It was noted that Petitioner did take a couple of falls and that x-rays were repeated in the nursing home at Dr. Driessnack's directive, and that the reports only indicated that she had not sustained any damage to the hip. It was noted that on exam in a wheelchair, Petitioner had no pain with gentle passive range of motion of the right hip. It was also noted that Petitioner could be weightbearing as tolerated and that new physical therapy orders were written. (PX4).

The records of Schuyler County Ambulance were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that a 9-1-1 call was made for a 79-year-old female patient with a complaint of weakness and leg pain. It was noted that Petitioner's family stated that she was very weak and in mild pain from surgery. Petitioner was transported to Sarah D. Culbertson Memorial Hospital in Rushville. (PX5).

The medical records of Sarah D. Culbertson Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on January 28, 2014, at which time it was noted that she fell and broke her right femur five days ago, that she had surgery at St. Francis in Peoria four days ago, and that she was discharged home. It was noted that Petitioner complained of weakness and that she had fallen twice. It was noted that Petitioner was admitted to a "swing" bed for further rehabilitation with physical and occupational therapies. The Discharge Summary dated February 11, 2014 noted that Petitioner's "swing" bed course was unremarkable, that she did have some significant swelling of the right lower extremity that was concerning but that venous Doppler suggested that there was no DVT, that she did well with physical and occupational therapies, and that she was felt sound for discharge on February 11, 2014. The Discharge Diagnosis was noted to be that of (1) right hip fracture surgically repaired on January 23, 2014; (2) significant peripheral edema, improved. The records further reflect that Petitioner underwent an outpatient physical therapy Initial Evaluation on February 18, 2014, at which time it was noted that she reported pain levels currently 2/10 but worse at night trying to sleep on her left side. It was noted that a discussion was had with Petitioner regarding trying to take Tylenol more regularly that week. (PX6).

The medical records of Quincy Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was issued a DME order for a standard manual wheelchair on February 27, 2014 by Dr. Schroeder. (PX7)

The Return to Work Slip dated April 9, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The record reflects that Dr. Driessnack allowed Petitioner to return to work without restrictions on April 10, 2014. (PX8).

The medical records of Dr. Idol Mitchell, DPM were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on July 1, 2014, at which time it was noted that she complained that she limped and had soreness in the lower back due to a short right limb, that she sustained an injury on January 23rd and had a rod placement the next day, and that it had left her with a

shortened right lower extremity. It was noted that Petitioner had been wearing a lift for the last three months that had helped but that she still had some discomfort and was still not walking right according to her. The diagnosis was noted to be that of acquired leg length discrepancy and gait disturbance. Petitioner was sent for an x-ray to try to quantitate the measurement. At the time of the January 14, 2014 visit, it was noted that Petitioner stated that the current lift was very comfortable and that she was not having any sustained lower extremity or back discomfort. It was noted that Petitioner was currently wearing a 5/8-inch lift in her sandals. It was noted that as they moved into an enclosed shoe with the change of season Petitioner may not be able to use more than 3/8-inch lift on the inside of the shoe, and that if she became symptomatic they would have to use an outsole lift. (PX9).

The medical records of McDonough District Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent x-rays on July 1, 2014 for a gait disturbance/leg discrepancy. It was noted that when measurements were obtained from the very top of the right femoral head to the right tibial plafond, the overall length was about 79.6 cm and that when similar measurements were obtained on the left from the top of the femoral head prosthesis tibial plafond, a measurement of about 81.4 cm was obtained. (PX10).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit11.

The Peterman Appliances Receipt dated February 12, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Invoice dated February 20, 2014 from Davis Electric, Plumbing, Heating & Cooling was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The Invoice dated March 11, 2014 from Davis Electric, Plumbing, Heating & Cooling was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The Invoice dated April 14, 2014 from Rex Powell Construction was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The Invoice dated December 31, 2014 from Rex Powell Construction was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.

The 2013 Travel & Wage Information was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The 2014 Travel & Wage Information was entered into evidence at the time of arbitration as Petitioner's Exhibit 18.

CONCLUSIONS OF LAW

With respect to disputed issue (B) pertaining to whether an employer-employee relationship existed between the parties, the Arbitrator finds that on January 23, 2014, an employee-employer relationship did exist between Petitioner and Respondent.

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. Instead, there are multiple factors to consider when assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill.App.3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Robertson v. Indus. Comm'n.*, 866 N.E.2d 191, 200 (Ill. 2007). Other relevant factors include the label the parties place on their relationship, and whether the parties' relationship was "...long, continuous, and exclusive." *Ware*, 318

Ill.App.3d. at 1122, 1126. No single factor is determinative and such determination of the employer-employee relationship rests on the totality of the circumstances. *Roberson*, 866 N.E.2d at 200.

In the case at hand, the Arbitrator acknowledges that a few factors admittedly tend to lean towards the finding that an independent contractor relationship between Petitioner and Respondent on the date of the accident at issue. First, the evidence reveals that Respondent did not necessarily dictate Petitioner's schedule. Petitioner testified she was not given set times to pick up the vehicle and that she was not given a set time to be back to Respondent with the vehicle, although she testified that she was required to come straight back to Respondent with the car as soon as possible. Also, Petitioner and Mr. Eyler testified that Respondent paid Petitioner a flat rate of $25.00 to $40.00 depending on the length of the trip and not on an hourly basis. Further, the evidence reveals that Respondent did not withhold income and social security taxes from Petitioner's compensation. Finally, Mr. Eyler testified that he considered his drivers to be independent contractors, although he further testified on cross-examination no drivers signed an independent contractor agreement and that he could admittedly not speak as to whether the other drivers considered themselves to be employees or independent contractors. Petitioner testified she considered Mr. Eyler her boss, and she further testified she thought she was both an employee and an independent contractor. On redirect examination, Petitioner testified that she did not understand the legal definition of each type of position.

However, the Arbitrator finds that several other factors in this case are highly persuasive of the finding of the existence of an employee-employer relationship. First, it appears that Petitioner was employed at-will, as there was no evidence (including that of an independent contractor agreement) specifying the conditions for which she could be discharged. Second, the evidence reveals that Respondent provided Petitioner with the materials and equipment to perform her work duties. Petitioner testified that she drove Respondent's vehicles to the auction sites and that she never drove her personal vehicle. The evidence further reveals that Respondent paid for the gas and provided Petitioner with a credit card to use for the gas and to pay for a hotel room when she went to an out-of-state auction. Petitioner also testified that sometimes Respondent provided her with jumper cables to be used when a vehicle would not start.

Third, Respondent's general business encompassed Petitioner's work duties. Respondent is in the business of buying and selling cars, and transporting cars back to its business location is logically part of that business endeavor. Fourth, the Arbitrator finds that the skill the work required is a also relevant factor in this case as well. The evidence reveals that Petitioner was not required to possess any particular specialized skills, which one would often expect to be the case with an independent contractor situation. The evidence in the case at hand, however, revealed that Petitioner simply had to have general driving skills and a valid regular driver's license.

Finally, and admittedly perhaps most significant to the Arbitrator, the evidence reveals that Respondent sufficiently controlled the manner of Petitioner's work. While it is true that Petitioner could leave to pick up a vehicle generally at her own schedule and choose her own route, she testified that she brought the vehicle straight back to Respondent as soon as possible and did not take it home first. The evidence reveals that Petitioner gave no input with respect to the cars to be purchased, and that that was solely Mr. Eyler's decision. After purchasing a vehicle, Mr. Eyler often gave Petitioner a paper with the specific car she was to pick up prior to her leaving for the auction. Petitioner testified that when she picked up vehicles, Mr. Eyler required that she check the gas, oil, tires, and body of the vehicle for things such as scratches. Petitioner testified that she was also required to check whether the mileage on the vehicle matched up to what she was told the vehicle was supposed to have had when Mr. Eyler purchased it. Mr. Eyler acknowledged on cross examination that he required drivers to verify that the vehicle had the same mileage on it as when he purchased it, that drivers were required to call him if the mileage did not match, that he required the drivers to check the oil and that he expected the drivers to check for scratches and damage to the vehicles.

In the case at hand, the Arbitrator finds to be both persuasive and factually analogous the case of *Ragler Motor Sales v. Industrial Commission*. *Ragler Motor Sales v. Indus. Comm'n*, 93 Ill.2d 66, 442 N.E.2d 903 (1982). In *Ragler*, the Illinois Supreme Court reviewed the Commission's finding that the claimant was an employee. Matthew Ragler, the owner of Ragler Motor Sales, testified at arbitration that he employed the claimant to perform various odd jobs for approximately 10 years. The claimant was paid on an hourly basis and taxes and social security were withheld. On October 27, 1978, Ragler fired the claimant. On November 15, 1978, the claimant went to an auto auction for Ragler. The parties had always considered the claimant's attendance at auto auctions as a separate job and Ragler customarily paid claimant $10.00 in cash to attend the auctions if a vehicle was purchased and claimant drove it back to Ragler's car lot. Ragler testified that the claimant was not responsible for test driving or otherwise evaluating the used cars Ragler was considering purchasing and did not participate in the decision to purchase a particular vehicle. The claimant had testified that he was to be paid $10.00 regardless of whether a vehicle was purchased and that he offered advice about the conditions, marketability and necessary repairs which the vehicle would require. He also testified that he frequently test drove cars. *Ragler*, 93 Ill.2d at 68-70, 442 N.E.2d at 903-905. The Supreme Court found the Commission's finding that the claimant was an employee was not against the manifest weight of the evidence. The Supreme Court reasoned that Ragler controlled and had the right to control the manner in which the work was to be performed and had the authority to supervise the activities of the claimant at the auctions. The court also noted that while no income tax or social security was withheld for the driving from auctions job, that factor is not controlling. Further, Ragler had the absolute right to discharge the claimant and considered the purchase of vehicles as part of his business which necessarily included transporting the vehicles back from the auctions. *Ragler*, 93 Ill.2d at 72, 442 N.E.2d at 905-906.

Having considered and reviewed the entirety of the evidence on the issue and having reviewed and considered the case law cited by both parties in their respective proposed decisions in this matter, the Arbitrator finds that on January 23, 2014, an employee-employer relationship did exist between Petitioner and Respondent.

With respect to disputed issue (C) pertaining to accident and disputed issue (F) pertaining to causation, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has met her burden of proving that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on January 23, 2014 and that her current condition of ill-being is causally related to the accident.

The Arbitrator finds that on January 23, 2014, an accident occurred that arose out of and in the course of Petitioner's employment by Respondent. On that day, Petitioner went to an auction site in Morton to pick up a vehicle for Respondent. The vehicle would not start. As Petitioner was pulling a portable battery charger, her boot got caught in its cord, causing her to fall on her right side. The Arbitrator notes that Petitioner testified at the time of arbitration that there were other times prior to the accident at issue when she would have to jump-start "dead" cars.

Furthermore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury. Following the fall, the evidence reveals that Petitioner was taken to the emergency room of OSF St. Francis Medical Center, where she was diagnosed with an intertrochanteric comminuted fracture of the right proximal femur and underwent surgery. Petitioner credibly testified about her treatment following the accident, and the record lacks any indication that she had any issues with her right hip or leg prior to the accident at issue.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met her burden of proving that she sustained accidental injuries that arose out of and in the course of her

employment with Respondent on January 23, 2014 and that her current condition of ill-being is causally related to the accident.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to her work accident of January 23, 2014. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 11 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 claims that she is entitled to temporary total disability benefits for the timeframe of January 23, 2014 through May 22, 2014. (AX1).

The records reflect that Petitioner underwent right hip gamma nail insertion on January 24, 2014 by Dr. Driessnack for a pre- and post-operative diagnosis of right hip intertrochanteric hip fracture. (PX3). Furthermore, the Return to Work Slip dated April 9, 2014 reflects that Dr. Driessnack allowed Petitioner to return to work without restrictions on April 10, 2014. (PX8). As a result of the foregoing, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 11 weeks, for the timeframe of January 23, 2014 through April 9, 2014.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, 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 impairment. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she was a driver for Respondent at the time of the accident at issue. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 79 years old on the date of the accident at issue. In light of Petitioner's release to full duty by her treating physician, 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 Petitioner testified that she returned to work for Respondent upon the completion of her medical treatment with Dr. Driessnack, but chose to quit shortly thereafter. As there was no evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected her future earnings capacity, 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 she has pain in her hip and that she sometimes needs help getting up from having sat for too long. Petitioner testified that she has to rub her whole leg and that she rubs the area from her right knee up to her right hip. Petitioner testified that she has to rub her leg every day, but that some days were not as bad as others.

Petitioner testified that her leg hurts worse if she does a lot of walking. At the time of the May 22, 2014 visit at Great Plains Orthopaedics, it was noted that Petitioner was doing well, that she had a little bit of pain when she did a lot of walking but was actually able to be up and about quite well, that she noted that she had some pain on the sides of both the right and left hips, and that she was unable to lie on her side for very long. It was noted that Petitioner was released for her right hip fracture and that she would return for ongoing follow-up of her left hip replacement with her operating surgeon at the appropriate timeframes. (PX4). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was somewhat corroborated by her treating records at the conclusion of her treatment. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **30% loss of use of the right leg** as provided in Section 8(e) of the Act.

With respect to disputed issue (O) pertaining to home repair expense reimbursement, the Arbitrator finds that Petitioner is not entitled to reimbursement of home repair-related expenses under the Act. The Arbitrator notes that not only was there no medical evidence of any type of prescription for the various home repairs that were performed after Petitioner's fall in this case, but there was also no evidence proffered by Petitioner that established the reasonableness and necessity of the repairs beyond her testimony that she felt that she needed to have the various home modifications be made. As such, the Arbitrator finds that Petitioner is not entitled to reimbursement of the home repair-related expenses.

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 CHAMPAIGN	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Clyde R. Gum,

Petitioner,

vs.

NO: 14 WC 13582

20 IWCC0576

University of Illinois Champaign Urbana,

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, temporary total disability and nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, with changes as stated herein, said decision being attached hereto and made a part hereof.

The Commission notes that in analyzing the nature and extent of Petitioner's injury, the Arbitrator neglected to specify the amount of weight to be accorded factor (v), evidence of disability corroborated by the treating records. Instead, the Arbitrator simply noted "... the results of the left shoulder MRI, Dr. Sams' operative findings and the examination findings of February 5, 2015." (Arb.Dec.[Addendum], p.10). The Commission modifies the Arbitrator's decision in this regard to show that this factor is accorded significant weight.

With respect to this evidence, the Commission notes that an MRI of the left shoulder performed on 4/22/14 revealed 1) no significant rotator cuff tears, probable mild tendinosis versus a very small partial undersurface rim rent tear supraspinatus tendon at its insertion with adjacent cystic change of the humerus, 2) AC degenerative change, marginal spurring and impress on the musculotendinous junction of the supraspinatus tendon which can be seen in the setting of impingement, and 3) subacromial subdeltoid bursitis. (PX3).

The record also shows that on 6/16/14 Petitioner underwent surgery at the hands of Dr.

Sams in the form of 1) left shoulder arthroscopy with rotator cuff repair, 2) distal clavicle excision arthroscopically, and 3) subacromial decompression with partial acromioplasty. (PX4). The postoperative diagnoses included left shoulder rotator cuff tear involving the supraspinatus, impingement syndrome and acromioclavicular joint osteoarthritis. (PX4).

In an office note dated 2/5/15, Dr. Sams recorded that Petitioner had done very well with physical therapy initially after surgery but that "... work comp as well as long term disability provider suggested that he not return to work hardening. I do not understand how I can rehab his shoulder to get him back to the level of activity he will be required to do to return to his job if he does not go to work hardening. I voiced my dissatisfaction with his noncompliance. I again have ordered work hardening for six weeks." (PX2).

In a note dated 2/19/15, Dr. Sams indicated that Petitioner could return to work on that date without restrictions. (PX4).

For his part, Petitioner testified that he returned to Dr. Sams on 12/18/14 at which time he "... was virtually pain free. I just still had a very small amount of weakness." (T.30). He agreed he was still on restrictions from work at that time and that his final visit with Dr. Sam was on 2/5/15. (T.30-31). He noted that at that point he "... felt great and was ready to go to work." (T.31). He noted that Dr. Sams was still recommending work hardening to improve his strength at that time, and that he was eventually released back to work on February 16th or 17th "... at my insistence that he release me to work." (T.31). Petitioner testified that he returned to full duty work and is currently working full duty for Respondent. (T.31-32). Petitioner denied suffering any new injuries to his left shoulder since 2/27/14. (T.32).

Currently, Petitioner notes that "I don't quite have the same range of motion that I normally have or had, and if I am doing overhead work it seems to get tired faster." (T.32). He indicated that he is still able to work full duty, noting that "I just can't do as much overhead work, like if I am helping a friend hang drywall or something like that I have to keep dropping my arm down and letting it rest." (T.32). He agreed that the current problem is with range of motion and lack of strength, noting that "... I used to be able to reach all the way around and like scratch areas on my back which I can't really do with that arm now." (T.33). He indicated that overall he is happy with the results from the surgery. (T.33).

Based on the above, and the record taken as a whole, the Commission affirms the Arbitrator's award of 12.5% person-as-a-whole pursuant to §8(d)2 of the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/29/19 is affirmed and adopted with changes 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 Circuit Court.

DATED: SEP 3 0 2020
o: 8/4/20
TJT: pmo
51

Thomas J. Tyrrell

Maria E. Portela

DISSENT

I respectfully disagree with the Majority opinion and would reverse the Decision of the Arbitrator finding Petitioner sustained his burden of proving an accident arising out of his employment with Respondent and his condition of ill-being was causally related to his work activities.

The facts are not in dispute. Petitioner was employed as a driver for the University of Illinois. During January and February of 2014, Petitioner was operating a "normal 4 wheel drive pick-up truck" while plowing snow in the course of his employment for Respondent. (T. 34) While he was plowing snow, Petitioner used his left upper extremity to steer the pick-up truck. (T. 13) Petitioner testified there were several snowfalls during January 2014 and through the entire winter. It would snow three or four inches and they would "get it cleaned up" and get a two or three day break and it would start snowing again. (T. 15) He worked 16 hour shifts during this time. (T. 15) On February 27, 2014, Petitioner noticed his left shoulder was tired and sore. (T. 11) He testified this began around the middle of January. (T. 12) He noticed the issues with his shoulder mostly while plowing snow. (T. 12) When asked to describe what he was doing exactly with his left shoulder while plowing snow, Petitioner responded, "Working the steering wheel only." (T. 13)

Petitioner was diagnosed with a left shoulder rotator cuff tear involving the supraspinatus, impingement syndrome and acromioclavicular joint arthritis and underwent a left shoulder arthroscopy with rotator cuff repair, distal clavicle excision arthroscopically and subacromial decompression with partial acromioplasty.

The Majority found "one-handed steering and maneuvering in tight spaces that Petitioner described are certainly within a layperson's comprehension" and further found, "Petitioner did not offer any medical testimony on the issue of causation but the Appellate Court has noted that

such testimony is not required to establish a compensable injury where the nature and effect of the work activities is within the common knowledge of laypeople," citing *Westinghouse Electric Company v. Industrial Comm'n*, 64 Ill.2d 244 (1976) and *Nunn v. Industrial Comm'n*, 157 Ill.App.3d 470 (1987).

Reliance on *Westinghouse* is misplaced. The Illinois Supreme Court in *Westinghouse* stated that medical testimony is not necessarily required to establish causation and disability but there, the occurrence was traceable to a definite time, place and cause. In the instant case, Petitioner alleged an accident under a repetitive trauma theory. Petitioner's burden of proof is more appropriately enunciated by the *Nunn* court.

The Appellate Court in *Nunn* held:

> Although 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 of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of...This is especially true in repetitive trauma cases. In a repetitive trauma case, there must be a showing that the injury is work-related and not the result of a normal degenerative aging process.

Nunn at 470.

Here, Petitioner is required to prove by a preponderance of the credible evidence that his condition was caused by his work activities. Whether the act of steering a pick-up truck is sufficiently repetitive, whether it required force, how much force was required, whether breaks would be necessary or would impact the progression of the condition, whether the repetition and force together were the cause, or a cause, of his left shoulder rotator cuff tear, impingement syndrome and acromioclavicular joint osteoarthritis, are all outside the knowledge of laypersons and, pursuant to *Nunn*, require a medical opinion to establish causation. Petitioner presented no medical opinion that his condition was caused by one-handed steering of a normal pick-up truck and not the result of the normal degenerative aging process. As such, he did not meet his burden of proof and the case should be reversed.

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GUM, CLYDE
Employee/Petitioner

Case# **14WC013582**

UNIVERSITY OF ILLINOIS CHAMPAIGN URBANA
Employer/Respondent

20 I W CC0576

On 10/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY GRAHAM SLEFO
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0522 THOMS MAMER & HAUGHEY LLP
ERIC S CHOVANEC
PO BOX 560
CHAMPAIGN, IL 61824

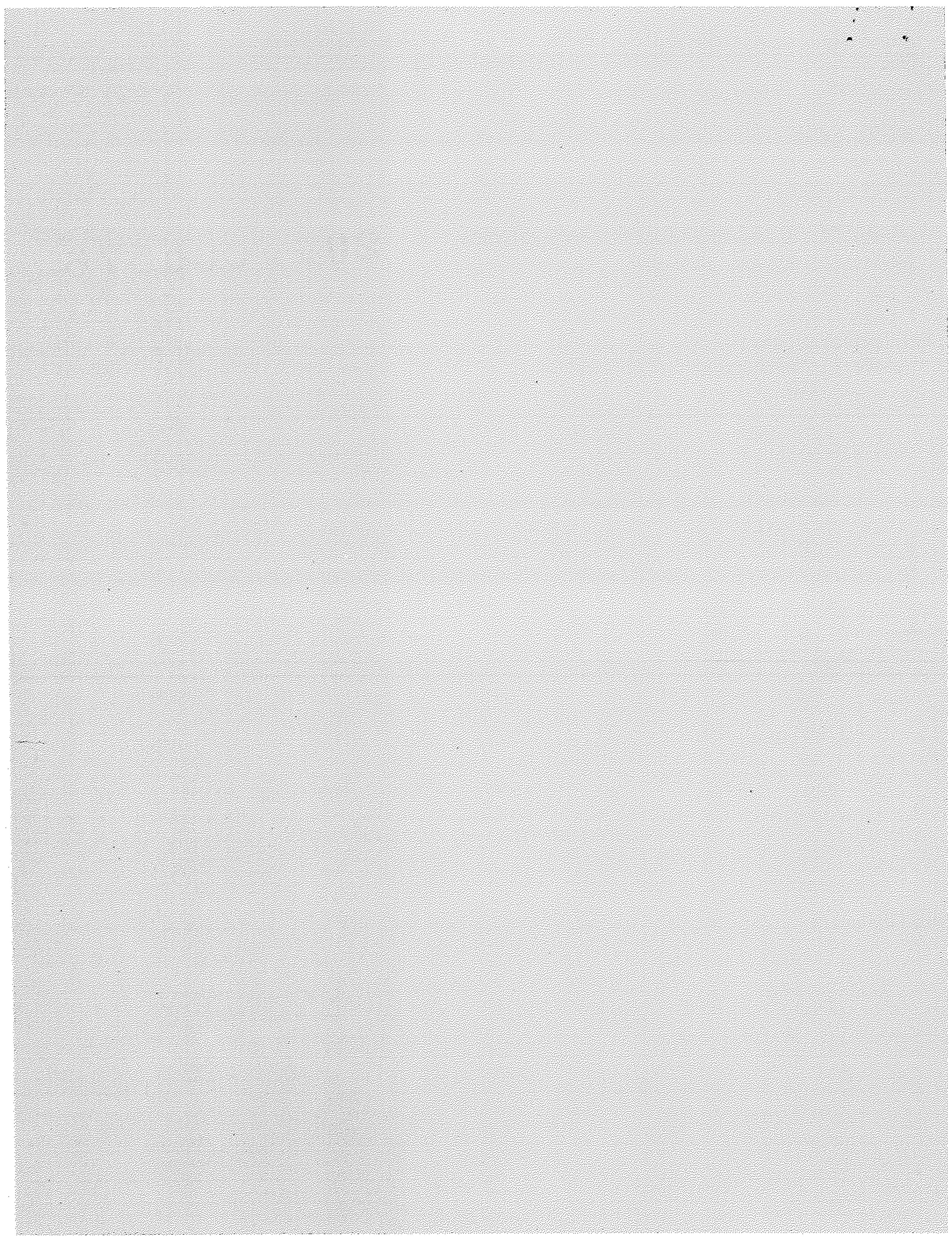
1073 UNIVERSITY OF ILLINOIS
100 TRADE CENTER DR
SUITE 103
CHAMPAIGN, IL 61820

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305 / 14

OCT 29 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission



STATE OF ILLINOIS)
)SS.
COUNTY OF **Champaign**)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§ 8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CLYDE R. GUM
Employee/Petitioner

Case # **14** WC **013582**

v.

Consolidated cases: **D/N/A**

UNIVERSITY OF ILLINOIS CHAMPAIGN URBANA
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, former Arbitrator of the Commission, in the city of **Urbana**, on **July 17, 2019**. On October 24, 2019, after Arbitrator Hemenway's departure, the Commission reassigned the case to Arbitrator Mason for the purpose of reviewing the transcript, exhibits and proposed findings and issuing a decision. The parties agreed to have Arbitrator Mason perform this function. 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 **2/27/2014**, 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 injuries secondary to repetitive trauma arising out of and in the course of employment.

Timely notice of the repetitive trauma injuries ***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 $**62,743.20**; the average weekly wage was $**1,206.60**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $804.04/week for 35-3/7 weeks, commencing 6/16/14 through 2/18/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services as outlined in PX 6, with the exception of the charges relating to non-accident-related care (ear wax cleaning) provided by Kirby Medical Group to Petitioner on August 28, 2014, as provided in Sections 8(a) and 8.2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C. Mason

Signature of Arbitrator

OCT 29 2019

10/29/19
Date

Procedural History

Former Arbitrator Hemenway conducted a hearing in this case in Urbana, Illinois, on July 17, 2019. On October 24, 2019, the Commission reassigned the case to Arbitrator Mason for the purpose of reviewing the transcript, exhibits and parties' proposed findings and issuing a decision. On October 25, 2019, Arbitrator Mason contacted counsel for both parties via E-mail, explained their alternatives, and secured their agreement to have her review the case and write a decision.

Summary of Disputed Issues

Petitioner, a longtime truck and snowplow driver, claims a left shoulder condition secondary to repetitive trauma manifesting on February 27, 2014. Petitioner testified he began experiencing left shoulder symptoms in mid-January 2014, while using his left upper extremity to turn the steering wheel of his assigned snowplow during 16-hour shifts. Petitioner explained he could use only his left hand and arm to turn the wheel because he had to use his right hand to operate the snowplow controls, which were mounted in the center of the truck. He initially underwent conservative care, including therapy and an injection, but eventually underwent a left shoulder arthroscopy on June 16, 2014. His surgeon, Dr. Sams, documented a rotator cuff tear in his operative report. Petitioner resumed full duty in mid-February 2015 and was continuing to work as a driver for Respondent as of the hearing.

Respondent did not call any witnesses or offer any documentary evidence. T. 3, 35.

The disputed issues include accident/repetitive trauma, notice, causal connection, medical expenses, temporary total disability and nature and extent. Arb Exh 1. T. 5.

Reviewing Arbitrator's Findings of Fact

Petitioner testified he lives in Bement, Illinois. He has worked for Respondent for 19 ½ years. T. 10. He works as a driver. He operates a variety of vehicles, including pick-up trucks, dump trucks, flatbeds, box trucks, hook trucks and trash trucks. During the winter, he also operates snowplows and salt trucks. T. 10-11.

Petitioner denied having any problems with his left shoulder or undergoing any left shoulder treatment before mid-January 2014. In mid-January 2014, he began experiencing left shoulder pain and fatigue, "mostly while plowing snow." T. 12.

Petitioner described the snowfall pattern in 2014 as different from the patterns he had experienced while operating a snowplow in the past. Beginning in early January 2014, and continuing thereafter, "it would snow three or four inches" and then clear up for two to three

days, only to have the snow reappear. Most of the snow fell overnight, which meant he had to work all night long to clear it away. Petitioner testified his shifts lasted 16 hours during this period. He was assigned to a parking structure that winter. The structure had four or five decks. T. 17. He had to work quickly to clear these decks of snow before the morning crew arrived. The parking spaces were metered and thus income-producing. T. 15. The lower, covered decks filled up quickly, leaving the overflow customers to park on the top deck, which was exposed to the weather. It was part of his job to keep the top deck plowed so that people who parked there would not slip or slide while making their way to the stairs or elevators. T. 14-16.

Petitioner testified he had to turn the steering wheel frequently, clockwise and counter-clockwise, while plowing the top deck because the deck was not large and he was required to pile accumulated snow in designated areas. He had to maneuver the snowplow around vehicles and parking meters. He could only use his left hand and arm to turn the wheel on the larger trucks because he had to use his right hand to operate the plow controls, which were mounted in the center of the truck. Since space was tight, he had to "turn the wheel a lot and sometimes very quickly to get the snow pushed in where it belong[ed]." The smaller trucks, including the pick-ups, had a control on a cord but he still had to use his right hand to move it. If he stretched his left arm over to move it, while also trying to steer, safety could become an issue because his fingers could "get caught up in that cord." T. 14.

Petitioner testified that, while operating a snowplow, he held his left arm straight in front of him, at shoulder height, so that he could "work the wheel in a full circle." T. 17.

Petitioner testified he continued performing his normal duties after his left shoulder became symptomatic in mid-January 2014. His symptoms worsened after each snow cycle. T. 13. By February 27, 2014, the symptoms had increased to the point that he could not finish his assigned duties. He began reporting his symptoms to his foreman, Stan Gudeman, in mid-January 2014. At that point, he told Gudeman his symptoms would improve after he rested. T. 18.

Petitioner testified that, after he finished his shift on February 27, 2014, he went to hang his keys on the upper row of the key box. Gudeman noticed he had difficulty "getting the keys up there." He told Gudeman his shoulder was "still hurting." Gudeman responded: "well, we need to take care of it." T. 11. Petitioner testified he completed and signed a First Report of Injury [PX 1] the following morning. T. 19, 20. Gudeman and a supervisor, Pete Varney, were present when he completed and signed this document. Petitioner testified that Gudeman had asked Varney to be present "because we were unsure of what [accident] date to put down." T. 20. Varney is currently Associate Director of Facilities and Services for Respondent. T. 20. It was at Varney's direction that he listed January 6th as the date of accident on the report. Varney told him "just put that [date] down because the snow really started getting heavy in early January" and "that's when you [Petitioner] actually started doing all the plowing." T. 20-21. Petitioner testified he also wrote down that he reported the injury to Respondent on February 27, 2014. T. 21.

PX 1 consists of two documents: a one-page First Report of Injury/Illness bearing Petitioner's signature and the date February 28, 2014 and a two-page First Report of Injury/Illness that appears to have been signed by Stan Gudeman on March 3, 2014. In the first document, Petitioner indicated he strained his left shoulder on January 6, 2014 "from plowing while driving with one hand" and reported this injury to his foreman on February 27, 2014. In the second document, Gudeman indicated Petitioner was injured on January 6, 2014 while plowing snow when he "turned steering wheel with 1 hand while raising plow with other hand." In response to a question asking "what object or substance directly harmed the employee?", Gudeman wrote "steering wheel pressure." He described the injury as a left shoulder strain/sprain. He identified "ergonomic factors" as a "contributing condition." In response to a question asking what control measures were going to be instituted to prevent recurrence, he wrote: "take time to stop and exercise arm" and "not doing repetitive motion for long times." Respondent raised no objection to RX 1. T. 6.

Petitioner testified it was on February 27, 2014 that it became apparent to him he had suffered a left shoulder injury due to plowing snow. T. 21.

Petitioner testified he saw Dr. Mandhan, his primary care physician, at Kirby Medical Group on March 18, 2014. T. 21-22. He did not seek treatment immediately after February 27, 2014 because he was waiting for a decision as to whether he should see an occupational medicine physician or his own doctor. The decision he received was "to see [his] own physician." T. 22. He explained to Dr. Mandhan how he injured his left shoulder. T. 22.

Records in PX 2 reflect that Dr. Mandhan recorded the following history on March 18, 2014:

> "50-year-old male in today for complaint of pain in the left shoulder for last 2-3 months. Denies any fall. This [has] been going on since January but getting worse now. Patient usually operates snow plower and works at the University. He had put in a lot of hours . . because of the cold weather and snow. He is right-handed. He is having difficulty with certain movements of the shoulder."

Dr. Mandhan noted tenderness and a limited range of abduction on left shoulder examination. He diagnosed shoulder tendinitis. He obtained left shoulder X-rays. The radiologist interpreted the films as showing "moderate degenerative change of the AC joint with joint space narrowing and prominent spurring." He prescribed Mobic and physical therapy. He directed Petitioner to return in four weeks. He indicated he might have to order an MRI at that time. PX 2.

Petitioner underwent an initial physical therapy evaluation at Kirby Medical Center on March 20, 2014. The evaluating therapist noted that Petitioner "began noticing L shoulder pain after driving a snow plow for extended hours this winter." She also noted that Petitioner

complained of pain when "reaching up for keys on hook at work." She noticed a decreased range of motion on left shoulder examination. PX 3.

Petitioner continued participating in physical therapy thereafter. A note dated April 3, 2014 reflects that Petitioner complained of significantly increased left shoulder pain after using the shoulder "a lot for work a few days ago." On April 17, 2014, the therapist noted that Petitioner was not tolerating range of motion well and had made "minimal progress." PX 3.

Petitioner testified that physical therapy did not help him. He was still experiencing pain and weakness. T. 23-24.

Petitioner returned to Dr. Mandhan on April 17, 2014 and complained of persistent left shoulder pain, rated 7/10. He informed the doctor that "therapy has not helped." On re-examination, the doctor noted a limited range of motion, especially in abduction above 90 degrees. The doctor reviewed the X-ray results. He prescribed an MRI and directed Petitioner to continue taking the prescribed medication and attending therapy. PX 2.

The left shoulder MRI, performed without contrast on April 22, 2014, demonstrated "no significant rotator cuff tears," "probable mild tendinosis versus a very small partial undersurface rim rent tear supraspinatus at its insertion with adjacent cystic change of the humerus," acromioclavicular degenerative changes, marginal spurring and subacromial subdeltoid bursitis. The radiologist indicated that lack of contrast limited his evaluation of the labrum but, allowing for this, he saw no gross labral tears or paralabral cysts. PX 3.

On April 29, 2014, Dr. Mandhan noted ongoing symptoms. He also noted that Petitioner denied any new injuries. He reviewed the MRI results with Petitioner and recommended an orthopedic consultation. PX 2.

Petitioner saw Dr. Sams, an orthopedic surgeon affiliated with Kirby Medical Group, on May 1, 2014. T. 25. The doctor noted a complaint of 6-7/10 left shoulder pain secondary to a work injury. He indicated that Petitioner reported working 12-16 hour shifts and "doing a lot of driving one-handed" while performing snow removal in January 2014. He also noted that Petitioner reported no relief from physical therapy. He interpreted the MRI images as showing AC joint osteoarthritis and "a possible small full-thickness tear of the rotator cuff of the anterior margin of the supraspinatus."

On initial left shoulder examination, Dr. Sams noted a "clearly painful range of motion with overhead motion," equivocal Neer's, positive Hawkins, 4/5 strength in the left supraspinatus, limited because of pain, and 5/5 left infraspinatus strength. He also noted tenderness to palpation over the acromion and AC joint.

Dr. Sams found Petitioner's examination consistent with impingement syndrome and rotator cuff tendinitis. In his view, Petitioner's shoulder was "so inflamed that he would be

unable to participate effectively with therapy." He offered and administered an injection. He directed Petitioner to return in two weeks, indicating he might require surgery. PX 2.

Petitioner continued attending therapy thereafter. On May 5, 2014, he reported significant improvement secondary to the injection. Three days later, he reported more soreness and indicated he had been "lifting a lot at work because they are short-handed." On May 12, 2014, he reported digging holes for three rose bushes the previous day and indicated his shoulder "didn't bother him too much." On May 15, 2014, the therapist noted that Petitioner had made "minimal progress" and "has not yet met PT goals."

On May 15, 2014, Petitioner returned to Dr. Sams. Petitioner reported improvement secondary to the injection but indicated that certain movements and positions were still painful. The doctor recommended four more weeks of therapy. PX 2.

A therapy note dated May 22, 2014 reflects that Petitioner had not experienced pain since the previous Monday and denied doing any heavy lifting at work. PX 3. Petitioner reported increased symptoms at the next two sessions. On June 2, 2014, the therapist noted that Petitioner's pain had increased to 4/10 due to using his left arm "quite a bit more at work on Friday."

On June 5, 2014, Petitioner returned to Dr. Sams and reported that the injection had "worn off to where he is back to his baseline." On left shoulder re-examination, the doctor noted positive Neer's and Hawkins, a full but painful range of motion, 4+/5 supraspinatus strength and 5/5 infraspinatus and subscapularis strength. He recommended a left shoulder arthroscopy with subacromial decompression, distal clavicle excision, possible rotator cuff repair and possible biceps tenotomy versus tenodesis. PX 2.

Dr. Sams operated on Petitioner's left shoulder at Decatur Memorial Hospital on June 16, 2014, performing an arthroscopy with arthroscopic rotator cuff repair, distal clavicle excision and subacromial decompression. PX 2, 3, 5. In his operative report, Dr. Sams documented a full-thickness supraspinatus tear. He described the labrum, infraspinatus, subscapularis and long head of the biceps tendon as intact. PX 5. He took Petitioner off work "until further notice" following the surgery. PX 4, 5.

At the first post-operative visit, on July 3, 2014, Dr. Sams described Petitioner as doing very well. He advised Petitioner to continue wearing a sling and start pendulum exercises in one week. PX 2.

On July 22, 2014, Dr. Sams noted that Petitioner reported minimal discomfort. He also noted that Petitioner recalled feeling pain after falling and catching himself with his left arm a few days earlier but indicated this pain "went away" and he was now experiencing only stiffness. The doctor recommended he wear the immobilizer for another week. He released Petitioner to work with no use of the left arm. PX 4.

Petitioner resumed therapy at Kirby Medical Center on July 25, 2014.

On September 4, 2014, Petitioner returned to Dr. Sams and reported some improvement following six weeks of therapy. The doctor noted that he "has continued range of motion and strength to gain." He recommended six more weeks of therapy. He noted that "it will take a full year for this shoulder to completely rehabilitate" but that Petitioner "will not likely be out of work for that year." PX 2.

On October 16, 2014, Dr. Sams noted that Petitioner was progressing but had "not yet gained enough strength to return to work." He recommended that Petitioner continue therapy and start work hardening. He noted that Petitioner "was denied work comp." PX 2.

Petitioner testified he did not transition to work hardening after seeing Dr. Sams on October 16, 2014 because he was "feeling much much better by then" and could not afford to pay a daily $25 co-payment while attending work hardening five days a week in Decatur. His bills were being put through his group insurance. T. 29-30.

Petitioner testified he returned to Dr. Sams on December 18, 2014. At that point he was "virtually pain free" but "still had a very small amount of weakness." The doctor continued his work restrictions.

On December 18, 2014, Dr. Sams noted that Petitioner did not pursue the physical therapy and work hardening he had recommended two months earlier because "he did not have approval from his insurance company and he could not afford to pay for it out of pocket." He noted that Petitioner was trying to do physical therapy at home and felt his range of motion was still improving. Petitioner's primary complaint was that he still lacked strength. On re-examination, the doctor noted forward flexion to 160 degrees, abduction to 140 degrees, 4+/5 supraspinatus strength and 5/5 infraspinatus strength. Dr. Sams indicated that Petitioner was "doing excellent" but was being "limited by his employer" in terms of returning to work since "he has to [meet] certain lifting requirements." He again recommended work hardening. He directed Petitioner to attend work hardening five days a week and return to him in six weeks. PX 2.

Petitioner testified he last saw Dr. Sams on February 5, 2015. As of that date he "felt great and was ready to go to work." The doctor was still recommending work hardening. Petitioner testified the doctor did not release him to work until February 16th or 17th. It was at his (Petitioner's) insistence that the doctor released him. He returned to full duty for Respondent and is still performing full duty. T. 31.

Dr. Sams' note of February 5, 2015 reflects that Petitioner "recovered very nicely" from the surgery "but has had issues with his employer as well as long term disability interfering with his work hardening." The doctor noted he had twice prescribed work hardening but Petitioner had not secured approval from either workers' compensation or Prudential, his long-term disability carrier. He also noted ongoing complaints of pain over the left acromioclavicular joint

and some "catching" in the left shoulder. On re-examination, he noted tenderness to palpation over the acromioclavicular joint and a "full range of motion with some evidence of pain." He again ordered six weeks of work hardening, indicated he failed to understand how he could rehabilitate Petitioner's shoulder "to get him back to the level of activity he will be required to do to return to his job" without this care. He directed Petitioner to return to him in eight weeks. PX 2.

Dr. Sams released Petitioner to unrestricted work as of February 19, 2015. [See last page of PX 4].

Petitioner denied sustaining any new left shoulder injuries after February 27, 2014. T. 32.

Petitioner testified he is able to work full duty but no longer has quite the same range of motion he had before. His left shoulder "seems to get tired faster" when he performs overhead work. T. 32. His ability to perform overhead tasks is limited. If he helps a friend hang drywall, he has to "keep dropping [his] arm down and letting it rest." T. 32. Before his injury, he used to be able to reach back to scratch his back. He cannot really do this with his left arm anymore. Overall, he is happy with the results of the surgery. T. 33.

Under cross-examination, Petitioner testified he is performing the same job he performed before the accident. He earns more money now than he did before the accident. When he plowed the parking decks, he drove a normal 4-wheel drive pick-up. T. 34. In terms of his duties, he performed more snow plowing than other tasks in the winter of 2014. T. 34. He did not experience a single traumatic accident where, for example, he turned and felt a pop in his shoulder. Instead, he developed left shoulder soreness as a result of constant activity. T. 34-35.

Respondent did not call any witnesses or offer any exhibits. T. 7, 35.

Arbitrator's Credibility Assessment

As noted at the outset, the arbitrator authoring this decision was not present at the hearing held on July 17, 2019 and thus did not have the opportunity to observe Petitioner. Petitioner's testimony concerning his duties, the snowplow operation, his work schedule and the mechanism of injury was detailed and consistent with his medical records. Petitioner's testimony concerning the complaints he voiced to his foreman and the directions he received while completing the First Report of Injury was credible. Petitioner essentially testified he followed the lead of a supervisor, Pete Varney, in identifying January 6, 2014 as the date of injury. Respondent did not call either the foreman or Varney to contradict any aspect of Petitioner's account.

Arbitrator's Conclusions of Law

Did Petitioner sustain injuries secondary to repetitive trauma manifesting on February 27, 2014? Did Petitioner provide Respondent with timely notice of said injuries? Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner sustained an injury to his left shoulder secondary to repetitive trauma manifesting on February 27, 2014. In so finding, the Arbitrator relies primarily on Petitioner's credible denial of any left shoulder problems or treatment before mid-January 2014 and his very detailed testimony concerning: 1) the recurrent snowfalls occurring between mid-January 2014 and February 27, 2014; 2) the 16-hour shifts he worked during this period; 3) his need to exclusively use his left hand and arm to steer the snow plow, secondary to ergonomic and safety factors; 4) the positioning of his left arm at shoulder height due to the need to frequently rotate the steering wheel in opposite directions while plowing snow in tight spaces, such as the top deck of his assigned parking structure; and 5) the transient relief that post-snowfall rest periods provided. No one affiliated with Respondent refuted any aspect of this testimony. In fact, in his First Report of Injury, to which Respondent did not object, Petitioner's supervisor, Stan Gudeman, corroborated Petitioner's account of his injury. Gudeman indicated that Petitioner was injured while plowing when he "turned steering wheel with 1 hand while raising plow with other hand." Gudeman went on to recommend a corrective measure of "not doing repetitive motion for long times." PX 1.

Petitioner did not offer any medical testimony on the issue of causation but the Appellate Court has noted that such testimony is not required to establish a compensable injury where the nature and effect of the work activities is within the common knowledge of laypeople. See, e.g., Westinghouse Electric Company v. Industrial Commission, 64 Ill.2d 244 (1976) and Nunn v. Industrial Commission, 157 Ill.App.3d 470 (1987). The one-handed steering and maneuvering in tight spaces that Petitioner described are certainly within a layperson's comprehension.

The Arbitrator further finds that February 27, 2014 is an appropriate manifestation date under Durand v. Industrial Commission, 224 Ill.2d 53 (2007). In that case, the Supreme Court cited Oscar Mayer v. Industrial Commission, 176 Ill.App.3d 607 (1988), for the proposition that "fairness and flexibility" are required in the setting of this date. In the instant case, it could be argued that Petitioner's injuries did not manifest until after February 27th since, as of that date, he had not yet seen a physician. Despite his symptoms, he continued working for several weeks after February 27th while awaiting a decision as to whether workers' compensation would cover his treatment.

The Arbitrator further finds that Petitioner provided Respondent with timely notice of his repetitive trauma injuries. Petitioner testified it was in mid-January 2014 that he first noticed left shoulder pain and weakness while plowing snow. T. 12. He also credibly testified he notified his foreman of his symptoms at that time but also told him the symptoms would lessen when he rested his arm between shifts. T. 18. He did everything possible to facilitate Respondent's investigation of his potential claim. It was on February 27, 2014 that his left shoulder was "hurting enough that [he] couldn't finish [his] job." T. 18. When his foreman

noticed he was having difficultly hanging his plow keys on an upper row of the key box, he told the foreman his shoulder was "still" hurting. T. 11. It was at this point that the foreman decided to complete a written accident report. Petitioner pushed through pain for weeks, in a manner that the Appellate Court has determined should not be held against him:

> "An employee who continues to work on a regular basis despite his own progressive ill-being should not be punished merely for trying to perform his duties without complaint. On the other hand, it is not this State's policy to encourage disabled workers to silently push themselves to the point of medical collapse before giving the employer notice of an injury."

Three "D" Discount Store v. Industrial Commission, 198 Ill.App.3d 43, 49 (1989). Petitioner also credibly testified it was at the direction of his supervisor, Pete Varney, that he identified January 6th as the date of accident. Varney fixed on January 6th because it was at this point that the cycles of heavy snowfall began. Even if this date could be said to be the appropriate manifestation date, Petitioner told his foreman about his symptoms in mid-January, well within the 45-day notice period.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims unpaid expenses from three medical providers: Kirby Medical Center, Kirby Medical Center Physicians' Billing and Decatur Hospital. PX 6. The Arbitrator has already found in Petitioner's favor on the issues of accident/repetitive trauma and causal connection. The Arbitrator notes that Respondent did not offer any utilization review evidence or any other opinion as to the reasonableness and necessity of Petitioner's care.

The Arbitrator, having reviewed the bills in PX 6 and correlating records, awards the claimed medical expenses other than the expenses relating to Petitioner's Kirby Medical Group office visit of August 28, 2014, subject to the fee schedule. Records in PX 2 reflect that Petitioner saw Dr. Mandhan on August 28, 2014 for a service (ear wax removal) unrelated to his work injury. The Arbitrator views the treatment underlying the awarded expenses as reasonable, necessary and causally related to Petitioner's left shoulder condition. Petitioner testified he derived some benefit from the pre-operative injection. He also testified he improved following the surgery and post-operative therapy. T. 29-31.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was disabled from June 16, 2014 (the date of the left shoulder surgery) through February 18, 2015 (the day Dr. Sams released him to full duty). Respondent disputes this claim based on its defenses as to accident, notice and causation. The Arbitrator has already found in Petitioner's favor on these issues. The medical records reflect that, as of Petitioner's last visit to his surgeon, Dr. Sams, on February 5, 2015, the doctor was still recommending six weeks of work hardening. The doctor expressed frustration that Petitioner

had not yet been able to participate in work hardening based on insurance denials. Petitioner credibly testified the doctor subsequently released him to full duty at his request. A work status note in PX 4 reflects that Dr. Sams released Petitioner to full duty as of February 19, 2015.

The Arbitrator finds that Petitioner was temporarily totally disabled from June 16, 2014 through February 18, 2015, a period of 35 3/7 weeks.

What is the nature and extent of the injury?

This case is post-amendatory, since Petitioner's repetitive trauma injuries manifested after September 1, 2011. Accordingly, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. That section sets forth five factors to be considered in determining the nature and extent of an injury, with no single factor predominating. The Arbitrator assigns no weight to the first factor, any AMA Guides impairment rating, since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's age as of the manifestation date and occupation. Petitioner was a 50-year old driver as of the manifestation date. The Arbitrator views him as a middle-aged individual who might reasonably be expected to remain in the workforce another ten to fifteen years. He credibly testified he routinely operates a snowplow during the winter months. He also credibly testified he exclusively uses his left hand and arm to steer while plowing snow because he must use his right hand to operate the centrally mounted plow controls. The left shoulder pain and "catching" he complained of at his last visit to Dr. Sams could affect his ability to steer a plow or perform overhead tasks as he continues working. The Arbitrator also gives some weight to the fourth factor, earning capacity. Petitioner resumed full duty in February 2015 and was still working as a driver as of the hearing. Under cross-examination, he conceded he now earns more than he did before he was injured. T. 34. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator notes the results of the left shoulder MRI, Dr. Sams' operative findings and the examination findings of February 5, 2015.

Having considered the foregoing, along with Petitioner's credible testimony concerning his ongoing symptoms, the Arbitrator finds that Petitioner established permanency equivalent to 12.5% loss of use of the person as a whole, representing 62.5 weeks of benefits under Section 8(d)2 of the Act.